NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Annual Report and Accounts 2016/17

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Contents

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Statement from the Chair

“I was delighted to be appointed as Chair of Sherwood Forest Hospitals, starting in March 2017. Although I joined the Trust towards the end of the financial year, the extent to which the organisation has transformed over the past twelve months, and continues to transform, has been very evident to me. There is obvious energy and enthusiasm amongst staff, which is clearly driven by a desire to deliver sustainable improvements, so enabling us to provide the best care possible to our patients.

The Trust remains committed to working in partnership with health and care organisations across the system to improve services across Nottinghamshire and beyond. We play a key role in local partnerships, which support the transformation of healthcare services and performance across the wider health and care system. These include the Nottinghamshire Sustainability and Transformation Plan, the mid-Nottinghamshire Better Together Alliance, and our strategic partnership with Nottingham University Hospitals. Through these partnerships we must continue to focus on delivering sustainable and affordable quality healthcare for the future.

Significant progress has also been made in engaging with our local communities, Trust members, key groups and individuals. We now have in place an ongoing programme of activities to make sure that we seek out feedback about our organisation and our services, as well as keeping people in the loop about latest news and developments. I have a personal interest in both this agenda and our essential work with partners and, as Chair, will ensure that we continue to build on the momentum achieved to date.

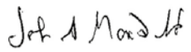
Supported by dedicated staff and a leadership team at divisional and corporate levels, Peter Herring, Chief Executive, has successfully developed and implemented a remarkable programme of transformation over the past year. I would like to thank Peter for his expert leadership, which has seen the Trust moving from being among the worst performing in certain areas, to becoming an exemplar in a number of areas including reducing mortality, sepsis management and emergency care.

I would also like to thank our partners, governors – in particular our lead governor, Sue Holmes, and formerly Colin Barnard - and local people for their ongoing support, dedication and commitment to our hospitals and the improvement work underway. Their support has made a tremendous difference to us, not least in helping to provide different perspectives and feedback to support improvement, as well as maintaining staff morale during what has been a very challenging period in our history.

Lastly, I would like to thank my predecessors during the year - Peter Marks, Louise Scull, and Sean Lyons – for their expert chairmanship, which has seen the organisation make excellent progress during a year of unprecedented change and transformation.

The new financial year will see us build upon the excellent work undertaken as we move even further towards our vision of becoming an outstanding organisation. Early on in the year we will establish a fully substantive Board leadership team. I very much look forward to welcoming our new Chief Executive, Richard Mitchell. It is a credit to Peter Herring, the leadership team and all our staff, that Peter will be handing over the reins of what is now a consistently well-performing organisation facing a positive future. There is still much to do, but the progress made to date will stand us in good stead, and as Chair I am committed to ensuring that we continue to drive forward - at the same pace - the improvement agenda already underway.”

John McDonald
Chair



We play a key role in local partnerships, which support the transformation of healthcare services and performance across the wider health and care system

Statement from the Chief Executive

“We are very proud of the work undertaken by staff and volunteers to deliver what was an extremely ambitious plan to turn around quality.”

“It has been a truly momentous year for the Trust, having delivered a major turnaround in quality and performance, and so proving our ability to operate as a well-performing organisation.

Not only have we successfully moved out of special measures, but our organisation is now an exemplar in a number of key areas where, as little as a year ago, we were among the lowest performing Trusts in the country. A positive Care Quality Commission (CQC) inspection saw us rated as ‘Good’ for Safety and ‘Good’ for Caring, and improved our overall rating to ‘requires improvement’. We are confident that we will improve significantly further on this position by the time of our next inspection.

We are one of the few Trusts in the country that has delivered consistently well against the emergency four-hour waiting standard. Our management of sepsis is considered best practice and has been commended by the CQC. Our mortality rates are among the lowest in the country, and we are now meeting, month on month, the vast majority of our NHS Constitution performance standards and targets, with those missed only by narrow margins.

We also achieved our financial control total last year, in fact performing slightly better than the plan.

This position marks a stepped improvement since the same time a year ago, and we are very proud of the work undertaken by staff and volunteers to deliver what was an extremely ambitious plan to turn around quality. We have also been much assured and heartened by the results of the recent staff survey, which demonstrates significantly higher levels of staff satisfaction and which puts us above the national average in many areas; in fact, every measure demonstrated some degree of improvement. Again, this is an absolute contrast to how staff were feeling last year, and reflects our focus on developing a positive, supportive culture at the same time as improving quality and performance.

We have placed great importance this year on stabilising the organisation and our leadership team, particularly following the decision not to pursue a merger with Nottingham University Hospitals. The Trust has endured significant transience for several years, which has been unsettling for everyone and has impacted heavily on quality, performance and staff morale. We have now successfully established a permanent executive team and a new Chair, with most leadership appointments at divisional level now complete.

This stability has already made a positive difference and will stand us in good stead as we build on the achievements made to date.

We have encouraged staff and volunteers to reflect positively on the past year’s events, and we have taken a number of opportunities to celebrate what we have achieved together. However, we are also clear that we cannot stand still or allow things to slip, and we are committed to delivering further improvements at a similar pace. We have therefore established a new vision to become an outstanding Trust as rated by our patients, staff, partners and local communities. This vision is underpinned by a set of strategic priorities, which encapsulate the key areas where we need to make the greatest difference. We are in the throes of preparing to launch our new vision, priorities and a supporting quality programme for the year ahead, and many staff have already expressed their dedication to this exciting new agenda.

As we move into the new year, we are looking forward to seeing our reputation develop and strengthen as public confidence in our services continues to grow. We are also seeking to strengthen relationships with our partners and others, and play a leading role in the transformation of services across the local health and care community.

It is important to end by noting that this year’s successes and achievements are down to the tremendous work of our staff and volunteers, as well as the support we have received from our various partners across health and social care. I would also like to acknowledge the strategic partnership with Nottingham University Hospitals, which has helped us to align and strengthen clinical services in a number of areas. My thanks also go to governors, patients, local people and groups who have continued throughout to support our work here at Sherwood Forest Hospitals.”

Not only have we moved out of special measures, but our organisation is now an exemplar in a number of key areas

Peter Herring
Chief Executive

Our Trust has made significant progress in our performance over the past year, having successfully moved out of special measures in November 2016 following the effective delivery of our major quality improvement programme

Performance Report

The following section provides a summary of our organisation, its history and purpose, the key risks affecting our ability to achieve our objectives, and our performance over the last year.

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.

Our Trust has made significant progress in our performance over the past year, having successfully moved out of special measures in November 2016 following the effective delivery of our major quality improvement programme. These improvements were recognised by the Care Quality Commission (CQC) in their July 2016 inspection, after which the Trust's overall rating improved from 'Inadequate' to 'Requires Improvement' and we were rated as 'Good' for Safety and 'Good' for Caring. In contrast to three years ago, we are now among the best performing Trusts in the country for a number of key areas, including mortality rates, the management of sepsis, and achievement of the four-hour wait emergency standard.

During the first half of the year we had been planning for a proposed merger with neighbouring Trust, Nottingham University Hospitals. This was part of a programme to achieve organisational stability and sustainable quality of services for Sherwood Forest Hospitals in the long-term.

However, the substantial progress made over the past year proved our ability to deliver the turnaround in quality required as a successful, standalone organisation. Both organisations agreed to cease plans for a merger in October 2016 and instead focus our efforts on developing a strategic partnership.

To ensure a stable, sustainable and high performing Board fit for the future, we actively recruited to a number of permanent senior appointments following the decision not to pursue a merger. In February 2017, the governors appointed John MacDonald as Chair of the Trust, and in March 2017 Richard Mitchell was appointed as Chief Executive.

Our Purpose

Whilst our staff, patients, local people and others have celebrated the positive developments achieved during the past year, we recognise that we have more to accomplish. We have developed a new and exciting vision to deliver outstanding healthcare across the Trust, and have agreed strategic priorities to support delivery of this aim. We remain committed to our long-standing 'CARE' values, which are now well-embedded within the organisation:

Our Vision	Dedicated people delivering outstanding healthcare for our patients and communities.
Our Strategic Priorities	1. To provide outstanding care to our patients 2. To support each other to do a great job 3. To inspire excellence 4. To get the most from our resources 5. To play a leading role in transforming local health and care services
Our Values	• Communicating and Working Together • Aspiring and Improving • Respectful and Caring • Efficient and Safe

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 433,000 outpatient appointments, more than 104,000 people attended our Emergency Department at King's Mill Hospital, 22,000 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 efficiency 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 a number of partnerships, including the Nottinghamshire Sustainability and Transformational Plan (STP) and the mid-Nottinghamshire Better Together programme.

We also continue to work closely with our neighbouring Trust, Nottingham University Hospitals, as part of an on-going, formal strategic partnership. Our partnership activities and contribution towards sustainability are discussed later within this report.

Risks to delivery of objectives

Our new vision clearly expresses our dedication to delivering consistently outstanding healthcare across all our hospitals and services. We are expecting to meet all nationally mandated standards as set out within the NHS Constitution within the next two years and have already made excellent progress. However, as for other NHS Trusts across the country, a number of areas will remain challenging as a result of increasing demand and continuing pressures, which are affecting both health and social care services; these include continuing to meet the four-hour emergency care standard, for which we have remained among the best performing NHS Trusts in the country over the past year despite these pressures. Our focus remains on improving the flow of patients through our hospitals, as well as on enhancing arrangements with partners for the timely discharge of patients when they are ready to leave hospital.

We continue to work with other health and care organisations through the Sustainability and Transformation Plan (STP) and Better Together to strengthen preventative services, self-care, primary care, and community-based health and social care services. Existing Better Together initiatives have already contributed to a safe reduction in the length of time patients spend in our hospitals, meaning that more people can regain their independence more quickly. We continue to develop these and other schemes to ensure that our hospitals and our partners are operating as efficiently and effectively as possible across local health and care services.

To build on our successes to date and support our journey towards becoming outstanding, the Trust has developed a new 'Advancing Quality Programme'. This follows on from last year's quality improvement plan, and targets areas that will have the greatest positive impact on the quality of care we provide. Areas of focus include improving the management of patients with mental health needs and learning disabilities, ensuring the appropriate and safe management of medicines, and improving the support given to patients nearing the end of their lives.

Performance Anaylsis

Throughout 2016/17 Sherwood Forest Hospitals has improved or sustained our performance against most operational standards. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT), and the target we must achieve is set at 92% of all patients treated as a minimum. We have successfully achieved this target for the last two years, as shown in the table below.

Referral to Treatment	2015/16	2016/17
Q1	92.0%	92.6%
Q2	92.3%	92.3%
Q3	92.0%	92.1%
Q4	93.8%	92.8%

To enable the continued achievement of this standard, our newly established 18-week delivery group meets weekly to review the latest information. Attended by representatives from all clinical divisions, and supported by the corporate function and information services, this group identifies the appropriate actions needed to ensure sustained performance.

Throughout 2016/17 Sherwood Forest Hospitals has improved or sustained our performance against most operational standards

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.

As can be seen in the table below, we achieved this target in the final quarter of 2016/17 and overall improvement has been realised during the past year. However, on-going capacity issues within our endoscopy service have affected our ability to meet demand, so limiting the sustainable improvements required.

As a result we have narrowly missed the DM01 target overall and continue to face difficulties in meeting this standard. We have a programme of work underway to create additional capacity within endoscopy with the aim of meeting this target consistently from around Autumn 2017. We also intend to introduce digital technologies over the next year, which will help us to optimise service delivery.

DM01	2015/16	2016/17
Q1	95.5%	98.8%
Q2	96.1%	96.0%
Q3	98.2%	98.0%
Q4	98.7%	99.4%

Cancer standards

By the end of the year, we had successfully met 7 of the 9 required standards relating to cancer, with the remaining targets (62 day wait target from urgent referral to treatment, and the 62 day wait target from screening to first treatment) being missed marginally as a result of patients choosing to defer their treatment. Our overall performance against each target is shown in the table below.

	Target	2015/16	2016/17
2 week wait all cancers	93%	95.20%	95.9%
2 week wait breast symptomatic	93%	95.20%	96.6%
31 day wait from diagnosis to 1st treatment	96%	98.30%	97.8%
31 day wait for subsequent treatment - surgery	94%	99.00%	100.0%
31 day wait for subsequent treatment - drugs	98%	99.70%	98.9%
62 day wait urgent referral to treatment	85%	84.00%	83.6%
62 day wait for first treatment from screening	90%	96.40%	89.2%

We successfully met 7 of the 9 cancer standards with the remaining two missed by a narrow margin

Stroke

The stroke service at King's Mill Hospital is one of only two Trusts in the East Midlands to have successfully achieved the highest possible 'A' rating from the Sentinel Stroke National Audit Programme (SSNAP). 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 ten 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.

	Sentinel Stroke National Audit Programme
October – December 2015	Level A
January – March 2016	Level B
April – July 2016	Level B
August – November 2016	Level A

Our stroke team has worked tirelessly over the past year to regain the top level A rating, following a slight dip to a level B service from January to July 2016. We remain committed to the continuous improvement of our stroke service, including the education of healthcare organisations within the hospital environment and community to ensure that patients receive timely, quality treatment, which is undertaken in the best place. We expect our assessment for the period December 2016 to March 2017 to reflect the improvements made.

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.

At Sherwood Forest Hospitals, performance in this area is formally monitored and evaluated 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 clinical and operational teams, as well as by various groups such as the divisional management board and those attending service, performance review or breach meetings. Teams have used 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.

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

Emergency Department (ED) 4-hour performance

Overall, the Trust achieved performance of 94.48% against the 95% 4-hour emergency standard in 2016/17. Although narrowly missing the target, this is a notable improvement compared with the previous year, and also places Sherwood Forest Hospitals as one of the consistently top performing organisations in England with regard to this target. Great focus has been placed on achieving this standard, which is a measure of both Trust and system-wide performance. A successful action plan was delivered to ensure achievement of the 95% standard during quarters 2 and 3, following a challenging start to the year.

ED 4-Hour Performance	2015/16	2016/17
Q1	96.01%	93.74%
Q2	95.91%	95.16%
Q3	94.77%	95.10%
Q4	91.17%	93.88%
Total for year	**94.43%**	**94.48%**

A successful action plan was delivered to ensure achievement of the 95% standard during quarters 2 and 3

Accident and emergency attendances

2016/17 saw a 1.84% increase in attendances across all sites at Sherwood Forest Hospitals. This includes the PC24 Primary Care Service, which works in conjunction with the King's Mill Hospital Emergency Department to enable us to provide a 'single front door'. Quarters 2 and 3 saw a consecutive increase of 5% in activity compared with the previous year.

Number of Accident & Emergency Attendances (PC24, KMH Emergency Department and Urgent Care Centre, Newark Hospital)	2015/16	2016/17
Q1	36,772	37,487
Q2	36,079	37,865
Q3	35,580	37,325
Q4	37,906	36,353
Total for year	**146,337**	**149,030**

Ambulance arrivals

The number of patients arriving via ambulance has increased by 6.78% 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. The majority of handovers are made within 15 minutes. Any delays resulting in them taking longer than 60 minutes are reported to our local commissioners.

We are now among the best performing Trusts in the region for ambulance handover times. We attribute this to the work undertaken in partnership with the local ambulance Trust as well as our enduring focus on ensuring an efficient process once at hospital. 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. Performance is also reviewed retrospectively by the ED team and by nursing staff.

Number of ambulances bringing patients to hospital in an emergency	2015/16	2016/17	Increase
Q1	7,559	8,123	7.46%
Q2	7,615	8,253	8.38%
Q3	8,015	8,661	8.06%
Q4	8,327	8,617	3.48%
Total for year	**31,516**	**33,654**	**6.78%**

Emergency admissions from the Emergency Department

Emergency admissions have increased by more than 10% this year, reflecting an increase in acuity and the average age of patients attending the department. This figure includes admission to the Ambulatory Care Unit, a service we have developed over the past year in accordance with best practice. Not only has the unit resulted in better quality of care for the patient, but this initiative has also helped improve performance against the target because patients are not admitted to an inpatient bed.

The Trust has developed a suite of performance indicators to help improve our understanding about the admissions data available. One such example is the information relating to admissions over a given week or month alongside the relative length of stay for each patient. This extra depth of understanding has enabled us to make key interventions in a more targeted way.

Emergency Admissions from the Emergency Department	2015/16	2016/17	Increase
Q1	6,876	7,790	13.29%
Q2	7,013	7,817	11.46%
Q3	7,506	8,538	13.75%
Q4	7,830	8,240	5.24%
Total for year	**29,225**	**32,385**	**10.81%**

Patient flow

Having an effective flow of patients through our hospitals, including the safe and timely discharge of patients, results in 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 urgent and emergency care division, the wider Trust, and by local health and care partners to improve performance across the local healthcare system as a whole. Within our own organisation, we have developed and delivered an accident and emergency improvement plan. This has addressed the root causes of performance challenges by, for example, aligning capacity to meet demand, altering rotas, and improving processes generally.

We are now working on supporting the 'Broadening of Accident and Emergency Oversight', a national plan introduced by our regulator, NHS Improvement. This involves making improvements to pathways for the sickest patients, the management of high volume service users, and to working arrangements during unsociable hours and weekends. These initiatives are leading to further improvements in our performance, with key actions including:

- Implementation of a new approach to the medical rota within ED, which has resulted in better alignment of demand and capacity
- Implementation of 'Ambscoring' enabling rapid recognition of those patients who can be seen and treated within the Ambulatory Care Pathway
- Introduction of an acute ambulatory in-reach service to treat those patients identified as outpatients, rather than admitting them unnecessarily. Together with Ambscoring, this initiative is supporting the avoidance of unnecessary admissions as well as improving patient flow. There is a target to see 1 in 4 medical patients within our Ambulatory Care service
- Reviewing patients whose length of stay exceeds ten days, as well as focusing efforts on the care of patients who have been in hospital for longer than 28 days. Our work in this area has resulted over the past year in a decrease in the average length of stay from 5.8 days to 4.8 days
- Implementation of the Respiratory Assessment Unit and ongoing improvements
- Roll out of the national initiative of 'red and green bed days', which is a visual management system to help identify wasted time in a patient's journey

Financial Analysis

We successfully achieved a better position than our planned control total, and are reporting a deficit of £49.1m for the year ending 31 March 2017. This figure is before the reversal of impairments, which reflects the revaluation of our assets to the current market value.

The total sum includes £12.6m of spend incurred as a result of joint work undertaken with Nottingham University Hospital to prepare for a proposed merger, encompassing critical work to successfully align and improve key clinical services. Our underlying performance relating to our usual business therefore amounts to a deficit of £36.4m, which is £4.8m better than the deficit position we had planned and agreed at the start of the year with our regulator, NHS Improvement (£41.2m).

During the year we received £15.0m 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, cancer and referral to treatment (RTT) waiting times. Available initially was a maximum of £10.3m, of which we received £10.1m. A further £4.9m 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 £14.3m of savings in total, which is £1.7m above the annual savings target of £12.6m. Among the key improvements realised are reductions in the number of patients not attending appointments, fewer outpatient appointments cancelled, improvements in the length of patient stays in hospital, achieving better prices for our supplies, and more effective staff rosters.

Plans are in place to continue to build on this good work and deliver further savings in 2017/18.

During the year we actively prepared for the proposed merger with Nottingham University Hospitals. We forecast that the cost of this programme would amount to £15.9m, and our financial plan for the year was adjusted by NHS Improvement to reflect this additional sum. The actual cost incurred was £12.6m in total, of which £1.4m enabled us to cover critical vacancies on an interim basis where it was inappropriate to recruit permanently owing to the merger, for example, senior manager and Board positions. The remaining £11.2m was transferred to Nottingham University Hospitals to cover costs incurred by them on behalf of both organisations, including improvement work undertaken to strengthen and align clinical services. NHS Improvement approved all costs before they were incurred.

NHS Improvement has set our 2017/18 control total to be a maximum deficit of £37.6m 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 delivery of the Better Together programme in mid-Nottinghamshire, which includes transformation schemes developed for implementation across all commissioners and providers, and which will contribute significantly to cost reductions within our hospitals.

We have successfully delivered a number of transformational initiatives that have improved patient care as well as reducing our costs

Income and expenditure

The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.

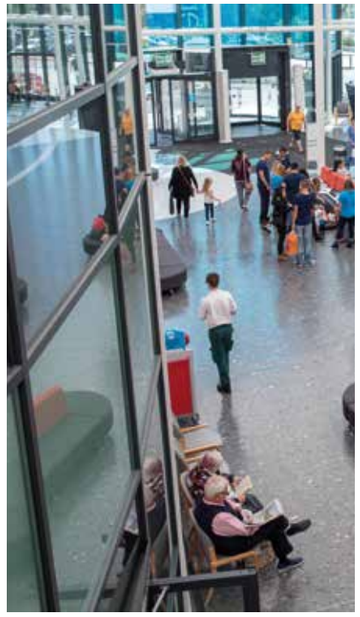
Operating income

Total operating income, excluding reversal of impairments for the year, was £295.6m which represented an increase of 11.2% from the previous year (£264.1m). Income received from patient care activities was £238.4m (£226.5m in 2015/16). Non-clinical income received contributes directly to the provision of healthcare services as well as the operating costs of the Trust. We can confirm that income from the provision of goods and services for the purposes of healthcare is greater than income from other services.

Operating expenses

Our total operating expenses (excluding impairments and depreciation) rose during the year to £314.8m from £291.2m in 2015/16, an increase of 8.1%. Of this £23.6m increase, £10.1m related to increased staff costs of which £6.0m represented an increase in agency spend required to cover the high numbers of vacant posts, most of which were clinical. Costs of £12.6m were incurred to support the proposed merger as described above. Other notable increases resulted from the growing number of patients seen and treated, inflation relating to pay and non-pay, and specific projects undertaken by our informatics service, although this particular expense was offset by related income.

More than half of our operating expenses - £196.1m (62.3%) - was spent on staff costs. A total of £48.1m (15.5%) of our expenditure (excluding depreciation and impairments) paid for prescription drugs, clinical supplies and services. The remaining £70.0m (22.1%) was spent on items relating to the PFI and mandatory contributions to the Clinical Negligence Scheme for Trusts. £12.6m was spent pursuing merger with NUH, of which £11.2m was transferred to NUH for the costs they incurred. All costs were agreed with the regulator, NHS Improvement and paid only when specific cash flows were received for these costs.



Fixed assets

During 2016/17 we invested £9.0m in our fixed asset infrastructure, which compares with £7.4m the previous year. This comprised £2.5m invested in buildings and the estate, £3.1m in equipment, and £3.4m in IT infrastructure. Of this expenditure, £5.3m was sourced from the Department of Health as a repayable loan.

Charitable funds

The Trust recognised £0.1m (£0.5m in 2015/16) 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 - the same value as in 2015/16 - to enhance the welfare of patients and staff, and support the Trust's activities.

Included in these figures are the generous donations received from the local community, voluntary services and local leagues of friends.

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. This continues to have a significant adverse impact on the balance sheet, because the associated financing arrangements and asset values are relatively low in comparison. The long-term borrowings on the balance sheet associated with PFI have reduced slightly to £327.6m (£333.6m in 2015/16) but the scale of this liability is a primary reason, along with the increasing income and expenditure deficit reserve, that the total taxpayers' equity amounts to a negative £234.3m. Payments of £44.0m were made in year relating to the PFI, of which £38.0m was recognised in income and expenditure.

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 net borrowings, supported by revenue term loans, were agreed and drawn. These amounted to £61.27m. As mentioned above, a capital loan of £5.3m was also agreed and drawn to support investment in fixed assets.

The capital loan is repayable in equal instalments up until February 2021 at an interest rate of 1.79% per annum. The revenue term loans are repayable in one instalment in 2020 at an interest rate payable of 1.5% per annum.

Principal risks and uncertainties

The Trust continued to strengthen its 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 Trust, 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 £35.8m in 2017/18. However, we face a number of risks in doing so, as follows:

- Our CIP target is £16.3m, which represents a total of 5.3% 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
- Our commissioners are planning for levels of activity in total to remain the same as in 2016/17, having identified schemes to mitigate the forecast growth in demand. There is a risk that any growth, particularly in emergency activity, will cost us more to deliver than the income we will receive
- We have a plan to reduce agency spend down to £22.2m in 2017/18. This requires a significant drive to recruit permanently to medical and nursing posts as well as working to engage temporary staff within the capped rates set by NHS Improvement. This challenge is the most significant with respect to our medical workforce
- Our plan includes the receipt of £8.8m 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

Going concern

In preparing the annual accounts, we are required to assess the basis of their preparation, specifically questioning the status of the Trust as a sustainable trading entity. This assessment takes into consideration all available information relating to the future prospects of the Trust, 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 Trust's business activities as well as the principal risks and uncertainties. Although access to cash support has not yet been finalised, the Trust has agreed to the deficit control total set by NHS Improvement. On this basis, the Board is satisfied that the Trust 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 Trust 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. More detail has been provided within Note 1 of the accounts.

Sustainability Report

Our obligations: ‘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.

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, and the frequency of such events is 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 Trust and our operations.

Policies

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

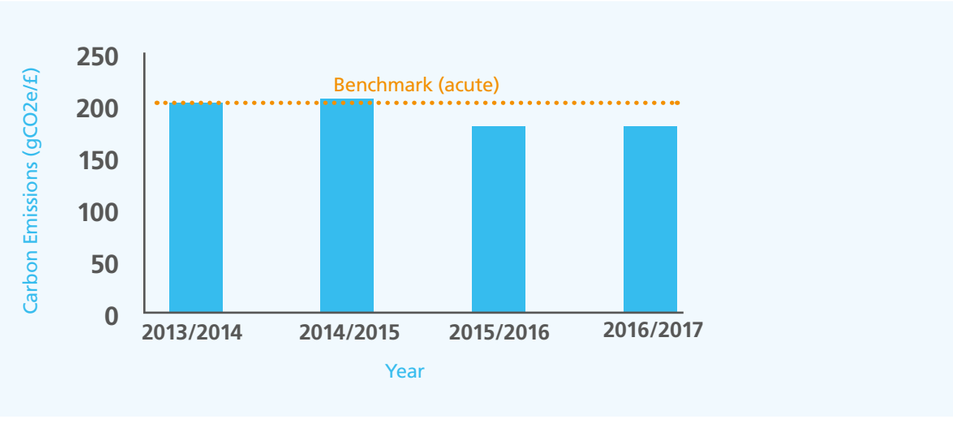
Area	Is sustainability considered?
Travel	Yes
Business Cases	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

Reducing our carbon footprint

We estimate our total carbon footprint to be 60,022 tonnes of carbon dioxide equivalent emissions (CO_2e) per year. This equates to 180 grams CO_2e for every pound spent on operating expenditure. The average emissions for an acute hospital Trust is 200 grams per pound, which means that we are performing above average.

This year we registered with the Carbon Saver Standards & Accreditation organisation and were delighted to be awarded the Gold Carbon Saver Standard. This is the highest accreditation possible and reflects our performance in relation to energy and waste over the past three years.

Organisation Carbon Footprint by Operating Expenditure ($gCO_2e/£$)



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.

Energy and carbon emissions

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 2016/17 is 21,706 tonnes of equivalent carbon emissions, which is 9.45% lower than 2015/16, and 11.5% lower than the baseline year of 2013/14.

Our total spend on fuel over the past year amounted to £3.15m, a 16.9% decrease when compared with the previous year. We have effectively reduced our annual energy costs for each fuel used thanks to our dynamic energy procurement strategy.

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

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

Our reducing energy carbon footprint has been influenced by a number of factors. Carbon emissions from gas consumption have decreased year-on-year since 2013/14, amounting to a 12% decrease in total. This is in part due to a 1.1% carbon factor reduction in 2014/15, but also reflects a year-on-year reduction in our gas consumption. Further investigation is required to understand if this reduction is weather related, or if it results from deliberate measures taken to reduce our use of energy. Our carbon emissions relating to use of electricity also decreased by 9.8% from the baseline year.

We are 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.

An extension is also planned to the geothermal system within the King's Mill reservoir. 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. Trials are underway relating to LED lighting and improved controls.

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. 2016/17 represents a slight increase above normal owing to the additional numbers of staff employed during this year on a temporary basis.

Category	Mode	2013/14	2014/15	2015/16	2016/17
Staff commute	Miles	3,121,633	3,266,100	3,266,100	3,621,528
	tCO_2e	1,153.36	1,200.06	1,181.14	1,308.86

We are in the process of installing electric vehicle charging points at the King's Mill hospital site to reduce our environmental impact even further.

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 to ensure that staff and hospital users are disposing of waste in the most appropriate way.

Waste recycled		2013/14	2014/15	2015/16	2016/17
Recycling	(Tonnes)	140.00	149.56	321.16	323.00
	tCO_2e	2.94	3.14	6.42	6.78

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:

- More than 180 tonnes of cardboard has been baled and sold
- 75 tonnes of confidential waste has been segregated for recycling
- 40 tonnes of furniture has been re-purposed and re-used
- 180 tonnes of dry mixed waste has been recycled
- The cost of clinical waste disposal has been cut
- Related training has been completed by more than 3,600 key staff members

Finite resource use – water

Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	129,275	145,608	137,442	155,423
	tCO_2e	118	133	125	141
Water and Sewage Spend		£334,597	£290,419	£312,508	£431,420

Water consumption rose significantly in 2016/17 and, 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 are presently undertaking a full review of the Trust's use of water. This will include installing additional water meters to assist in the identification of excessive use or leaks. We have also explored the possibility of using a borehole to complement our water supply, but it was determined that the yield from the aquifer[2] would be insufficient.

[2]An aquifer is an underground layer of water-bearing permeable rock, rock fractures or unconsolidated materials (gravel, sand, or silt) from which groundwater can be extracted using a water well.

Social, Community and Human Rights

We are committed to treating all our service users and staff 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.

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.

Directors' Report

The Board of Directors is responsible for the management and performance of the Trust and also for setting the future strategy.

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 and performance.

During the year the Trust has been re-inspected by the Care Quality Commission (CQC) and the overall rating has been improved from 'Inadequate' to 'Requires Improvement', and NHS Improvement lifted the Trust out of special measures in November 2016.

The primary responsibility of the Board of Directors is to promote the long-term success of the Trust by creating and delivering high quality services within the funding streams available. The Board seeks to achieve this through setting strategy, monitoring strategic priorities and providing oversight of implementation by the management team. In establishing and monitoring its strategy, the 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: Sean Lyons (Chairman), Louise Scull (Chair), Peter Marks (Acting Chair and Vice Chair), John MacDonald (Chair) Tim Reddish (Senior Independent Director), Ray Dawson, Claire Ward, Neal Gossage, Ruby Beech and Graham Ward, all Non-Executive Directors.

Peter Herring (Chief Executive and Managing Director), Peter Homa (Chief Executive), Dr Andrew Haynes, Suzanne Banks, Barbara Beal, Mandie Sunderland, Paul Robinson, Julie Bacon, Jon Scott, Roz Howie, Peter Wozencroft, Paul Moore, Shirley Clarke (Company Secretary), and Jo Yeaman. Full biographies of our directors and non-executive directors, together with their terms of office can be found on our website.

The balance, completeness and appropriateness of 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 Trust. 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 newly recruited Chair (John MacDonald) declared to the Governor Nomination and Remuneration Committee prior to appointment a significant commitment as Chair of University Hospital North Midlands NHS Trust. Louise Scull, who served as Chair whilst the Trust was pursuing a merger with Nottingham University Hospitals NHS Trust (NUH), declared a significant commitment as Chair of NUH. Sean Lyons, who served as Chairman until 10 June 2016, had no other significant commitments during the year.

Attendance at Board Meetings

	Public		Private	
Name	Actual	Possible	Actual	Possible
Sean Lyons	2	2	2	2
Louise Scull	3	4	3	4
Peter Marks	10	11	10	11
John MacDonald	0	1	0	1
Peter Herring	12	12	12	12
Peter Homa	4	4	4	4
Suzanne Banks	6	6	6	6
Barbara Beal	2	3	2	3
Mandie Sunderland	1	2	1	2
Paul Robinson	12	12	12	12
Dr Andrew Haynes	10	12	10	12
Peter Wozencroft	11	12	11	12
Paul Moore	3	3	3	3
Julie Bacon	12	12	12	12
Shirley A Clarke	11	12	11	12
Ray Dawson	9	12	9	12
Tim Reddish	10	12	10	12
Neal Gossage	11	12	11	12
Claire Ward	9	12	9	12
Ruby Beech	9	12	9	12
Graham Ward	11	12	11	12
Jo Yeaman	5	5	5	5
Jon Scott	5	5	5	5
Roz Howie	7	7	7	7

The primary responsibility of the Board of Directors is to promote the long-term success of the Trust by creating and delivering high quality services within the funding streams available

The Trust is 'dedicated to outstanding care'. This statement articulates our commitment and ambition to excel and to continually improve the quality of our services

Register of interests

The Register of Interests for all members of the Board is reviewed regularly and is maintained by the Head of Corporate Affairs/Company Secretary, who is based at Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, HG17 4JL.

All members of the 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 Trust.

The Trust maintains NHS Litigation Authority insurance, which gives appropriate cover for any legal action brought against its directors to the extent permitted by law.

Patient care

The Trust is dedicated to outstanding care. This statement articulates our commitment and ambition to excel and to continually improve the quality of our services. The Trust's four core values underpin this ambition and describe the manner in which we will operate: communicating and working together, aspiring and improving, respectful and caring, and efficient and safe.

Following the CQC's inspection in 2015, a comprehensive quality improvement plan was developed. This has been robustly managed and successfully implemented in full. The Trust welcomed the findings of the subsequent CQC visit in July 2016, which rated the Trust as 'Good' in both the 'Safety' and 'Caring' domains. This recognises the progress we have made in realising the significant improvements required across our services as set out within our quality improvement plan. We have now achieved a firm foundation on which to make progress towards becoming outstanding. Our quality agenda is shaped by our experiences over the past two years in particular, and reflects our unwavering pursuit of new or better ways in which to improve the experience of patients when they are in our care.

For details of how we are working with partners to deliver improvements in patient care, please see the ***Stakeholder Relations*** section.

Quality improvement plan summary

The quality improvement plan, developed in response to the 2015 CQC inspection, has been robustly managed and delivered at pace. It was successfully implemented in full by the end of March 2017, resulting in stepped improvements throughout our hospital services. The notable progress made since the previous inspection was formally recognised by CQC inspectors during their return to the Trust in July 2016.

As a result of the sustained and significant improvements delivered, particularly in relation to the safety of care and effectiveness of leadership across the Trust, the CQC revised the Trust's rating from 'Inadequate' to 'Requires Improvement'. The Secretary of State for Health - the Rt. Honourable Jeremy Hunt MP - issued a personal video message in which he congratulated our staff for the excellent progress made. He said that the removal of special measures and positive CQC report 'was a tremendous testament to [our staff's] continued commitment and drive to improve'.

Staff across the organisation have fully embraced the extensive change programmes underway, all of which have been underpinned by cultural and organisational development to ensure long-term sustainability of the improvements made. This approach has ensured that new standards and ways of working are becoming firmly embedded within our 'business as usual' systems and processes.

It is widely recognised across the Trust that the rigorous process and attitude towards continuous improvement has been integral to the successful delivery of the quality improvement plan. This same rigour will be applied as we develop our onward journey to advancing the safety and quality of care we deliver to our patients.

The culture of the organisation is transforming to become one focused on continuous improvement and learning, with a genuine desire to provide the safest, highest quality of care that our patients deserve. There is recognition of what good care looks like and a drive to push beyond traditional boundaries to deliver it. The latest staff survey reflects the effectiveness of changes delivered, including cultural developments, with significant improvements in staff satisfaction and morale compared with the previous year.

Improvements in quality governance

We have also made significant progress with regard to our governance structure during 2015/16. This aspect was criticised by the CQC during the 2015 inspection and was a key element of our quality improvement plan. As a result of the extensive work undertaken, the Section 29a improvement notice issued in 2015 was withdrawn in September 2016.

The reporting structure from 'ward to board' has been streamlined with the terms of reference for committees having been reviewed to ensure that each group's purpose and objectives are clear. A governance framework is in place within each clinical division, with a direct reporting requirement to the Trust's Patient Safety Quality Board (PSQB).

The PSQB is the key committee for safety and quality, and reports directly to the Board's Quality Committee. It drives the agenda for patient safety and quality across the organisation, monitoring the effectiveness of governance in its widest sense, and holding specialist areas and the clinical divisions to account for the care they provide.

The PSQB ensures that timely and accurate accounts of quality standards are presented, that good practice is recognised and rewarded, and that any risks to the safety of patient care are identified with remedial action taken where required. It also ensures that lessons are learned and shared effectively across the organisation.

Our comprehensive quality dashboard takes account of the 'Single Oversight Framework', published by NHS Improvement in September 2016, and is now used routinely to monitor and evaluate our performance against key safety and quality indicators. This dashboard is sensitive enough to support rapid intervention when deterioration is noted and to ensure that optimum care remains uncompromised.

Involvement of governors

The Trust's Council of Governors plays an important role in the delivery of safe, high quality care. Members of the Governing Body are represented on key committees and working groups, including the Quality Committee and the Outpatient Working Group. 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.

Partnerships

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.

Better Together and the Nottinghamshire STP

We are an active partner in the mid-Nottinghamshire Better Together Alliance programme, 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.

Over the last year we have continued to work with Better Together partners on innovative payment mechanisms that will better match resource distribution with service provision in both community and hospital settings. The principles of risk and reward are at the core of our shared approaches to service transformation and resource distribution.

We are also members of the Nottinghamshire Sustainability and Transformational Plan (STP). This five-year plan describes how partners will improve the quality of care, the health and wellbeing of local people, as well as the finances of health and care services across Nottinghamshire. Through the STP, we work with health and care partners to transform services across the wider region, making them more effective and efficient in meeting the needs of local people. Our joint work also helps to ensure that patients and carers have an increasingly seamless experience between one service and the next.

The most significant element of transformation within the STP relates to the area of urgent and emergency care. The aim is to reduce emergency attendances and acute medical admissions, as well as enable patients admitted to hospital to return to the community as soon as safely possible. We are fully committed to these aims, although remain circumspect about achieving the impact required on activity volumes and income levels in the immediate term. This is because recent years have seen an overall growth in activity, despite the best efforts of the system to mitigate increases in demand for urgent and emergency care.

In relation to planned care, the STP focuses on the reduction of unwarranted variation in all services, from primary care assessment and the thresholds for onward referral to hospital specialists, through to every aspect of hospital-based care and back into the community for a patient's follow up and rehabilitation. Our continuing aim is to implement evidence-based best practice in all aspects of planned care, so that we can focus our resources on meeting patient needs as best as possible whilst driving down the overall costs of providing these services.

By helping to avoid unnecessary hospital attendances and admissions, these joint programmes both complement our internal focus on improving patient flow and reducing patients' length of stay in hospital. As a result of the collective effort to improve the quality and efficiency of our local health and care services, in recent years we have been successful in reducing the number of beds within our hospitals by around 100.

Strategic partnership

During 2015/16, we embarked upon a strategic partnership with neighbouring Trust, Nottingham University Hospitals. The original purpose behind the proposal to merge formally was to strengthen Sherwood Forest Hospitals as a Trust and to improve the quality of services provided. Additionally, the union of the two organisations presented opportunities for both parties to enhance our respective performance and efficiency, and to deliver enhanced quality of care for local people.

Following the successful delivery of our quality improvement programme, which culminated in a positive CQC report and the removal of our Trust from special measures, the decision was taken not to pursue a formal merger. It was clear that we had demonstrated our capability to deliver wholesale change effectively and sustainably, and we were therefore considered capable of operating as a standalone organisation.

Regardless of the merger decision, the opportunities resulting from working more closely together are still apparent. Both organisations benefited from the shared work undertaken over the past year to align clinical services and improve the quality of care in a number of areas. We therefore remain committed to a strategic partnership and have redefined its purpose. Our shared ambition will see us strengthening clinical networks further, and working together to provide safe and sustainable clinical services across Nottinghamshire.

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.

	2016/17		2015/16	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	93,138	194,924	65,084	154,432
Total non-NHS trade invoices paid within target	78,306	177,427	31,858	118,037
Percentage of non-NHS trade invoices paid within target	84%	91%	49%	76%
Total NHS trade invoices paid in the year	2,606	39,625	2,418	16,889
Total NHS trade invoices paid within target	2,013	35,306	771	10,541
Percentage of NHS trade invoices paid within target	77%	89%	32%	62%

Remuneration 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

The Remuneration Committee met six times during the year and key decisions made include the remuneration of the Chief Executive, Chief Nurse, Chief Operating Officer, Director of Human Resources and OD, and Director of Governance. Recruiting to these posts permanently was crucial in ensuring a substantive and stable leadership team to deliver our strategic vision of becoming an outstanding organisation.

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 2016/17.

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. A number of interim arrangements were phased out during the year. During 2016/17, non-executive directors successfully appointed to the following posts:

Substantive contracts:

- Chief Operating Officer
- Director of Governance
- Director of HR and OD
- Chief Nurse

Secondment agreements:

- Chief Executive
- Chief Nurse

Interim contractor / fixed term contracts:

- Chief Executive
- Chief Nurse

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 separate lease car allowance is paid to one senior manager. Another senior manager is in receipt of a cash equivalent. The lease car allowance or cash equivalent was withdrawn for new appointees in 2016. The lease car allowance is not offered to recent appointees.

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	Car allowance	Pension	Business expenses	Relocation expenses
All senior managers receive a basic pay element to their remuneration, which is pro-rata for part time staff	A historic allowance of up to £5,000, provided as a contribution to a lease car or as a cash alternative, More recent appointees do not receive this	The Trust pays employer contributions for all senior managers who are enrolled in the NHS pension scheme	Refund of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Up to £6,000 is available to newly appointed senior managers in accordance with the terms of the Trust's general relocation scheme

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 2016, one senior manager received a 1% pay award.

Senior managers paid more than £142,500 per annum

Where a senior manager is paid more than £142,500 per annum, the 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 £142,500 per annum, as required by NHS Improvement's guidelines on pay for very senior managers in NHS Trusts and Foundation Trusts.

The remuneration framework is consistent with best practice and external benchmarking

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 the 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 Trust's affairs.

Non-executive directors each have terms of no more than three years and are able to serve two concurrent terms (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 third term if the Council of Governors are in agreement.

Their remuneration framework, as agreed previously by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2016/17 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 2016/17.

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 Trust 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 year one non-executive director resigned. The balance of the Board still complies with the Code of Governance, which requires both that at least half the Board of Directors, excluding the Chairperson, should comprise 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. There are six non-executive directors, excluding the Chair, and six 'voting' executive directors including the Chief Executive.

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 Trust, 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 2016/17.

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 2016. All other national NHS terms are mirrored for Trust senior managers, including annual leave and sick pay.

Service contracts

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

Annual Report on Remuneration

Major decisions on senior managers' remuneration:
There were no major decisions on senior managers' remuneration during 2016/17.

Substantial changes to senior managers' remuneration during the year and the context for these:
There were no substantial changes to senior managers' remuneration during 2016/17.

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.

The 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 six times:

Name	Meetings attended out of possible total
Sean Lyons (Chairman)	1/1
Louise Scull (Chair)	1/1
Peter Marks (Vice Chairman)	6/6
Tim Reddish (Senior Independent Director)	5/6
Ray Dawson	6/6
Graham Ward	6/6
Neal Gossage	5/6
Ruby Beech	5/6
Claire Ward	4/6

The Board appoints the Remuneration and Nominations Committee and its membership comprises only non-executive directors

The committee also invited the assistance of the Chief Executive (Peter Herring, Peter Homa), Executive Director of Human Resources and OD (Julie Bacon), and the Head of Corporate Affairs and Company Secretary (Shirley A Clarke). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

The 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 four times:

Name	Meetings attended out of possible total
Sean Lyons (Chairman)	1/1
Sue Holmes (Lead Governor)	3/4
Jim Barrie (Public Governor)	4/4
Jayne Leverton (Public Governor)	2/4
Keith Wallace (Public Governor)	4/4
Cllr David Payne (Appointed Governor)	3/4
Roz Norman (Staff Governor)	2/4

The committee also invited the assistance of Senior Independent Director (Tim Reddish), Improvement Director (Eric Morton), Executive Director of Human Resources and OD (Julie Bacon) and Head of Corporate Affairs and Company Secretary (Shirley A Clarke). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

The committee successfully appointed a new Chair (John MacDonald) with the support of an external recruitment agency. The committee developed a robust recruitment programme, which identified suitable candidates who were invited to an interview process involving two stakeholder groups: one comprising external stakeholders and governors; and the other, members of the Board. Candidates were subsequently interviewed by a panel comprising governors with a representative from NHS Improvement and the Senior Independent Director acting in an advisory capacity. Only the governors on the panel were allowed to vote and the preferred candidate was chosen after consideration by the interview panel of feedback from each of the stakeholder groups.

The Governor Remuneration and Nomination Committee successfully appointed a new Chair (John MacDonald)

Disclosures required by Health and Social Care Act

Governor and director expenses - During the year the Trust reimbursed expenses incurred in respect of Trust business as follows:

Directors		Total paid 2015/16 £	Total paid 2016/17 £
Sean Lyons	Chairman	3,550.32	861.78
Louise Scull	Chair	N/A	No claim
Peter Marks	Non-executive director	627.79	361.80
Ray Dawson	Non-executive director	1,628.40	1197.68
Claire Ward	Non-executive director	1,121.07	355.10
Tim Reddish	Non-executive director	472.02	397.46
Neal Gossage	Non-executive director	1,537.48	1,405.20
Ruby Beech	Non-executive director	No claim	No claim
Graham Ward	Non-executive director	No claim	No claim
Peter Herring	Chief Executive	1,692.63	34.72
Peter Homa	Chief Executive	N/A	No claim
Karen Fisher	Acting Chief Executive	133.68	No claim
Susan Bowler	Chief Nurse	100.17	No claim
Suzanne Banks	Chief Nurse	0.00	2,633.26
Barbara Beal	Interim Chief Nurse	N/A	No claim
Graham Briggs	Interim Director HR & OD	5,663.74	No claim
Julie Bacon	Executive Director of HR & OD	N/A	65.52
Peter Wozencroft	Director of Strategic Planning and Commercial Development	448.56	446.40
Susan Barnett	Interim Chief Operating Officer	24,000.00	N/A
Jon Scott	Interim Chief Operating Officer	No claim	No claim
Roz Howie	Chief Operating Officer	No claim	No claim
Dr Andrew Haynes	Executive Medical Director	No claim	No claim
Paul Robinson	Chief Financial Officer	845.74	778.99
Paul Moore	Director of Governance	N/A	No claim
Shirley Clarke	Head of Corporate Affairs and Company Secretary	No claim	27.72
	TOTAL	**41,821.60**	**7,703.85**

Governor	Constituency		Total paid 2015/16 £	Total paid 2016/17 £
Amanda Sullivan	Appointed Governor	NHS Newark & Sherwood and Mansfield & Ashfield CCG	No claim	No claim
Angie Emmott	Staff Governor	Newark Hospital	64.59	100.74
Ann Mackie	Public Governor	Newark & Sherwood	N/A	349.06
Carol Atkinson	Co-opted Governor	Derbyshire	N/A	5.09
David Payne	Appointed Governor	Newark & Sherwood District Council	No claim	No claim
Debra Barlow	Public Governor	Mansfield	N/A	No claim
Dilip Malkan	Staff Governor	King's Mill & Mansfield Community Hospitals	N/A	No claim
Eddie Olla	Staff Governor	King's Mill & Mansfield Community Hospitals	N/A	No claim
Ian Holden	Public Governor	Newark & Sherwood	N/A	98.00
Jackie Hewlett-Davies	Public Governor	Ashfield	N/A	No claim
Jayne Leverton	Public Governor	Ashfield	N/A	No claim
Jim Aspinall	Appointed Governor	Ashfield District Council	No claim	No claim
Jim Barrie	Public Governor	Newark & Sherwood	No claim	330.43
John Barsby	Public Governor	Mansfield	No claim	No claim
John Wood	Public Governor	Mansfield	N/A	No claim
Keith Wallace	Public Governor	Mansfield	N/A	No claim
Ken Gibson	Volunteer Governor	Newark Hospital	N/A	163.12
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	136.40	291.64
Nick Walkland	Public Governor	Rest of East Midlands	No claim	656.22
Nigel Nice	Public Governor	Newark & Sherwood	526.79	N/A
Ron Tansley	Volunteer Governor	King's Mill & Mansfield Community Hospitals	No claim	No claim
Roz Norman	Staff Governor	King's Mill & Mansfield Community Hospitals	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	52.92	33.29
Valarie Bacon	Public Governor	Derbyshire	274.79	267.36
Yvonne Woodhead	Appointed Governor	Nottinghamshire County Council	No claim	No claim
	TOTAL		**1,055.49**	**2,402.35**

Senior managers' disclosure

Name and title	2016/17 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)	Pensions related benefit (bands of £2,500)	2016/17 Total	2015/16 (£'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)	Pensions related benefit (bands of £2,500)	2015/16 (£'000) Total
	£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors												
Mr P Herring[1] (Chief Executive Officer) Appointed 19 November 2015 (Managing Director 1 September to 31 October 2017)	350 - 355	2,500	0	0	0	355 - 360	170 - 175	1,400	0	0	0	175 - 180
Mr P O'Connor (Chief Executive Officer) Left 9 April 2015	N/A	N/A	N/A	N/A	N/A	N/A	0 - 5	500	0	0	40 - 42.5	45 - 50
Ms K Fisher (Acting Chief Executive Officer) Left post 18 November 2015	N/A	N/A	N/A	N/A	N/A	N/A	100 - 105	100	0	0	467.5 - 470	570 - 575
Mr P Robinson (Chief Financial Officer)	150 - 155	800	0	0	0	150 - 155	145 - 150	800	0	0	0	150 - 155
Ms B Beal (Chief Nurse) Appointed 7 November 2016 - left post 5 February 2017	20 - 25	0	0	0	0	20-25	N/A	N/A	N/A	N/A	N/A	N/A
Ms S Banks[2] (Chief Nurse) Appointed 18 January 2016 - left 31 August 2016 Re-appointed 6 February 2017	65 - 70	2,600	0	0	87.5 - 90	155 - 160	30 - 35	0	0	0	0	30 - 35
Dr A Haynes (Executive Medical Director)	180 - 185	0	0	0	20 - 22.5	200 - 205	175 - 180	0	0	0	205 - 207.5	385 - 390
Ms K Rogers (Non-voting Director of Corporate Services / Company Secretary) Left 30 August 2015	N/A	N/A	N/A	N/A	N/A	N/A	40 - 45	0	0	0	50 - 52.5	90 - 95
Ms S Clarke (Non-voting Director of Corporate Affairs / Company Secretary) Appointed 1 September 2015	85 - 90	0	0	0	55 - 57.5	145 - 150	45 - 50	0	0	0	35 - 37.5	85 - 90
Mr P Moore (Non-voting Director of Governance) Appointed 18 January 2016 - left 1 July 2016 - re-appointed 1 March 2017	50 - 55	0	0	0	0	50 - 55	45 - 50	0	0	0	0	45 - 50
Mr P Wozencroft (Non-voting Director of Strategic Planning and Commercial Development)	105 - 110	400	0	0	57.5 - 60	165 - 170	100 - 105	400	0	0	0	100 - 105
Mr G Briggs[3] (Director of Human Resources) Appointed 27 May 2015 - left 31 March 2016	N/A	N/A	N/A	N/A	N/A	N/A	120 - 125	6,300	0	0	0	125 - 130
Ms J Bacon[3] (Director of Human Resources) Appointed 16 February 2016	160 - 165	300	0	0	0	160 - 165	15 - 20	0	0	0	0	15 - 20
Ms S Bamett (Non-voting Director of Operations) Appointed 5 January 2015 - left 17 December 2015	N/A	N/A	N/A	N/A	N/A	N/A	225 - 230	24,900	0	0	0	250 - 255
Mr J Scott (Chief Operating Officer) Appointed 23 November 2015 - left 28 September 2016	170 - 175	0	0	0	0	170 - 175	165 - 170	0	0	0	0	165 - 170
Mrs R Howie[4] (Chief Operating Officer) Appointed 1 October 2016	50 - 55	0	0	0	212.5 - 215	265 - 270	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	100 - 105	4,000	0	0	0	105 - 110	N/A	N/A	N/A	N/A	N/A	N/A
Mrs S Bowler[5] (Executive Director of Nursing and Quality) Left post 30 October 2015	40 - 45	N/A	N/A	N/A	N/A	40 - 45	100 - 105	100	0	0	15 - 17.5	115 - 120
Non-Executive Directors												
Mr J MacDonald (Chair) Appointed 1 March 2017	0 - 5	0	0	0		0 - 5	N/A	N/A	N/A	N/A		N/A
Mr S Lyons[6] (Chair) Left 10 June 2016	10 - 15	900	0	0		10 - 15	50 - 55	3,800	0	0		55 - 60
Ms L Scull[6] (Chair) Appointed 11 June - left 23 October 2016	10 - 15	0	0	0		10 - 15	N/A	N/A	N/A	N/A		N/A
Dr P Maris[6] (including Acting Chair from 24 October 2016 to 14 February 2017) Left 14 March 2017	25 - 30	900	0	0		25 - 30	10 - 15	600	0	0		15 - 20
Mr R Dawson (including Acting Chair from 14 to 28 February 2017)	10 - 15	1,200	0	0		15 - 20	10 - 15	1,600	0	0		15 - 20
Mr MJ Chivers Left 31 October 2015	N/A	N/A	N/A	N/A		N/A	5 - 10	0	0	0		5 - 10
Dr J McSorley Left 31 May 2015	N/A	N/A	N/A	N/A		N/A	0 - 5	600	0	0		0 - 5
Mr T Reddish	10 - 15	400	0	0		15 - 20	10 - 15	500	0	0		15 - 20
Ms C Ward	10 - 15	400	0	0		10 - 15	10 - 15	1,100	0	0		10 - 15
Mr G Ward Appointed 1 December 2015	10 - 15	0	0	0		10 - 15	0 - 5	0	0	0		0 - 5
Ms R Beech Appointed 1 November 2015	10 - 15	0	0	0		10 - 15	5 - 10	0	0	0		5 - 10
Mr N Gossage Appointed 10 May 2015	10 - 15	1,400	0	0		15 - 20	10 - 15	1,300	0	0		10 - 15

[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] Ms J Bacon and Mr G Briggs performed the role jointly from 16 February to 31 March 2016

[4] 2016/17 costs disclosed 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

[5] Other Salary relates to salary 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 costs noted above for 2016/17 exclude non-recoverable VAT where charged.

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 2016-17 was £350,000 - £355,000 (2015-16, £175,000 - 180,000). This was 15.74 times (2015-16, 7.98 times) the median remuneration of the workforce, which was £22,458 (2015-16, £22,236). In 2016-17, no employees (2015-16, 1) 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.

	2016/17	2015/16
Band of highest paid directors' remuneration (£000's)	**350 – 355**	**175 - 180**
Median total remuneration (£)	**22,458**	**22,236**
Ratio of median to highest paid Director	**15.70**	**7.9**
No. of employees paid more than highest paid director	**0**	**1**

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 has been calculated based on the mid-point of the reported payments in respect of the highest paid director. These payments reflect invoiced payments made excluding non-recoverable VAT, and as such do not reflect an annualised equivalent salary. The prior year comparator excludes agency board members.

During the year a substantive appointment was made for the highest paid director, and on an annualised equivalent salary basis the median remuneration would be 11.8 times (2016/17) to 7.9 times (2015/16).

Pension disclosure

		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	54
Dr A Haynes	0 - 2.5	5 - 7.5	75 - 80	225 - 230	1531	90	1621	63
Ms S Clarke	2.5 - 5	0	10 - 15	0	129	30	159	21
Mr P Moore	0	0	25 - 30	70 - 75	428	0	384	0
Mr P Wozencroft	2.5 - 5	0	30 - 35	85 - 90	492	73	565	51
Mrs R Howie	0 - 2.5	2.5 - 5	25 - 30	85 - 90	343	27	508	115

		2015/16						
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 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr P O'Connor	0 - 2.5	5 - 7.5	55 - 60	175 - 180	1197	52	1264	26
Mrs S Bowler	0 - 2.5	2 - 2.5	40 - 45	120 - 125	738	22	770	9
Mrs K Rogers	2.5 - 5	0 - 2.5	15 - 20	35 - 40	203	28	234	18
Mr P Wozencroft	0	0	25 - 30	85 - 90	494	0	492	0
Ms K Fisher *	20 - 22.5	60 - 62.5	60 - 65	190 - 195	785	387	1183	265
Dr A Haynes	7.5 - 10	25 - 27.5	70 - 75	215 - 220	1316	198	1531	128
Ms S Clarke	0 - 2.5	0	5 - 10	0	85	43	129	29

* Ms K Fisher acted as Chief Executive Officer from 1st April to 18th November 2015, then continued to work for the Trust in a non-Board member capacity until the end of the financial year - the pensions figures reflect the full year / year end values

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 directors' remuneration and non-executive directors' fees.

Peter Herring
Chief Executive
25 May 2017

Staff Report

This section presents facts and figures relating to our workforce and discusses the findings of the national staff survey, which showed higher levels of staff satisfaction

The largest group employed by the Trust 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 2016 to 31 March 2017 are:

Average number of persons employed (Whole Time Equivalent)

	Permanently employed	Other Number
Medical and Dental	199	215
Administration and Estates	882	45
Healthcare Assistants and other support staff	833	13
Nursing, midwifery and health visiting staff	1,102	7
Nursing, midwifery and health visiting learners	0	1
Scientific, therapeutic and technical staff	321	17
Healthcare science staff	108	0
Other	19	10
TOTAL	3,464	308

Breakdown of staff (actual headcount as at 31 March 2017)

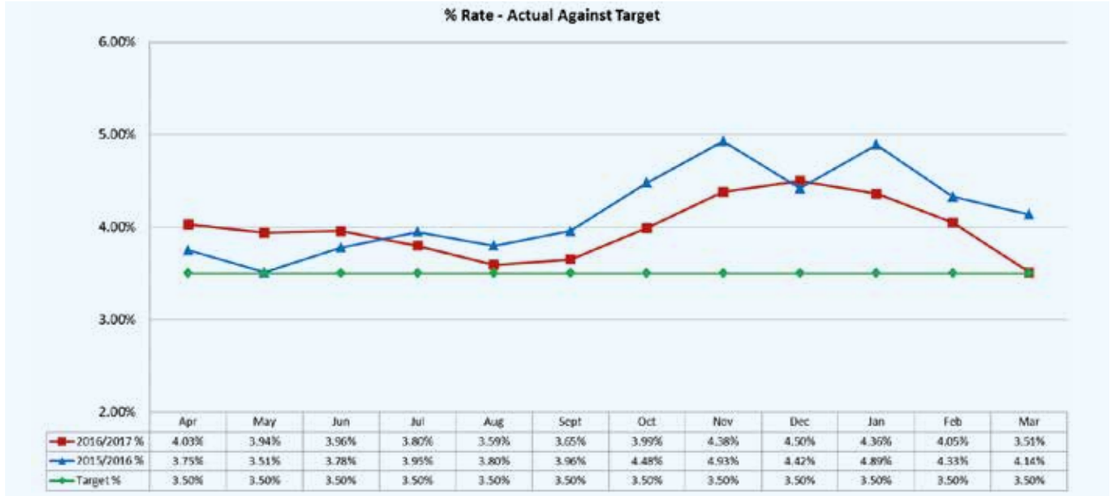
	Male	Female
Directors	10	7
Other senior managers	59	106
Employees	785	3,591
TOTAL	854	3,704

Sickness absence – annual report 2016/17

Our target sickness absence for the Trust for 2016/17 remained at 3.50%.

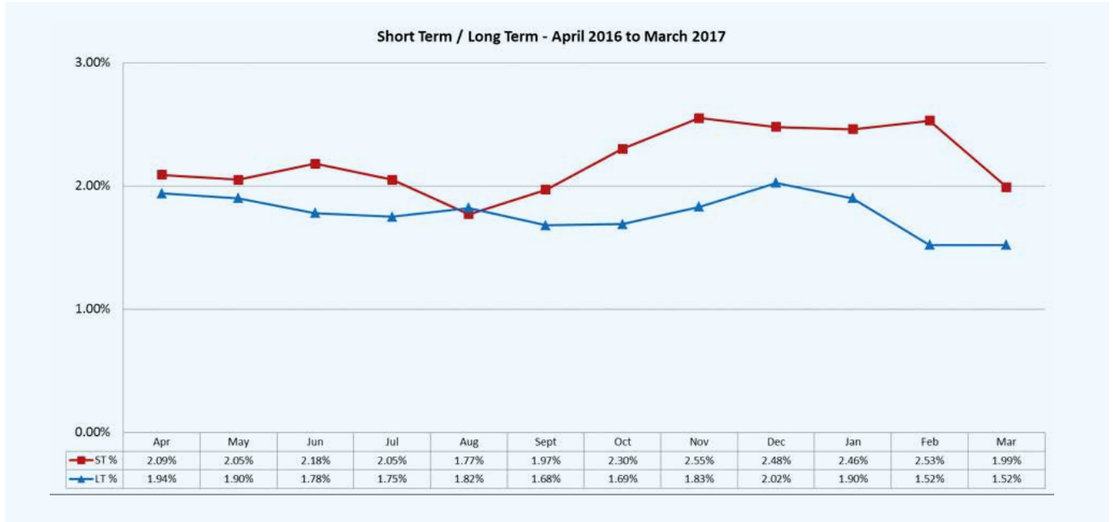
The total sickness absence rate for 2016/17 was 3.98%, compared to 4.17% in 2015/16. The estimated cost of paying absent staff stood at £4.58m, compared to £4.66m in 2015/16.

The chart below details Trust performance against target in month for 2016/2017 against 2015/2016:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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%
2015/2016 %	3.75%	3.51%	3.78%	3.95%	3.80%	3.96%	4.48%	4.93%	4.42%	4.89%	4.33%	4.14%
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%

The graph below shows a comparison of sickness absence rates in terms of short and long-term rates for 2016/2017:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ST %	2.09%	2.05%	2.18%	2.05%	1.77%	1.97%	2.30%	2.55%	2.48%	2.46%	2.53%	1.99%
LT %	1.94%	1.90%	1.78%	1.75%	1.82%	1.68%	1.69%	1.83%	2.02%	1.90%	1.52%	1.52%

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.

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

Key priorities for 2017/18 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 developing 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

It is a statutory requirement that public bodies must report sickness absence data as part of their staff report that has been presented above. For consistency the data must also be in-line across the NHS and with similar data for the Core Department. It is therefore necessary to reconcile NHS ESR data with the 'Cabinet Office' data reported by central Government that is presented below:

Sickness Absence – January 2016 to December 2016			
Figures converted by DH to Best Estimates or Required Data Items		Statistics Published by NHS	
Average WTE 2016	Average Sick Days Per WTE	FTE Days Available	WTE- Days recorded Sickness Absence
3,945	9.6	1,439,910	61,721

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 2016 we had 46 live policies relating to supporting and developing current and prospective staff. During 2016/17, 26 were reviewed as part of the planned review cycle, making sure that any amendments were aligned with relevant legislative changes and best practice.

Expenditure on consultancy

We incurred costs of £935,296 (£2,822,000 in 2015/16). These costs were predominantly related to the development of financial improvements.

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.

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2016	0
Of which...	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	5
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	5
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

Please note: The engagements identified in the table above have either left the Trust or been placed in a substantive on-payroll assignment.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

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

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

We confirm that there have been no redundancy and termination payments made to serving senior officers within 2016/17.

National NHS Staff Survey – 2016

We participate in the national NHS staff survey, which is undertaken once every year. We elect to survey the minimum sample of 1,250 staff, who are randomly selected from all staff groups.

The survey opens from the beginning of September and runs until early December. The response rate for the 2016 survey was 41%, which was below average for acute Trusts in England and which is slightly lower than our response rate of 45% in 2015. This is shown in the table below:

Survey response rate

	2015	2016		Trust improvement/deterioration
	SFH	SFH	(all Trusts in England)	
Response rate	45%	41%	44%	-4%

Areas identified for action following the 2015 staff survey

In response to the 2015 NHS staff survey findings, remedial actions were incorporated into the Trust's Quality Improvement Plan (QIP). Delivery was overseen by the Organisational Development and Workforce Committee. Core areas we addressed during the year are discussed below:

- **Staff engagement:** this was given a high priority, with an emphasis on ensuring that staff receive regular and honest information about the Trust such as operational performance, CQC activity and ratings or the proposed merger. Senior managers sought to engage with staff using innovative and creative communication methods, for example through the executive open briefing sessions held for all staff at each hospital site, improved monthly senior manager briefings, the electronic staff bulletin, social media, intranet and so on. Through these methods, staff had the opportunity to see, hear from and ask questions of senior managers. A staff engagement forum was established to inform and monitor this work. Manager training was implemented to enable managers to understand the importance of engaging with staff and to enable them to do this more effectively. This was supported by a toolkit and toolbox sessions. The effectiveness of this work was evaluated and the findings informed the next phase of our staff engagement work.
- **Developing an open and transparent culture:** we wanted to ensure that staff had the confidence to raise concerns via appropriate mechanisms, with the confidence that these will be appropriately considered by adopting an open door policy and no blame culture. The Trust appointed two 'Freedom to Speak Up' guardians. Their role and contact details were widely publicised through manager and staff briefings, newsletters, posters, pop up banners and drop-in sessions. Where staff raised concerns, we ensured that these were addressed appropriately and that feedback was provided to the person raising the concern.
- **Appraisal and staff development:** we continued to monitor appraisal rates, and focus was given to ensuring consistent achievement of the Trust's 98% appraisal rate target with all staff having a personal development plan aligned with their appraisal as well as organisational objectives. We ensure that all staff attend mandatory training.
- **Staff health & wellbeing:** following the roll out of the Mentally Healthy Workplace training the previous year, this training was incorporated into the manager training programme. We chose to use the CQUIN health and wellbeing targets as the framework for promoting health and wellbeing initiatives with the aim of improving the health and wellbeing of staff. This action plan was well received by our lead Clinical Commissioning Group, and we have delivered all tasks identified within the action plan.

We ensure that all staff are consistently and fairly managed in accordance with Trust HR policies and procedures, providing support, guidance and coaching via HR business partnering, occupational health, training and development.

Summary of findings

The survey is comprised of different sections, or 'findings', which pursue a specific line of questioning.

It should be noted that at the time of the 2016 staff survey the Trust was facing significant challenges, most notably in preparing for the planned merger with Nottingham University Hospitals and which many staff reported to be unsettling.

We were also still in special measures and remained a target for negative media attention. Like all other NHS Trusts in the country, we continued to operate against a backdrop of significant financial pressures and continued high demand on services. However, despite these pressures our results improved in 10 key findings (specific areas of questioning) and there was no change in the remaining 22.

The following table shows how the findings for our Trust compare with the national average for similar Trusts in England, and demonstrates at a high level the overall improvement achieved over the past three years.

Year (Total number of key findings)	2014 (29)	2015 (32)	2016 (32)
Best 20%	1 Key Finding	2 Key Findings	8 Key Findings
Better than the average	4 Key Findings	3 Key Findings	8 Key Findings
Average	4 Key Findings	9 Key Findings	6 Key Findings
Worse than the average	11 Key Findings	6 Key Findings	7 Key Findings
Worst 20%	8 Key Findings	12 Key Findings	3 Key Findings

Overall indicator of staff engagement

The overall indicator of staff engagement for the Trust was 3.86, which is above average when compared with Trusts of a similar type. This is an improvement on the result of 3.68 in the previous year, which was below national average. Results are detailed within the following table:

NHS Staff Survey Comparison for Overall Staff Engagement – 2014, 2015 and 2016		
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

Where staff experience has improved

Staff experience has improved in a number of key finding (KF) areas as shown below:

- **KF32:** Effective use of patient/service user feedback
- **KF13:** Quality of non-mandatory training, learning or development
- **KF10:** Support from immediate managers
- **KF14:** Staff satisfaction with resourcing and support
- **KF1:** Staff recommendation of the organisation as a place to work or receive treatment

Where staff experience has deteriorated

We are delighted that the 2016 survey results showed no areas of deterioration.

Highest and lowest ranking scores

The following rankings show how our 2016 staff survey results compare with those of other acute Trusts in England. Reports from the National Survey Centre also identify where there is a statistically significant change. The * in the two following tables identify those scores that are slightly different to results of the 2015 survey, although none are statistically significant.

2016 Top 5 ranking scores

	2015 (previous year)	2016 (current year)		Trust improvement/ deterioration
	SFH	SFH	Benchmarking group (Acute Trusts in England)	
Key Finding 29 % reporting errors, near misses or incidents witnessed in last 12 months	89%	95%	90%	+6%*
Key Finding 13 Quality of non-mandatory training	4.02	4.13	4.05	+0.11 (improved)
Key Finding 28 % witnessing potentially harmful errors, near misses or incidents in the last month	29%	26%	31%	- 3%*
Key Finding 2 Staff satisfaction with the quality of work and care they are able to deliver	3.97	4.08	3.96	+0.11*
Key Finding 3 % agreeing that their role makes a difference to patients/service users	91%	92%	90%	+1%*

2016 Bottom 5 ranking scores

	2015 (previous year)	2016 (current year)		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (Acute Trusts in England)	
Key Finding 23 % witnessing physical violence from staff in last 12 months	2%	3%	2%	-1%%
Key Finding 18 % attending work in last 3 months despite feeling unwell because they felt pressure	70%	64%	56%	6%*
Key Finding 22 % experiencing physical violence from patients, relatives or the public in last 12 months	14%	19%	15%	5%*
Key Finding 25 % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	30%	30%	27%	0%*
Key Finding 6 % reporting good communication between senior management and staff	20%	30%	33%	+10% (improved)

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) has been in place since April 2014 and was designed to be 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 results from 2016/17.

	Q1 FFT	Q2 FFT	Q3 Staff Survey
How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	83.44%	87.5%	74%
How likely would you be to recommend this organisation to friends and family as a place to work?	60.93%	73.95%	68%
Number of respondents	302	96	505

The Q3 Staff Survey questions are slightly different:

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

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 on the following key areas, both of which formed part of our improvement plan in response to the 2015 survey:

- **Q1 –** Staff engagement
- **Q2 –** Observing and reporting errors

The feedback received was used alongside the information gained from exit interviews to monitor progress of our improvement plans and to inform future initiatives to improve the experience of staff and patients.

Leaver interviews

Staff 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, and which is then returned to the Human Resources (HR) Team.

We value staff feedback and triangulate the information received from leavers 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 and Assistant HR Business Partners 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. It was hoped that this approach might appeal to more staff and lead to an increase in the number of staff giving feedback as they leave us. However, this has not proved to be the case and a full review of leaver interview /feedback will be undertaken early in the forthcoming year.

Future priorities, targets and monitoring

Detailed analysis of the staff survey results enabled us to identify any concerns which were specific to divisions or particular staff groups. As a result, key actions were identified for particular divisions or managers, and these sit alongside Trust-wide actions in an overarching action plan.

The OD and Workforce Committee has responsibility for approving the action plan and for receiving regular reports to monitor the progress of implementation.

Priority areas for 2017/18 include:

- Staff engagement
- Embedding the Trust's values and behaviours, setting clear professional expectations for all staff
- Embedding the CQUIN staff health and wellbeing work undertaken in 2016/17 and building on this through the 'Happy, Healthy, Here' initiative to achieve the same CQUIN target in 2017/18
- Creating a safe environment

We will be introducing a number of initiatives in 2017/18, including a new OD and Workforce strategy and a Happy, Healthy, Here campaign. These aim to improve the staff experience, achieve more effective engagement with staff, develop and maximise talent, and support staff health and wellbeing. They will be closely aligned with organisational objectives to support our journey to becoming 'outstanding'.

Equality Reporting

We are committed to providing an environment where all staff, service users and carers enjoy equality of opportunity. Promoting equality, embracing diversity and ensuring full inclusion for people who use our services is central to our vision and values, and these elements are fundamental to us as we build strong communities and services. 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.

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. We now have two employees who act as champions for BAME (Black, Asian and Minority Ethnic) and LGBT (Lesbian, Gay, Bisexual and Transgender) groups. 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 for BAME and LGBT groups.

The Diversity and Inclusivity Group regularly reviews reports on equality data, including workforce information, recruitment data, the workforce race equality standard, the equality delivery system (EDS2) and the staff survey. This group investigates equality patterns to improve the experience of staff and patients.

Our objectives reflect an inclusive approach to the protected characteristics of the Equality Act 2010. We continue to work with others, for example the Nottinghamshire Health and Wellbeing Board, the Clinical Commissioning Group's Quality and Performance Scrutiny Committee, and the Nottinghamshire NHS Equality and Engagement Network.

We published our Workforce Race Equality Standard results on 1 July 2016 and analysis of its nine metrics results have informed the development of equality objectives for 2017/18, along with the EDS2 engagement outcomes, to address any areas of inequality.

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.

Valuing our Members

During the year we have developed and approved a communications strategy. This focuses on engaging with our Foundation Trust members and encouraging feedback as well as sharing news, information and opportunities to attend membership events.

Our Council of Governors is required to represent the interests of Trust members and the public, and will seek the views of members on material issues or changes being discussed by the Trust. Governors are a key link between members, the wider public and the Board of Directors and play a leading role in membership recruitment and engagement.

One of the key challenges for us as a membership organisation is to secure sustainable membership interest and involvement at the same time as ensuring that membership is representative of the local communities we serve.

Over 17,000 people from the local population have chosen to support us by joining us as members, and we value their continuing support. Membership has fallen during the year by some 1,000 public members as a result of detailed cleansing of the membership database. We continue to focus on engaging with our membership as part of our journey to become an outstanding organisation.

Our membership is comprised of two electable constituencies:

- Staff constituency
- Public constituency

Staff constituency

Our employees continue to be registered as members as part of an opt-out scheme. Staff membership ensures that a large majority of staff are able to participate in, and offer their view on developments at the Trust. We have approximately 5,000 employees and volunteers who are classed as staff members.

The staff constituency is divided into four classes:

- King's Mill Hospital, including Mansfield Community Hospital
- Newark Hospital
- Volunteers at King's Mill Hospital, including Mansfield Community Hospital
- Volunteers at Newark Hospital

Public constituency

As well as residing within the geographic boundaries described below, public members must meet the eligibility criteria as described within the Trust's Constitution.

In order to ensure that our public membership is representative of those eligible to become members, we analyse the membership profile against that of our catchment area population to reflect age, gender and ethnic group.

There are five public constituencies:

		Total membership (March 2017)
Mansfield	includes the geographic boundaries of Mansfield District Council and the ward of Welbeck from Bassetlaw District Council	5,442
Ashfield	includes the geographic boundaries of Ashfield District Council and the wards of Ravenshead and Newstead from Gedling District Council	5,316
Newark and Sherwood	includes the geographic boundaries of Newark and Sherwood District Council plus wards from Bassetlaw, South Kesteven and Rushcliffe District Councils	4,213
Derbyshire	includes wards from Bolsover and North East Derbyshire District Councils	1,832
Rest of East Midlands	includes the remainder of the East Midlands region which is not covered in the other constituencies	913
Rest of England		180

We will continue to work closely with our members and engage them in our Trust's activities

Public membership breakdown at 31 March 2017

	Number of Members	Membership Profile	Population Profile	Trend
Age (years)				
0 – 16	2	0.01%	19.62%	↑
17 – 21	156	0.86%	6.36%	↓
22+	16,420	91.77%	74.03%	↓
Not Stated	1,317	7.36%	0	
Ethnicity				
White	16,099	89.88%	98.7%	↓
Mixed	31	0.18%	1.85%	→
Asian	92	0.56%	6.29%	↓
Black	35	0.22%	1.74%	↓
Other	10	0.05%	0.34%	→
Not stated	1,628			
Gender				
Male	6,553	36.62%	49.37%	↓
Female	11,112	62.1%	50.63%	↓
Not stated	230			

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 2016/17 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 and Newark hospitals and are open to all members.

- **Healthy living members' events:**

  These sessions offer tips and advice to members on the everyday lifestyle changes that can be made to promote healthy living, e.g. organ donation and 'smoke free' stop smoking services.

- **Member engagement events:**

  These events were delivered across all three hospital sites. Member events included emergency lifesaving (delivered by East Midlands Ambulance Service) and a Newark Hospital service event which showcased the new Urgent Care Centre and other services available at the hospital.

- **Meet the governor events:**

  These events, undertaken across all three hospital sites, 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.

- **Annual general meeting/annual members meeting:**

  Held on 26 September 2016 at King's Mill Hospital, this event was attended by members who visited the interactive display stands as well as attending the organ donation 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. 2017/18 promises to be an exciting year for the Trust as we engage with our partners to start delivering the local elements of the Nottinghamshire Sustainability and Transformation Plan, and which will require significant engagement with our members both directly and through our governors.

Members can contact their governors either through the Trust 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 general 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 the members of the Trust 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 the Trust's 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.

Reports and updates were received from each of the governor committees:

- Performance and Strategy
- Patient Quality and Experience
- Membership and Engagement
- Nominations and Remuneration

During the year, the Council also recruited a new Chair and approved the appointment of the new Chief Executive.

Council of Governors


Jayne Leverton
Ashfield


Jackie Hewlett-Davies
Ashfield


Sue Holmes
Ashfield


Kevin Stewart
Ashfield


John Wood
Mansfield


Debra Barlow
Mansfield


John Barsby
Mansfield


Keith Wallace
Mansfield


Jim Barrie
Newark and Sherwood


Ian Holden
Newark and Sherwood


Ann Mackie
Newark and Sherwood


Martin Stott
Newark and Sherwood


Valerie Bacon
Derbyshire


Nick Walkland
Rest of East Midlands


Dilip Malkan
King's Mill Hospital


Roz Norman
King's Mill Hospital


Samantha Annis
Newark Hospital


Eddie Olla
King's Mill Hospital


Angie Emmott
Newark Hospital


Ron Tansley
Volunteer


Cllr Jim Aspinall
Ashfield District Council


Dr Amanda Sullivan
NHS Nottinghamshire


Cllr Yvonne Woodhead
Nottinghamshire County Council


Louise Knott
Vision West Notts


Cllr Sharron Adey
Mansfield District Council


Cllr David Payne
Newark and Sherwood District Council

Attendance at Council of Governor meetings

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

Governors	Constituency	Elected/Appointed	Meetings Attended/ Total Possible Meetings	Elected/ Appointed
Amanda Sullivan	Newark and Sherwood CCG	Appointed	3/6	01.05.2016
Angie Emmott	Staff Governor, Newark Hospital	Elected	5/6	01.05.2016
Ann Mackie	Public Governor, Newark and Sherwood	Elected	5/5	01.05.2016
David Payne	Newark & Sherwood District Council	Appointed	6/6	01.05.2016
Jim Aspinall	Ashfield District Council	Appointed	4/6	01.05.2016
Sharron Adey	Mansfield District Council	Appointed	2/6	01.06.2015
Yvonne Woodhead	Nottinghamshire County Council	Appointed	0/6	14.10.2013
Debra Barlow	Public Governor, Mansfield	Elected	3/5	01.05.2016
Dilip Malkan	Staff Governor, King's Mill Hospital & MCH	Elected	2/5	01.05.2016
Eddie Olla	Staff Governor, King's Mill Hospital & MCH	Elected	5/5	01.05.2016
Ian Holden	Public Governor, Newark and Sherwood	Elected	5/5	01.05.2016
Jackie Hewlett-Davies	Public Governor, Ashfield	Elected	4/5	01.05.2016
Jayne Leverton	Public Governor, Ashfield	Elected	3/5	01.05.2016
Jim Barrie	Public Governor, Newark & Sherwood	Elected	2/6	01.05.2016
John Barsby	Public Governor, Mansfield	Elected	5/6	01.11.2014
John Wood	Public Governor, Mansfield	Elected	4/5	01.05.2016
Keith Wallace	Public Governor, Mansfield	Elected	5/5	01.05.2016
Kevin Stewart	Public Governor, Ashfield	Elected	4/6	01.11.2014
Louise Knott	Vision West Notts College	Appointed	5/6	01.03.2015
Martin Stott	Public Governor, Newark & Sherwood	Elected	3/6	01.05.2016

Continued

Governors	Constituency	Elected/ Appointed	Meetings Attended/ Total Possible Meetings	Elected/ Appointed
Nick Walkland	Public Governor, Rest of East Midlands	Elected	5/5	01.05.2016
Ronald Tansley	Volunteer Governor, King's Mill Hospital	Elected	6/6	01.05.2016
Roz Norman	Staff Governor, King's Mill Hospital & MCH	Elected	3/6	01.05.2016
Samantha Annis	Staff Governor, Newark Hospital	Elected	3/6	01.05.2016
Sue Holmes (Lead Governor from 01.05.16)	Public Governor, Ashfield	Elected	6/6	01.11.2014
Valerie Bacon	Public Governor, Derbyshire	Elected	6/6	01.08.2016
Colin Barnard (Lead Governor to 30.04.16)	Public Governor, Ashfield	Elected	1/1	Tenure ended 30.04.16
Annie Palmer	Public Governor, Rest of East Midlands	Elected	1/1	Tenure ended 30.04.16
Andy March	Public Governor, Mansfield	Elected	1/1	Tenure ended 30.04.16
Nigel Nice	Public Governor, Newark & Sherwood	Elected	1/1	Tenure ended 30.04.16
Beryl Perrin	Public Governor, Ashfield	Elected	1/1	Tenure ended 30.04.16
Nicola Waller	Public Governor, Derbyshire	Elected	2/2	Tenure ended 30.04.16
Wesley Burton	Staff Governor, King's Mill Hospital & MCH	Elected	1/1	Tenure ended 30.04.16
Alison Beal	Staff Governor, King's Mill Hospital & MCH	Elected	1/1	Tenure ended 30.04.16
Ken Gibson	Volunteer Governor, Newark Hospital	Elected	2/2	Resigned – Jan 2017

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, membership engagement events, and various committees. These included Trust board committees where governors act as observers and report back to Council of Governor meetings.

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 Trust so they can engage with members and the general public.

During the year, governors played a key role in ensuring the Board of Directors followed a robust and transparent process both during the preparation for a proposed merger with Nottingham University Hospitals, as well as the development of a formal strategic partnership once the decision had been taken not to pursue a merger.

We acknowledge and respect the unique contribution of individual governors and the Council of Governors as a whole in contributing to the future development of our Trust. We are also grateful for the support of the Lead Governor, Colin Barnard, who left the Trust during the year and his successor, 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 2016

Public and staff governors are elected to serve for a period of up to three years. During 2016 the majority of public governors and all staff and volunteer governors reached the end of their three year tenure. Therefore, governor elections took place in April 2016, with all staff, volunteer and ten public governors being elected from 1 May 2016 with the two public governors from Derbyshire taking up their posts from 1 August 2016. All new and existing governors have undertaken their statutory duties with enthusiasm and the Trust appreciates their commitment as we continue our improvement journey into 2017/18.

On behalf of my fellow governors, I would like to thank each and every staff member and volunteer for their tireless contribution

Lead Governor Annual Report 2016/17

In my first year as Lead Governor, I have seen the Trust turn a major corner. Already in special measures, the year before we had received a poor CQC report and this brought with it major challenge and disappointment for staff, volunteers and governors alike. We also started the year facing a potential merger with our neighbouring Trust on the back of the organisation's poor performance and relative instability.

However, with some fresh leadership in place, our staff found the energy and resolve to combine efforts in delivering an extremely ambitious programme to improve quality. I am very proud to say that the Trust has achieved this plan in full, resulting in markedly better care and experience for patients as well as higher levels of satisfaction for staff. This transformation culminated in the removal of special measures and a commendable CQC report that underlined the improvements made. Whilst the merger did not go ahead for a number of reasons, we were delighted that the Trust had proven its ability to perform effectively as a standalone organisation; a position which staff have continued to build on and strengthen ever since.

Of course, there is still more to be done, but whilst there is no room for complacency, it is important that we celebrate the major progress that has been made over the past year.

On behalf of my fellow governors, I would like to thank each and every staff member and volunteer for their tireless contribution, and for making us truly proud of our local hospitals once again. I would also like to acknowledge the efforts of the Trust's leadership, from those in wards and clinics up to the Board, in driving forward improvements as well as galvanising and supporting people to deliver the transformation needed.

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.

The Board of Directors is focused on achieving long-term success for the Trust through the pursuit of 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.

The Board of Directors brings a wide range of experience and expertise to its stewardship of the Trust 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 seven non-executive directors including the Chair (holding majority voting rights), six executive directors (voting), including the Chief Executive, and three 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 the strategic direction of the Trust 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. 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 Chair, with the support of the Company Secretary ensures that the directors and governors receive accurate, timely and clear information, making complex information easier to digest and understand. Directors are encouraged to update their skills, knowledge and familiarity with the Trust's business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with governors. The Board is regularly updated on governance and regulatory matters.

There is an understanding whereby any non-executive director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Head of Corporate Affairs/ Company Secretary at the Trust's expense. The 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 Trust and its strategies, and all Board members 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. The 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. The Board receives monthly updates on performance, and delegates via the Chief Executive the management of overall performance, which is conducted principally through the setting of clear priorities and ensuring that the Trust is managed efficiently to the highest quality standards and in keeping with its values.

Refreshed in June 2015, our engagement policy was developed with the Council of Governors in response to the recommendations contained in the Code of Governance to address engagement between the Board of Directors and the Council of Governors. This policy outlines the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support on-going interaction and 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 Trust.

Counter fraud

The 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.

The Trust continues to work to maintain an anti-fraud culture and has 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 Trust. A number of staff bulletins were issued during the year to highlight how staff should raise concerns and suspicions.

The Trust is 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 the Trust. Rigorous investigation and disciplinary or other actions are applied as appropriate. The Trust uses best practice, as recommended by NHS Protect. During the year we have published and publicised our policies and procedures for staff to report any concern about potential fraud. This is reinforced by awareness training.

NHS Litigation Authority

The Trust's CNST premium has increased by £1.21m in 2016/17 (£7.53m to £8.74m). This represents a 16% increase, which is in line with the average national increase of 17%.

Committees of the Board

During the year the committees of the Board, most of which were chaired by a non-executive director, included:

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

The Audit and Assurance Committee was chaired by Ray Dawson (Non-Executive Director), who is a fellow of the Chartered Institute of Management Accountants and holds 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 6/7
- Tim Reddish 5/7
- Graham Ward 6/7
- Peter Marks* 1/1

**Peter Marks stepped down from the committee during the year.*

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

In assessing the quality of the Trust's 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.

The committee works with Counter Fraud Service and Trust 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. This includes assurance from the Finance Committee regarding risks to the financial position of the Private Finance Initiative liabilities and the associated impact on cash and liquidity.

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:

- Head of internal audit opinion on both financial and non-financial matters
- External audit opinion on the accounts, the external value for money opinion
- Letter of representation to external audit
- Going concern/principal risks and uncertainties

Standards of business conduct

The Board of Directors recognises the importance of adopting the Trust'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 2016/17 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. Recommendations made from audits are followed up by internal audit as well as being reported separately to the Audit and Assurance Committee. This ensures that all recommendations are sustainably implemented within the organisation.

External audit service (KPMG)

KPMG has been the Trust's external audit provider since 2007, having won a tender for a 3-year period with a 2-year option to extend, and which was exercised.

A second tender exercise was carried out in 2012, also won by KPMG, which commenced on 1 November 2012 and ran until 31 October 2015, with an option to extend for a further 12 months. The Audit and Assurance Committee exercised this option at the November 2015 meeting.

As the current external audit contract period expired on 31 October 2016, the contract needed to be extended or re-tendered. Owing to merger plans with Nottingham University Hospitals having been deferred to the following year at that time, an extension of the current KPMG contract to cover the 2016/17 Annual Accounts was agreed at the meeting on 8 September 2016.

Following the decision in October 2016 not to pursue a merger, the contract for statutory audit services for the Annual Report and Accounts is being re-tendered with effect from the 2017/18 accounting year.

The Trust incurred £62,345 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12 month period to 31 March 2017 (£62,345 net of VAT for the period to 31 March 2016). Non-audit services amounted to £7,150 net of VAT (£5,920 net of VAT for the period to 31 March 2016).

To ensure the independence of the external auditors, non-audit services required during the year are not carried out by a member of the team conducting the external audit, but by team members with separate lines of accountability.

Remuneration and Nomination Committee

As at 31 March 2017 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 Trust and to ensure the executives are fairly rewarded for their individual contributions to the Trust'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 2017, the Board considers that it was fully compliant with the NHS Foundation Trust Code of Governance with the following exceptions, where the Trust has alternative arrangements in place.

The governance structure, which has evolved over the year to keep pace with an ever changing environment, will stand the Trust 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 prior to each board meeting. This helps to ensure that the Trust continues to look to current and evolving best practice as a guide in meeting the governance expectations of patients, members and the wider stakeholder community. The effectiveness of the Board will continue to be assessed, both through self-assessment and an external review planned for 2017.

In common with the health service and public sector as a whole, the Trust is operating in a fast changing and demanding external environment, particularly as we understand and respond to the changes resulting from the Health and Social Care Act 2012. The Trust recognises the need to deliver significant increases in efficiency whilst maintaining high quality care at a time when budgets are tight. We will continue to build on the improvements made to date in responding to these challenges, working through our exceptional and dedicated staff.

The Trust ensured that due regard was taken to its legal obligations by developing and implementing a governor development programme. 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.

The roles and responsibilities of the Council of Governors are described in the Constitution, together with detail 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.

The Trust has a detailed scheme of delegation, which was reviewed and updated during 2016/17. This sets out, explicitly, those decisions reserved to the Board, those which may be determined by standing committees, and those that are delegated to managers.

All members of the 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 of the Trust and are involved in patient and staff engagement events.

The 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. Governors were also fully involved in the decision not to pursue a proposed merger with Nottingham University Hospitals but instead establish a formal strategic partnership to focus on joint clinical pathways for the benefit of all our patients.

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 the 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 NHS Providers.

In April 2016, the Board of Directors and Council of Governors approved an amendment to the Trust's Constitution. Relating to disqualification, the following section was removed to ensure the Constitution complied with current legislation and to support the proposed merger with Nottingham University Hospitals:

> **8.7.1** An individual may not become or continue as a Director of the Trust if:
>
> **8.7.1.8** he is an executive or non-executive director or governor of another NHS Foundation Trust, or an executive director, non-executive director, Chairman, Chief Executive Officer of another Health Service Body.

NHS 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, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters 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 was placed in segment 4 until being removed from special measures in November 2016. It was then re-allocated to segment 3 due to the outstanding conditions on our licence, namely S106 for which a compliance certificate was received 6 April 2017, and S111 relating to Trust leadership, which is under review by NHS Improvement.

This segmentation information is the Trust's position as at 31 March 2017. The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score Finance to provide
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	I & E Margin	4	4
Financial controls	Distance from financial plan	1	1
	Agency spend	4	4
Overall Scoring		**3**	**3**

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
- 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.

Peter Herring
Chief Executive
25 May 2017

Annual Governance Statement

Scope of responsibility

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

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals 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 Hospitals NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the Annual Report and Accounts.

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives

Regulation

We were placed in special measures in June 2013 as a result of the Sir Bruce Keogh Rapid Response Reviews into Trusts in England that had been persistent outliers on mortality statistics. In April 2015, Monitor issued us with a compliance certificate with regard to the explicit terms of the section 106 undertakings, identifying concerns with financial sustainability and governance, target breaches and board governance. In response we developed and delivered action plans for short-term recovery, financial governance, targets, and governance. Monitor also applied a section 111 on the Trust in April 2015 with regard to concerns in respect of leadership and governance. In March 2017, NHS Improvement lifted the S106 undertakings and is also reviewing the requirements of the section 111.

We were inspected by the Care Quality Commission (CQC) in June 2015, the report from which was published in October 2015 and rated the Trust as 'Inadequate' overall. In two of the CQC domains - Safe and Well-led - we were rated as 'Inadequate'; for Responsive and Effective we were rated as 'Requires Improvement'; and for Caring we were rated as 'Good'. The CQC re-inspected us in June 2016 with regard to the Well-led and Safety Domains. In recognition of the significant progress and improvements delivered, the report published in November 2016 rated us as 'Requires Improvement' for the Well–led domain and 'Good' for the Safe domain, resulting in the uplifting of our overall rating to 'Requires Improvement'.

In acknowledgement of the improved rating awarded by the CQC and the evident progress made, in November 2016, NHS Improvement confirmed the recommendation from CQC's Chief Inspector of Hospitals, Professor Sir Mike Richards, that the Trust should be removed from special measures. Jim Mackey, Chief Executive of NHS Improvement, stated in his letter: 'This is an excellent result and you and all of your staff involved in this effort deserve congratulations'.

With respect to performance against specific targets and standards, this Annual Report describes what we have achieved and provides further explanation where standards have not been achieved.

A significant amount of work has been undertaken during the year through a robust quality improvement programme. Described elsewhere in this report, this programme reflects the actions we have taken to improve quality and patient safety.

By the end of the year, the performance of our teams resulted in the Trust meeting most national targets and standards. Plans are in place to achieve all standards set out within the NHS Constitution within the next two years.

Our operational performance and progress against our quality improvement programme is reported to NHS Improvement through our monthly performance review meetings. During these meetings we also provide updates on financial, operational and staffing performance as well as clinical governance, strategies and partnership working.

Details of full-year performance can be found in the performance report contained within this Annual Report. These outcomes have been reported to the Board, Council of Governors and NHS Improvement, and relevant Board papers have been published on our website.

We are very proud of our staff for the excellent progress made towards ensuring the delivery of consistently safe, high quality services that achieve national standards and result in an excellent patient experience to all our patients. We recognise that there is more to do, and the progress made over the past year provides a strong foundation on which to strengthen and continue to improve our performance.

Capacity to manage risk

Our Board of Directors provides strategic leadership and commitment to the maintenance of an effective risk management framework within the Trust. The Chief Executive has overall accountability for the management of risk and chairs the Board Risk Committee. The Board Risk Committee was introduced in November 2015 to improve our risk management process and provide assurance to the Board with regard to risks and respective mitigation plans to address issues and areas of concern. Responsibility for the management of risk in specific areas has been delegated to appropriate members of the Trust's executive team.

The Risk Management Policy continues to define the organisation's approach to risk, the roles and responsibilities of the Board and senior management, and the risk management framework that is in place. The Policy is reviewed annually by the Board Risk Committee, which also receives regular reports from clinical divisions and corporate departments in relation to significant corporate and operational risks, and assurance.

There is a range of further policies in place which collectively define for all staff groups their roles and responsibilities in relation to the identification and management of different types of risk, and which are reviewed in line with the Risk Management Policy.

Risk management training will be enhanced in 2017/18 and incorporated within a new Good Governance Training and Education Programme, to be introduced from April 2017. This will include a range of classroom based training sessions, supplemented by e-learning materials and guidance documents. The communication of governance and risk messages will be delivered through a refreshed Learning Matters newsletter as well as the weekly staff bulletin.

Risk specialists in areas such as patient safety, security, health and safety, information governance and supply chain all provide invaluable expertise to support us in the effective management of operational, corporate and strategic risks.

Established organisational learning mechanisms, including the use of root cause analysis in incident investigations, policy and process reviews, clinical and organisational audit, data analysis, improvement planning, internal communication channels, and training programmes all enable us to continue to improve the level of risk awareness at all levels of the organisation. This supports our aim to achieve continuous improvement in the quality and safety of services, and to wholeheartedly embrace a culture of learning.

The risk and control framework

The Risk Management Policy sets out our appetite for risk and the primary responsibilities for managing risk within the organisation, as well as the structures, systems and processes by which risks are identified, recorded, evaluated and controlled.

The Board Risk Committee is now firmly established and has monitored progress with the development of our corporate and operational risk registers and their alignment with the principal risks within the Board Assurance Framework. The Committee also oversees the work of risk specialisms including the Information Governance Group, which supports the role and responsibilities of the Senior Information Risk Owner (SIRO); and the Resilience Assurance Committee (RAC), which has responsibility for the Trust's emergency planning and business continuity arrangements and ensures that duties under the Civil Contingencies Act 2004 continue to be met. This structure enables the Board Risk Committee to discharge its own responsibilities with regard to providing assurance to the Board as to the appropriateness and effectiveness of the risk management framework.

The most significant strategic risks continue to be the maintenance of sufficient numbers of skilled staff to deliver our full range of clinical services; and financial sustainability as funding levels reduce in real terms year on year, whilst substantial cost pressures remain. The 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.

Every member of staff has a responsibility for responding appropriately to the risks and issues they identify, which includes the reporting of incidents and near misses. Divisional and departmental management teams are responsible for ensuring that all reported incidents are investigated appropriately, and for developing and maintaining local risk registers, which are monitored through the divisional management structure and the Board Risk Committee.

The implementation of the Risk Management Policy is further supported by:

- Established governance arrangements through the Board, its committees and sub-committees, clinical divisions and corporate departments
- A structured risk management framework that defines strategic, corporate and operational risks
- A Board Assurance Framework that defines principal strategic risks
- A risk scoring matrix that ensures a consistent approach to the rating and prioritisation of risks
- Policies for the reporting, investigation, management and analysis of incidents, complaints, concerns and claims
- A comprehensive management process for serious incidents
- A staff induction and mandatory training programme

Board Assurance Framework

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method of ensuring effective and focused management of principal risks to the delivery of the Trust's objectives. The Board defines principal risks and ensures that each is assigned to a lead director as well as to a lead committee for appropriate management and assurance. The BAF was in place throughout 2016/17 and has been further refined this year to provide a clearer definition of those corporate risks considered by the Board to be of strategic significance.

These strengthened governance arrangements are founded on the operation of the BAF, and include the presentation and scrutiny of information to provide evidence and support the assurance of control effectiveness at all committees of the Board.

The Board Risk Committee reviews the BAF every month to ensure principal risks are accurately rated and prioritised, and that appropriate actions are being taken to manage those risks. Lead committees regularly receive and scrutinise information to enable them to take assurance that principal risks are being managed effectively.

The principal risks currently identified on the BAF are:

BAF Ref	Principal Risk
AF1	Safe and effective patient care
AF2	Managing emergency demand
AF3	Managing elective demand
AF4	Financial sustainability
AF6	Staff engagement and morale
AF7	Staffing levels
AF8	Senior leadership stability

Principal risk AF5, which related to organisational sustainability, was removed from the BAF during 2016/17 as the Board considered that actions taken during the year with regard to the long-term future of the Trust had reduced this risk to a tolerable level.

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.

Head of Internal Audit opinion

The Head of Internal Audit has provided a 'significant assurance' opinion on the Trust's internal control system, which is designed to meet the organisation's objectives and which ensures that controls are generally applied consistently. This improvement in the Head of Internal Audit's opinion reflects the improvements made by the Trust in embedding risk management throughout the organisation and implementing and sustaining a robust BAF assurance process through the Board Risk Committee.

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

The Trust is compliant with NHS Foundation Trust Condition 4. The Trust's governance committee structures were overhauled during 2015/2016 in order to reduce the number of committees serving the assurance committees and to refocus the assurance committees of the Board of Directors and the management committees. This structure has provided the 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.

During the year, the Board has received assurance regarding the performance of the Trust through the introduction of the Single Oversight Framework Integrated Performance Report. Implemented in October 2016, this brings together performance metrics and information relating to workforce, quality priorities, staffing and finance. Reports to Board from the Audit and Assurance Committee and the Board Risk Committee provide further assurance to the Board on the effectiveness of risk management and internal control; these include reports from internal and external audit.

Quality governance

The key elements of the Trust's quality governance arrangements are:

- The introduction of a Patient Safety and Quality Board, chaired by the Chief Nurse or Executive Medical Director, whose purpose is to provide the Quality Committee with assurance that high standards of care are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place across the organisation to identify and mitigate risks and issues with regard to quality governance
- Significant work to improve risk registers, through enhanced risk management processes overseen by the Board Risk Committee
- Appropriately skilled members of the Board of Directors provide rigorous challenge to the quality governance processes through receipt of reports relating to quality governance, including the quality aspects of the Single Oversight Framework Integrated Performance Report, which are overseen by the Chief Nurse and Executive Medical Director
- Internal and external audit reports are reported to the Audit and Assurance Committee
- Each strategic risk identified on the BAF has an appropriate executive director lead
- The quality improvement plan comprised ten key work streams, each with an appropriate executive director lead and supported by the programme management office and divisional leads
- The Raising Concerns (Whistleblowing) Policy is embedded throughout the organisation and is supported by two 'freedom to speak up' guardians who have received focused training in order to support staff in raising concerns
- The Audit and Assurance Committee oversees data quality and receives regular reports with regard to data quality metrics, data quality projects, data quality incidents and action plans to address issues identified

Data quality

All of our staff must adhere to our Data Quality Policy as well as guidance issued within the Data Protection Act 1998.

Validation is a fundamental part of our processes when capturing data to ensure that the information recorded is of a good quality. We undertake regular validation processes and data checks/audits on data being recorded to assess its completeness, accuracy, relevance, accessibility and timeliness. These processes provide assurance that the data we collect and report is fit for purpose.

Patient data is collected and processed by multiple staff across our organisation and therefore the data quality may affect, and be affected by, a wide range of staff and activities. Data quality is embedded into our values, cultures, and ethos such that 'right first time' is the only accepted outcome. Our staff understand the value of capturing high quality data in real time to improve patient care.

The following are activities we undertake to ensure the appropriate use and capturing of data across the Trust:

- Ensure both operational and clinical staff are made aware of the importance of data quality and validation of their data. This is achieved through addressing training and educational needs, by delivering awareness sessions and undertaking regular communication
- Improved engagement between clinical and administrative staff
- Consider all challenges to the accuracy of our data and where necessary update processes to reflect these constraints
- Implement the local performance reporting tools developed that demonstrate, following audit, the accuracy of our data
- Ensure that correct patient demographic data is available so that patients can easily be identified and can be contacted and communicated with effectively
- The data quality team provides a resource for all users to refer to if they are having issues or to help apply guidance regarding standards
- The data quality team has a timetable for auditing data on a rotational basis to provide assurance regarding our data

Pension controls

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.

Equality, diversity and human rights

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

Carbon reduction

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

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

The 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 the 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 have struggled to maintain a full staffing establishment, in the main due to recruitment difficulties which are concentrated in the nursing and medical workforce as well as senior and divisional management. This is largely driven by national shortages as opposed to local factors. However, the fact we are surrounded by high profile teaching hospitals and have suffered poor publicity due to historical difficulties in performance, including a poor CQC rating, being placed into special measures, and financial challenges has exacerbated this problem. The high number of vacancies in certain areas has a direct influence on our use of agency staff and expenditure on variable pay.

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

- **Executive-led Taskforces:** The Trust has a Medical Taskforce and a Nursing Taskforce, both of which are core work streams within the Trust's cost improvement programme (CIP) and have a focus on reducing agency spend. The Medical Taskforce is led by the Medical Director, and the nursing equivalent by the Chief Nurse. Work stream meetings are chaired by the executive lead every two weeks, and the programme of work is performance managed
- **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 the nursing and medical work streams)
- **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

- **OD and Workforce Committee:** This Committee receives regular reports on related topics such as sickness absence, recruitment and retention reports, and staff engagement
- **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, the Trust has 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. Costs incurred during the merger process are fully reflected in the annual accounts.

We have ended the year with a deficit of £49.1m. 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 delivery and patient experience. Our partnership work on the 'vanguard' Better Together programme for mid Nottinghamshire is pivotal to achieving this, as is the Nottinghamshire Sustainability and Transformation Plan.

Liquidity support has been agreed with NHS Improvement/the Department of Health in the form of loans and working capital facility. A total of £66.57m of working capital facility, £61.27m of revenue loans and £5.3m of capital loans have been drawn down during 2016/17. 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 2017/18, as the Trust is planning to deliver the deficit control of £37.6m set by NHS Improvement. It is therefore the Trust's intention to prepare our account 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 £14.3m for 2016/17. The programme was delivered through fifteen key work streams, progress was reported monthly to the Finance Committee, with risks identified and mitigating actions agreed and implemented. The Programme for 2017/18 has been developed for implementation in April 2017, and delivery will be underpinned by the same robust governance process.

As described elsewhere within this report, the Board of Directors approved a quality improvement plan in November 2015. This combined actions within the existing quality improvement plan with those highlighted by the CQC. The plan encompassed ten work streams underpinned by detailed action plans. The delivery of this plan was led and owned by managers and staff across the organisation, ensuring that actions implemented were subsequently sustained. The achievements accomplished by this programme directly resulted in stepped improvements, enabling the Trust to be removed from special measures following a positive CQC inspection that saw our overall rating being uplifted to 'Requires Improvement'.

Information governance

Information Governance (IG) is the responsibility of both the Head of Corporate Affairs and of the Chief Finance Officer, who is the Trust 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 Medical Director as Caldicott Guardian and the SIRO share the chair of the IG Group, a working group that operates as part of the IG department. The reporting and management of risks relating to data and security are safeguarded by ensuring that all employees of the Trust are reminded of their data security responsibilities through education. Over 4,000 staff members received mandatory IG training in 2016/17,

and regular reminders are shared via staff communications. Near misses and lessons learnt are used to inform the training programme, ensuring that the programme remains dynamic and reflects current and meaningful issues to facilitate greater staff engagement and ownership of IG processes.

For the 2016/17 submission, the Trust has fully implemented all IG Toolkit requirements set out within the Caldicott recommendations report. We maintained our satisfactory 'green' rating, with 82% compliance.

There were two reportable incidents with regard to information governance during 2016/17. Both incidents relate to information disclosed in error. These incidents have been investigated and closed by the Information Commissioners Office (ICO), with no further action other than for the Trust to ensure that related policies and guidelines are updated.

The Trust reported one cyber security incident during the year. This is presently being investigated by the ICO and pertains to a third party supplier who holds employee data. The outcome of the ICO investigation will enhance our understanding and awareness of cyber security issues.

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, as well as 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 staff are notified about updates to policies and guidelines via the staff bulletin as soon as they are published on the staff intranet.

As part of ensuring compliance with the information governance agenda, the Trust has reviewed the terms of reference for the Information Governance Group. This group now has a more strategic focus to ensure that 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 Caldicott Confidential and IG Group, which identifies learning from incidents and develops the actions required to address them and help to prevent recurrence. This group also reviews national guidance in order to inform both strategy and policy, and the development of implementation plans and processes.

The Information Governance department is actively involved in developing meaningful partnership working with neighbouring healthcare providers. This helps to ensure that the sharing of patient data is protected in line with national guidance in a seamless, robust and effective way across the whole of Nottinghamshire. Two examples of partnership working where information governance considerations have played a key role are:

- **East Midlands Radiology Consortium (EMRAD)**

  This is a consortium of seven NHS Trusts, chosen by NHS England, to develop new arrangements between hospitals for sharing staff, services, resources and appropriate and relevant patient information to help improve the quality of care provided to patients. This will ensure an enhanced patient experience across multiple geographies.

- **Nottinghamshire Community Care Portal**

  Currently, health and social care providers across Nottinghamshire hold individual paper and electronic records. The portal, presently in the process of being developed, will ensure that information about patient healthcare is available to the right healthcare staff at the right time. The portal is a collaboration between hospitals, GPs, primary and community-based services, mental health and social care services.

Care Quality Commission Compliance

At the start of this financial year we were not fully compliant with the registration requirements of the CQC, having previously had conditions placed on our registration under section 31 of the Health and Social Care Act 2008 with regard to sepsis management, and a section 29A warning notice with regard to quality and the safety of patients.

As detailed elsewhere within this report we implemented a quality improvement plan to address the issues identified. In April 2016 the CQC confirmed that we had successfully met the part of the section 29A warning notice relating to the fit and proper persons requirement; and later, in September 2016, it was confirmed by the CQC that the Trust had met the requirements of the section 29A warning notice in its entirety. In May 2016, CQC confirmed the removal of the section 31 conditions on our registration.

The CQC rated the Trust as 'Inadequate' overall during its inspection in 2015. In July 2016, the CQC carried out an unannounced follow up inspection to check progress against their 2015 findings. As a result, they uplifted the Safe domain from 'Inadequate' to 'Good', and the Well-led domain from 'Inadequate' to 'Requires Improvement'. This resulted in an overall improvement in our rating from 'Inadequate' to 'Requires Improvement'.

Sherwood Forest Hospitals NHS Foundation Trust is now fully compliant with the registration requirements of the Care Quality Commission.

Sherwood Forest Hospitals NHS Foundation Trust is now fully compliant with the registration requirements of the Care Quality Commission

Annual Quality Report

The directors are required under the Health Act 2009 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 Sherwood Forest Hospitals NHS Foundation Trust's performance over the period covered from April 2016 to 31 March 2017 and indicates that there are appropriate controls in place to ensure the accuracy of data.

These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse and operationally led by the Deputy Chief Nurse
- Quality governance and quality and performance reports are include in the Trust's 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 and knowledge to deliver their responsibilities

All indicators included within the Quality Report are reported on a regular basis. Reports are shared with the divisions and the Board. Specific indicators within the report are also monitored and reported via the monthly performance management meetings with divisions, through the Patient Safety and Quality Board, Quality Committee and the Board of Directors. Undertaken by the Trust's internal auditors, a recent review of quality account reporting structures delivered significant assurance.

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. Work will continue in 2017 to ensure the robustness of the policy framework that supports effective risk management across clinical and non-clinical areas. This will help to provide greater assurance that the quality data reported to the Board is an accurate reflection of what actually happened. Key elements of the CQUIN programme and quality report are reported to the Board of Directors and divisional management teams. Provided in the Quality Report, the Trust's external auditors have provided a qualified assurance opinion in relation to 18-week incomplete pathways and emergency care 4-hour wait indicators.

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, Risk 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 Assurance' opinion for 2016/17. This is an improvement on last year's opinion and reflects the improvements made by the Trust in both embedding risk management throughout the organisation, 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 2016/17 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
- The findings of the CQC inspection undertaken during the year
- The lifting of sanctions on our provider license by NHS Improvement
- The lifting of conditions on our CQC registration
- Removal from special measures by NHS Improvement

Conclusion

There are no other significant internal control issues I wish to report. I am satisfied the Trust 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.

Peter Herring
Chief Executive
25 May 2017

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 2016/17, and states and explains our quality priorities for 2017/18.

The retrospective elements of this report pertain to the activities undertaken by the Trust during the financial year of 2016/17 and incorporate all of the mandatory reporting requirements set out by Monitor, referenced within the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2016/17
- Data Dictionary

Part 1 - Statement of the Quality Account from Peter Herring Interim Chief Executive

Our Quality Report and Accounts for 2016/17 detail the steps we have taken to improve delivery of quality care to our patients during what has been perhaps one of the most remarkable years in the Trust's history.

During 2016/17 we achieved a major turnaround in the quality and safety of services; not only did we successfully move out of special measures, but our organisation is now an exemplar in a number of key areas.

A positive Care Quality Commission (CQC) inspection in July saw us rated as "Good" for Safety and "Good" for Caring, and improved our overall rating to "Requires Improvement".

We continued to develop and implement a detailed Quality Improvement Plan (QIP) to deliver positive changes in the way care is planned and delivered. The QIP focussed on ten work streams for improvement:

- Leadership
- Governance
- Recruitment and retention
- Personalised care
- Safety culture
- Timely access
- Mandatory training
- Staff engagement
- Maternity
- Newark

During 2016/17 our staff delivered improvements across the Trust including:

- Becoming one of the strongest performing Trusts in England for delivery of the emergency access standard – to treat and discharge or admit 95% of urgent and emergency attendances within four hours. In the face of increasing numbers attending, we achieved this standard in the second and third quarters of the year and only narrowly missed achieving in the final quarter
- Beating the threshold set by NHS England that acute Trusts should have no more than 48 cases a year of C.difficile , with just 28 cases reported
- Achieving the 2016/17 Sepsis national CQUIN with an initial focus on embedding the sepsis protocol and sepsis screening tool within all areas of the Trust. The success of this improvement has been recognised by the fact that the Trust is a finalist in the National Patient Safety Awards
- Reducing falls per 1,000 bed days through safety improvements driven by learning and adoption of best practice. The Trust figure for March 2017 is 6.20. The National average is currently 6.63
- Continue to reduce mortality as measured by Hospital Standardised Mortality Ratio (HSMR). This measure indicates if more, or fewer, patients are dying that would be expected given the health profile of the local population. Sherwood Forest has moved from being one of the worst in the country in 2013 to being among the top 30 per cent today
- Implementing the Patient Safety Culture programme to create an open culture where all staff understand the connection between what they do and how that impacts patient safety and that staff are empowered to learn and initiate improvements
- No medication related "never events" have been reported at any of our hospitals and reported "near misses" have been investigated internally and action plans implemented. Medicine safety remains a priority and we continue to work on areas such as medicine allergies and potential adverse reactions and introduction of new technology to minimise infusion incidents
- Increasing the number of patients whose medicines are reconciled within 24 hours of admission. We are a high-performing Trust within the East Midlands but we still aim to improve our performance. The national target is 95% of patients to have their medicines reconciliation started within 24 hours of admission with the ideal target being 100%. We are at 82%, above the national average of 74.2% for acute Trusts
- Publishing a refreshed review of services at Newark Hospital. Newark Hospital Vision and Strategy, Three Years On, which updates the vision for the hospital and how it fits in with planned local changes to hospital and community NHS care. The vision includes the completion of a £700,000 investment to create an Urgent Care Centre, a commitment to further increases in the range of surgical and medical day-case services available, and more outpatient consultations and diagnostic tests available for a wider range of conditions

I am confident that the information in this report accurately reflects our performance and provides an honest and consistent reflection of where we have succeeded and exceed in delivery on our plans.

We acknowledge that we are still rated as "requires improvement" but are proud of the hard work and dedication shown by our staff in delivering better, safer and more effective care.

Our quality improvement priorities in 2017/18 will be progressed through our Advancing Quality Programme and will focus on:

1. Enhancing our overall Patient Safety Culture
2. Implementing a mobile clinical digital platform that gives healthcare professionals and carers access to all the data, information and knowledge they need in real time
3. Consistently undertaking and improving our mortality reviews
4. Ensuring safe medicine prescribing
5. Working towards ensuring an effective, safe service across our hospitals 24/7, where patients can access routine services seven days a week where appropriate
6. Improving the discharge experience for all patients and ensuring that they return to the most appropriate place of residence at the right time, with the right information, appropriate equipment and a clear plan of any required next steps
7. Providing an equal emphasis on mental health as well as physical health
8. Ensuring we provide effective patient information for every patient that comes into contact with our services

Our continued focus on improving quality and patient safety through the Advancing Quality Programme underpins our ambition to deliver outstanding care to our patients and communities.

Peter Herring
Chief Executive
25 May 2017

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

2.1.1 Providing high quality, safe care

Sherwood Forest Hospitals is committed to providing high quality care to every patient that accesses its services and is focused on continuous improving the quality and safety of our care through our Advancing Quality Programme. Our quality priorities for 2016/17 have been discussed and agreed by our Board of Directors.

We have used the following evidence and information sources to identify and agree our priorities for 2016/17:

- 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

How do we monitor the progress of Key Quality Priorities?

To be a safe organisation, the Trust requires effective governance at all levels. This requires an infrastructure which ensures that risks to both quality and financial sustainability are identified and well managed. This will ensure that timely actions are taken to improve performance and safety in a sustainable manner.

The Trust has developed a new comprehensive committee and governance structure which reports from ward to Board (Appendix 1). All Quality Priority work programmes are regularly discussed at the appropriate designated committee. This ensures effective monitoring systems are in place to track progress against each of our quality priorities.

Throughout 2016/17 the Trust Board received monthly and quarterly quality reports, which identified how the Trust was performing against a range of key performance indicators. For 2017/18 the reporting process is underpinned by a strengthened assurance process. Formal monitoring and measurement of our quality priorities during 2017/18 will be reported through a range of committees and groups, these in turn report into the Quality Committee and Board of Directors. Please see Appendix 1 for committee structure.

Further scrutiny and assurance will be facilitated via the quality and performance meeting attended by the Trust and chaired by the Clinical Commissioning Group (CCG).

Our quality priorities for 2016/17 have been discussed and agreed by our Board of Directors

2.1.2 Key quality priorities for 2017/18

From our longer list of priorities we have identified three improvement areas which we would like to give particular focus to in 2017/18, shown in the table below:

	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 comprehensive clinical handover (medical and nursing) to ensure that the right action is taken at the right time to optimise care.
Key Quality priority 2	Recognise and respond effectively to deteriorating patients.	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.
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.

2.1.3 Key Priority 1 – Providing safe services outside core hours (This is a new priority for 2017/18)

The Trust has long recognised the requirement to provide safe, high quality, sustainable services over a seven day period and over 24 hours a day, however it is clear that there are significant challenges to be faced in ensuring that all areas of the Trust are staffed and can respond efficiently and effectively to the needs of our patients regardless of day of the week or time of the day.

How we address this is outlined within the 'Hospital 24' Programme of the 'Advancing Quality' Improvement Plan and will address the issue of what, where and when services should be provided but specifically how we can provide safe care outside traditional 'normal' working hours. As such the Trust believes the development of this way of working is critical to improving the quality and safety of our services and has recommended this as one of our new key quality priorities for 2017/18.

What do we aim to achieve in 2017/18?

Providing 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. The 'Hospital 24' Programme aims to standardise the way in which the hospital operates between daytime 8am-8pm and out of hours 8pm-8am, weekends and bank holiday periods.

Implementing Nerve Centre as the Trust-wide system that will further enhance care and minimise risk associated with sudden and unexpected clinical deterioration. Via the widespread issuing of hand-held devices a range of staff including adult and Paediatric ward-based staff, doctors in training, the Emergency Department and mobile staff such as Critical Care Outreach and Hospital Out of Hours teams will have real-time access to crucial clinical information enabling them to respond rapidly and make key clinical decisions to optimise patient care and improve outcomes for patients. Nerve Centre will facilitate the appropriate prioritisation and allocation of clinical tasks by the Hospital Out of Hours team and provide an electronic means of facilitating comprehensive clinical handover (medical and nursing) to ensure that the right action is taken at the right time by the right health professional.

2.1.4 Key Priority 2 – Recognise and respond effectively to deteriorating patients

Every year in the UK there are 150,000 cases of Sepsis, resulting in a staggering 44,000 deaths. Sepsis is a medical emergency; it arises when the body's response to an infection injures its own tissues and organs and can rapidly lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

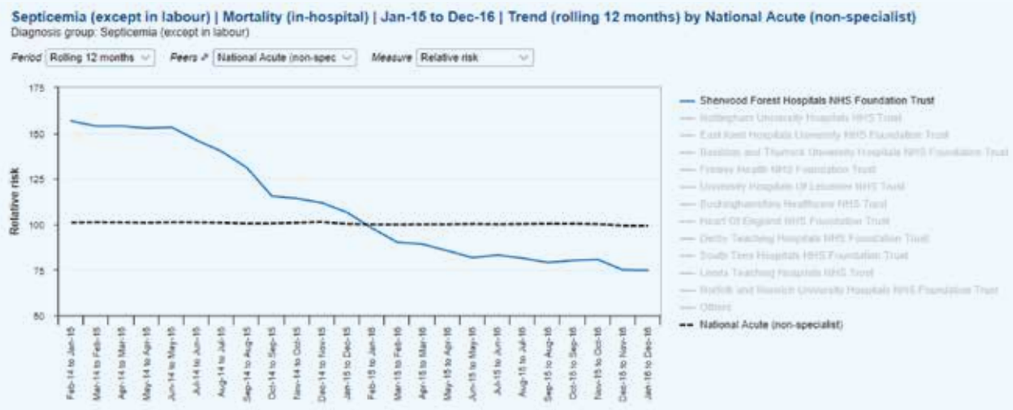
Although Sepsis remains an important area of focus for the Trust we recognised that the same improvement focus needed to be in place for all patients whose clinical condition deteriorated. As a consequence the Trust widened this focus to ensure that it had the appropriate staff with the appropriate skills and competencies to recognise and respond effectively to a patient if their clinical condition deteriorated.

Following the Inspection by the Care Quality Commission in 2015 a section 31 Enforcement Notice was placed on the Trust as a result of poor performance in relation to the management of patients with suspected or diagnosed Sepsis.

This resulted in weekly reporting on the early identification, screening and appropriate treatment of patients both on attendance in the Emergency Department and whilst an inpatient within the hospital. In response to the significant progress made and improvement in Sepsis performance metrics the Section 31 was lifted on the 31st May 2016.

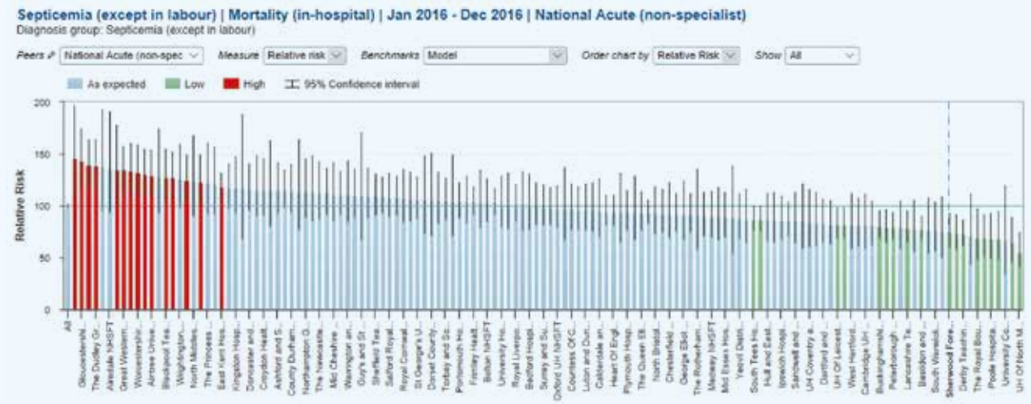
The following graphs (graphs 1 & 2) indicate this shift in position through 2016.

Graph 1 – Sepsis mortality



From being amongst the worst performing Trusts in the country, graph 2 below indicates the current position (to the end of Q3) in the lowest quartile.

Graph 2 – Sepsis mortality



What did we aim to achieve in 2016/17?

- To embed a recognised sepsis local protocol/screening tool within all areas of the Trust
- To administer intravenous antibiotics to patients presenting with sepsis within one hour of presentation
- Implement 2016 NICE guidelines for Sepsis when released
- To monitor improvement in recognising and responding to deteriorating patients

How are we performing against these targets?

The Trust achieved the 2016/17 Sepsis national CQUIN. The initial focus in 2016/17 was to embed the sepsis protocol and sepsis screening tool within all areas of the Trust and thus ensure that sepsis patients received intravenous antibiotics (IV) antibiotics within 1 hour. Both sepsis screening and delivery of IV antibiotics in emergency admission areas has been >90% through 2016/17. There is a system of exception reporting on any missed cases which feeds into local governance to support shared learning and sustainment of the improvements made.

During 2016/17 we saw positive improvement in compliance with sepsis screening on the in-patient wards. This was reinforced by oversight from Matrons with clear governance reporting processes. Compliance with in-patient sepsis screening is now consistently >90%. We achieved >90% delivery of antibiotics in patients that deteriorate with sepsis. Crucial to responsible antimicrobial prescribing is the timely review of antibiotics with appropriate changes as required. Our reviews evidence that >90% of sepsis patients had medication review within 72 hours of commencing antibiotics.

NICE published a guideline for sepsis in 2016. Our Trust clinical guideline was updated in March 2017 to mirror the NICE guideline.

Following the lifting of the Section 31 the weekly Sepsis Task force was decommissioned. It had long been recognised by the Trust that a wider focus on the deteriorating patient as a cohort rather than a small, defined group was required. The Deteriorating Patient Group (DPG) was formed in May 2016 in response. DPG reports directly to the Patient Safety Quality Board.

The Terms of Reference clearly set out the purpose and objectives of the group and incorporate those disparate groups that manage acutely ill patients. It holds to account and agrees the work programmes of each group in order to receive the required assurances that the Trust has robust systems and processes in place to recognise and rescue individuals when their condition deteriorates and that we respond accordingly and appropriately.

To ensure that a focus on sepsis specifically was maintained a monthly Sepsis Working Group (SWG) was initiated. SWG is accountable for:

- Reporting Sepsis-related HSMR through the Deteriorating Patient Group
- Managing and responding to the weekly inpatient Sepsis Screening Audit providing exception reports for opportunities missed, including the ongoing audit of Critical Care admissions. The weekly audit also reports compliance with appropriate escalation, sepsis screening and application of the Sepsis Six Care Bundle (this includes the administration of antibiotics within 1 hour)
- Ensuring that appropriate training is provided for nursing and medical staff in the identification, escalation and timely and appropriate management of Sepsis
- Ensuring compliance with current NICE guidance

What do we aim to achieve in 2017/18?

Our focus will be to continue to embed and extend the work programme from 2016/17 and to further the collaboration currently underway with the Trust Infection, prevention and Control Team, specifically around the appropriate use of antibiotics and Antimicrobial Stewardship in general.

The team are being recognised nationally for this innovative approach to the effective management of infection of which Sepsis is one component as finalist in the National Patient Safety Awards.

This will be monitored through the Deteriorating Patient Group (DPG) which reports to Patient Safety and Quality Board.

2.1.5 Key Priority 3 - To improve the safe use of medicines

Improving the safe use of medicines has been a quality priority for the Trust in previous years, however recognising the national drive to improve medicines incident reporting and ensure safer care the Trust has chosen to continue medication safety a Key Priority for 2017/18.

As a Trust we are striving for the safest possible use of medicines. Medicines are the most commonly used intervention in the NHS, accounting for the second greatest spend after staff and are inherently one of the highest risks to patient safety. There is a continual stream of national guidance relating to safe use of medicines and a heightened requirement for improvement nationally. The Patient Safety Alert published in March 2014, issued a directive to all NHS Trusts to appoint a Medication Safety Officer (MSO) to oversee, advise and assist the Chief Pharmacist in setting the strategy for improving the safety of medicine usage. Medication usage is so commonplace in hospitals that healthcare professionals can become blasé and hence underestimate the potential implications of poor practice and lack of attention when prescribing, administering or dispensing medicines. The organisation is aiming to ensure that all healthcare staff who handle medicines do so in a manner that optimises their usage and protects patients from harm.

Nationally medication safety is high profile and within Sherwood Forest Hospitals NHS Foundation Trust (SFH) we identified there was scope for considerable improvements in how medications were handled. Moving medicines safety to a Trust priority has helped to engage all staff in this agenda and drive safer practice.

What did we aim to achieve in 2016/2017 and how are we performing?

We have focussed on a number of achievable goals for 2016/2017 these are:

- **To achieve zero medication related 'never-events'.**

  This aim was achieved; no medication related never-events have been reported within any of our hospitals. The Trust has had a number of 'near-misses' which have been investigated internally, action plans developed and implemented including process and policy changes. The Trust MSO attends a regional meeting where information on serious incidents such as 'never-events' is shared and provides an opportunity for learning and process review in advance of any incidents occurring.

- **Introduction of Guardrails® IV pump software to minimise infusion incidents.**

  The Guardrails® software has been introduced on the Intensive Care Unit and is running successfully for a limited number of 'high risk' intravenous medications. The roll out to the Trust has been delayed due to concerns that the display on the CareFusion pumps is inadequate to easily and safely allow administration of all medicines. This has been escalated to NHS Improvement as a national safety concern.

- **Revitalisation of self-administration of medicines across the Trust.**

  The Self-Administration of Medication Policy has been ratified by the Drug and Therapeutics/ Medicines Management Committee and made available to staff on the intranet.

- **Improve the management of patients with allergies and adverse reactions to medication.**

  This focus echoes a nationwide agenda to improve patient care in this area. There have been 22 reported instances in 2016/17 where patients received a medication to which they had a documented allergy and this is measured through the national Medication Safety Thermometer (MST). This is a point of care survey which follows three steps to identify potential patient harm. Data is collected on one day each month, the same day nationally, in order to benchmark against other Trusts and monitor local improvements.

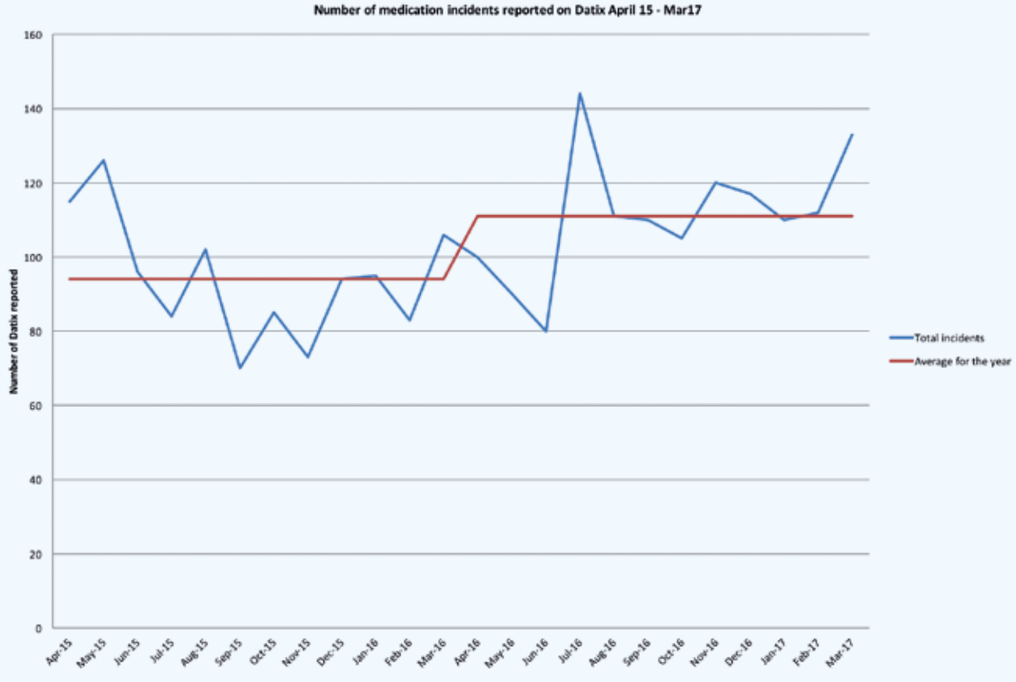
The MST shows good compliance with the documentation of allergy status on medication charts at the Trust with an average of 98.4% compliance. National average is 96.2% for documentation of allergy.

The Trust has introduced red wrist bands as a visual means to identify those patients with allergies. A Task and Finish Group has been formed to review and implement the recommendations from the recent NICE Guideline, 'Drug Allergy: Diagnosis and Management' which aims to improve the management of patients on initial presentation of allergy. The aim of this group is to revitalise and relaunch the Trust policy with a communication plan and audit programme to underpin this work. It is expected that the new policy will be available by the summer 2017. The planned introduction of electronic prescribing and medicines administration to our Trust in 2018 will greatly reduce the risk of patients receiving medicines to which they are allergic.

- **Increase the reporting rate for medication-related incidents and near misses reported on Datix® and improve learning from incidents.**

  An organisation with a positive safety culture is deemed as one with a high level of incident reporting and a low level of harm and the Trust has continued to increase reporting of medicine related incidents. Incidents allow us to review process and issues prior to patients coming to harm so increasing the reporting leads to better outcomes and safer systems for patients. The learning from incidents continues to be shared via the Divisional Governance Meetings, presentations and newsletters. A medication safety Facebook group has been set up to utilise social media to share learning from incidents with Trust employees. Graph 3 highlights the number of reports per month within the Trust.

Graph 3: Number of medication related incident reports per month on Datix®



The investigation process of medication incidents has been strengthened with the appointment of a Medication Safety Officer. All medication related incidents resulting in any patient harm are discussed at the Medication Safety Group. Investigations are conducted into all incidents causing moderate harm and for all 'no harm' or 'low harm' incidents where there is opportunity for learning. Feedback to members of staff reporting the incidents has also improved.

- **To increase the number of patients whose medicines are reconciled within 24 hours of admission to hospital.**

  Whilst the Trust is high performing within the East Midlands region in terms of medicines reconciliation we aim to further improve our performance in this area. The national target is set at 95% of patients to have their medicines reconciliation started within 24 hours of admission with the ideal target being 100%. The MST data shows on average, 82% of all medicines reconciliation within 24 hours, which is above the national average of 74.2% for acute Trusts.

  The Pharmacy service continues to provide cover for the Emergency Admissions Unit 7 days a week. Although the MST shows the Trust is performing favourably against this target, the Trust would like to better understand the actual risk to patients and continue to improve the rate of medicines reconciliation. This target will continue into 2017/18 with a programme of work to improve pharmacy services at a weekend.

- **To increase access to the Summary Care Record (SCR) database.**

  The SCR is a national database containing information on patients medications prescribed from GP practices. Currently only the Pharmacy and Pre-op Assessment teams have access to the SCR. The initial aim was to allow medical staff access to this database but this has been superseded by a Nottinghamshire-wide drive to create universal access to a Community Portal. This will give access to medication information as well as information from other healthcare providers.

- **To reduce the number of patients with omitted doses of critical medicines (e.g. antibiotics, insulin's etc.).**

  Considerable work has been undertaken across the Trust to minimise the number of patients that miss or have delayed doses of medicines including critical medicines. Measured by the Medication Safety Thermometer the Trust is performing well in comparison to national averages. The current average for missed doses at the Trust is 4.9%, for omissions excluding a valid clinical reason and patient refusal, compared to national average of 14.2%. The current level of missed critical medication in the Trust is 2.8 % compared to a national average of 7.1%.

- **Reduce the number of medication-related incidents resulting in moderate/severe harm by 25%, particularly for high-risk medicines such as opioids, insulin's and anticoagulation.**

  The Trust has achieved a 90% reduction in the number of moderate/severe harm medication incidents experienced by our patients. 12 incidents were reported for 2015/16 which resulted in moderate harm or above compared to 1 medication incident reported for 2016/17. This incident was fully investigated, the duty of candour policy followed and actions put into place to reduce the likelihood of this occurring again.

What do we aim to achieve in 2017/2018?

In 2017/2018 we aim to build on the work already undertaken and focus on a number of achievable goals which will help to improve the safe use of medication within the Trust.

- **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 reporting rate is increasing but more work needs to be done to ensure that this is embedded. Medication incident investigation will be improved with significant near-misses and low harm incidents being investigated by the MSO. Reporter feedback will also improve as part of this process and a variety of communication methods used to share the learning for incidents reviewed.

- **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.**

  A programme of work will be underway in 2017 to better understand the risk to patients in terms of medication safety when admitted at the weekend. The achievement of this goal is reliant on expansion of the level of service provided by Pharmacy at weekends.

- **To ensure a 72 hour review of medications for patients presenting with Acute Kidney Injury, for patient on antibiotics and those with outstanding medicines reconciliation issues.**

  A review of medication on admission is essential to ensure patient receive the correct medication for their exiting and acute conditions. We also need to ensure that as the patient improves, we review medication to ensure it is optimised at each stage of their care.

Considerable work has been undertaken across the Trust to minimise the number of patients that miss or have delayed doses of medicines

Monitoring and reporting

The Medicines Management Committee chaired by the Chief Pharmacist and Clinical Director for Medicines Management will oversee and monitor progress with achieving the medicines safety targets. The Medicines Safety sub-group will operationally lead on the activities that are central to the successful achievement of the majority of the targets. The Medicines Management Committee reports to the Patient Safety and Quality Board and progress reports will be taken via this route.

2.1.6 Supplementary Quality Priorities for 2017/2018

We have identified a number of supplementary quality priorities in line with Quality Account requirements that will be implemented during 2017/18. A summary of our quality priorities is included in the table below:

	Supplementary Quality priorities	Outcomes
Improving the safety of our patients	Patient Safety Culture programme	We will enhance our overall Patient Safety Culture programme and to support this we plan to: 1. Implement Schwartz Rounding to maximise and facilitate learning opportunities for the wider organisation. 2. To reinvigorate the 'Sign Up to Safety' Campaign. 3. Introduce Patient Safety Conversations (PSC) to promote an open culture to discuss with staff about how we can make patients safer.
	Reduce harm from falls	1. 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. 2. Drive improvements with a structured audit process and programme for 2017/18. 3. Drive accountability and improvements by setting target reductions by Division. 4. Continue to progress with evidence based practice and develop safety improvement programmes through learning from best practice and innovations.
	To reduce the number of infections	1. Ensure 90% of all antimicrobials are reviewed with a clear plan documented in the medical notes/medication chart within 72 hours. 2. 10% reduction of post 48 hour Escherichia coliform (E.coli) bacteraemia associated with urinary tract infection using the 2016/2017 rate as a benchmark. 3. Reduce the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark.

Summary of Quality Priorities *(continued)*

	Supplementary Quality priorities	Outcomes
	Underpinning these objectives will be the continued development of the Trust's safety culture work programme.	
Improving the effectiveness of clinical care	Improve the quality of our discharge	1. Ensure that safe discharge processes are identified in relevant patient pathways. 2. Undertake a review of all discharges reported to the Trust as 'unsafe' to drive improvements and changes in practice. 3. Implement identified innovations and programmes of good practice related to discharge as they are identified through the year. 4. In conjunction with the Patient Experience Team, design an evaluation tool to measure the experience and effectiveness of patient discharge.
	Improve our care and learning from mortality review	We will improve the care we deliver to our patients and ensure widespread learning from the review of care delivered to those patients who die whilst inpatients in the hospital by: 1. Identifying and eliminating avoidable factors associated with inpatient mortality. 2. Implementing a standardised approach to the review of mortality across all specialty areas to support the identification of defects in care and/or avoidable factors. 3. Implementing an electronic Mortality Data Collection Tool to capture relevant intelligence on the care delivered to patients. 4. Training medical staff to apply the Structured Judgement Review methodology to support comprehensive mortality review. 5. Developing a 'Learning from Deaths' repository to be shared across the Trust.
	To improve the care of patients coming to the end of their life	1. To ensure there is adequate provision of specialist and general palliative care to hospital patients - supported by a contract for service delivery and an End of Life care team workforce plan. 2. To deliver key quality standards to support palliative care of patients in hospital. 3. To improve the coordination and responsiveness of palliative care.

Summary of Quality Priorities *(continued)*

	Supplementary Quality priorities	Outcomes
	Underpinning these objectives will be The Trust's continued development work to learn from patients and staff incidents, outcomes, processes and narratives of care.	
Improving patient experience	Improve the experience of care for patients with dementia and their carers	1. Increase the numbers of staff completing dementia training, especially at Tier 2. 2. Continue to make adjustments that make the care environment more dementia-friendly. 3. Continue to grow the Dementia Champions network that was re-launched in December 2016. 4. Enhance our PLACE audit scores for dementia environments. 5. Implement and embed the principles of 'John's Campaign'.
	Using feedback from patients and their carers	1. Understand and improve our patients experiences, sharing our vision for engagement and involvement 2. Involve stakeholders in shaping services and improvements 3. Understand the Patient Journey using new feedback mechanisms
	Safeguarding vulnerable people	1. Promote and maintain safe practice of all people who work as part of SFH. 2. Evidence improvement of the effectiveness of our care of vulnerable children, young people and adults. 3. Implement initiatives which understand and enhance service user experience.
	Underpinning this objective will be the continued delivery of the patient experience and involvement and organisational development work programmes.	

Many of our quality priorities focus on similar aspects to 2016/17, allowing the Trust to further improve and embed the quality of our care and we would direct the reader to the data quality section of the Quality Account. This section also updates the reader on mandated elements of the Trust Quality Account including the staff survey. Where we have a new quality priority we have described why we have chosen to focus on this.

These quality priorities were identified through discussions with, and feedback from, patient, staff, governors and stakeholders.

2.2 Statement of Assurance from Board

Each year we look after over 54,000 inpatients, 430,000 outpatients, and 126,000 attendances to our emergency department and over 3,400 women who choose to give birth at King's Mill Hospital. We employ 4,500 staff, including 186 consultants, working in hospital facilities that are some of the best in the country.

During 2016/17 Sherwood Forest Hospitals NHS Foundation Trust provided 59 relevant services. 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 2016/17 represents 86% of the total income generated from the provision of relevant health services by Sherwood Forest Hospitals NHS Foundation Trust for 2016/17.

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 newly established ward accreditation programme led be the Deputy Chief Nurse and the quality visits undertaken jointly with our Clinical Commissioning Group colleagues.

2.2.1 Participation in Clinical Audits

Clinical Audit Submission to Quality Accounts 2016/17

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 primarily evidence where their services are doing well and secondly identifies other areas where improvements need to take place in order to improve outcomes for patients.

Participation in Clinical Audit

During 2016/17, 31 national clinical audits and 5 national confidential enquiries covered relevant health services that Sherwood Forest Hospitals Foundation Trust provides.

During that period the Sherwood Forest Hospitals Foundation Trust participated in 27 of 31 (87%) 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 2016/17 are as follows:

National Clinical Audit & Enquiry Project Name
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma
Asthma (paediatric and adult) care in emergency departments
Bowel Cancer (NBOCAP)
Cardiac Rhythm Management (CRM)
Case Mix Programme (CMP)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit programme (FFFAP)
Inflammatory Bowel Disease (IBD) programme
Major Trauma Audit
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Audit of Dementia
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery
National Diabetes Audit - Adults

(Continued)

National Clinical Audit & Enquiry Project Name
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Ophthalmology Audit
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Nephrectomy audit (BAUS)
Oesophagi-gastric Cancer (NAOGC)
Sentinel Stroke National Audit programme (SSNAP)
Severe Sepsis and Septic Shock – care in emergency departments
Stress Urinary Incontinence Audit (BAUS)

National Clinical Audits 2016/17

The national clinical audits and national confidential enquires that Sherwood Forest Hospitals Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

	National Clinical Audit & Enquiry Project Name	Included in NHSE Quality Account List (2016/17)	Part of NCAPOP commissioned by HQIP (Y/N)	%
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%
2	Adult Asthma	Yes	No	100%
3	Asthma (paediatric and adult) care in emergency departments	Yes	Yes	75%
4	Bowel Cancer (NBOCAP)	Yes	Yes	100%
5	Cardiac Rhythm Management (CRM)	Yes	Yes	100%
6	Case Mix Programme (CMP)	No	Yes	100%
7	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
8	Diabetes (Paediatric) (NPDA)	Yes	Yes	100%
9	Elective Surgery (National PROMs Programme)	Yes	Yes	100%
10	Endocrine and Thyroid National Audit	Yes	Yes	100%

(Continued)

	National Clinical Audit & Enquiry Project Name	Included in NHSE Quality Account List (2016/17)	Part of NCAPOP commissioned by HQIP (Y/N)	%
11	Falls and Fragility Fractures Audit programme (FFFAP) 2 parts	Yes	Yes	100% / 75%
12	Inflammatory Bowel Disease (IBD) programme	Yes	Yes	
13	Major Trauma Audit	Yes	No	82%
14	Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%
15	National Audit of Dementia	Yes	Yes	100%
16	National Cardiac Arrest Audit (NCAA)	Yes	No	95%
17	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	Yes	0%
18	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	Yes	No	24%
19	National Diabetes Audit - Adults	Yes	Yes	100%
20	National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
21	National Heart Failure Audit	Yes	Yes	
22	National Joint Registry (NJR)	Yes	Yes	100%
23	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
24	National Ophthalmology Audit	Yes	Yes	0%
25	National Prostate Cancer Audit	Yes	Yes	10%
26	Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
27	Nephrectomy audit (BAUS)	Yes	Yes	100%
28	Oesophagi-gastric Cancer (NAOGC)	Yes	Yes	100%
29	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
30	Severe Sepsis and Septic Shock – care in emergency departments	Yes	Yes	100%
31	Stress Urinary Incontinence Audit (BAUS)	Yes	Yes	100%

National Clinical Outcome Review Projects 2016/17

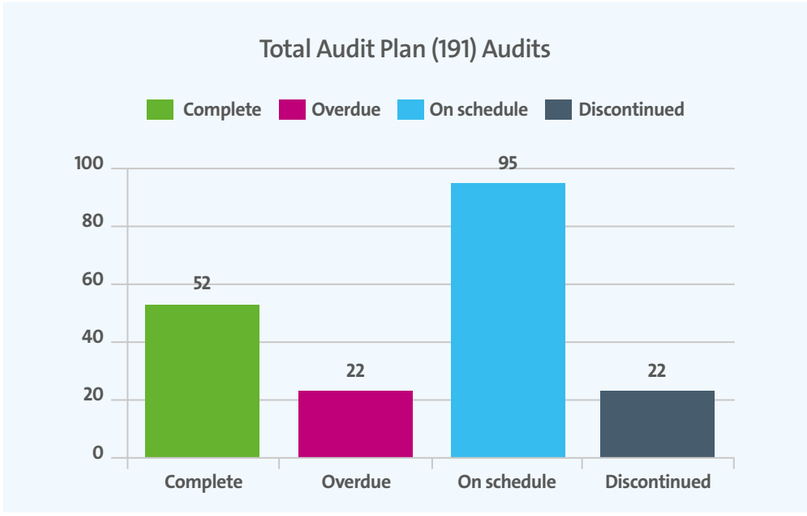
The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals Foundation Trust participated in during 2016/17 are as follows:

Study Title	Participation	Project Status	%
Mental Health	Yes	Cases submitted	100%
Acute Non Invasive Ventilation	Yes	Cases submitted	100%
Chronic Neuro-disability	Yes	Cases submitted	100%
Acute Pancreatitis	Yes	Cases submitted	100%
Young Peoples Mental Health	Yes	Cases submitted	100%

Outcomes and Learning from Clinical Audits Undertaken During 2016/17

The number of clinical audits both national and local which formed part of the 2016/17 Audit Plan was as follows:

Total Number of Audits of the 2015/16 Plan	191
Number of Local/Other Audits	155
Number of National Audits, including NCEPOD	36
Number of Audits still on-going (as at 31st March 2017)	95
Number of Audits completed	52



An audit was undertaken to review improvements in the identification of patients over the age of 75 with dementia/delirium. The findings were generally positive as a result

The reports of all previous national and local clinical audits were reviewed by the provider in 2016/17 and Sherwood Forest Hospitals Foundation Trust has taken the following actions to improve the quality of healthcare provided. Below gives examples of some of the clinical audits undertaken during 2016/17 and describes the type of learning which occurred related to:

- Learning around Patient Safety
- Learning around Clinical Effectiveness
- Learning around Patient Experience

Audit: Antibiotic Durations

- Learning around Patient Safety
- Learning around Patient Experience

Following a review of antibiotics in this area an audit was undertaken to assess whether patients were receiving the most appropriate antibiotics for the right duration. The audit identified that the number of occasions in which samples have been taken for culture during appendectomy operations has increased, the empiric antibiotic given to patients is appropriate in more numbers of patients, and more patients are receiving the right antibiotics for the right duration.

Audit: Orthopaedic Readmissions

- Learning around Patient Safety
- Learning around Clinical Effectiveness
- Learning around Patient Experience

A re-audit was undertaken in the Trust regarding re-admission to hospital following orthopaedic surgery. The re-audit demonstrated a re-admission rate of 1.38% which is significantly lower than the national performance of 7%.

Audit: Improving Detection and Referral of Patients over the age of 75 with Delirium and Dementia

- Learning around Patient Safety
- Learning around Clinical Effectiveness
- Learning around Patient Experience

An audit was undertaken to review improvements in the identification of patients over the age of 75 with dementia/ delirium. The findings were generally positive as a result of this audit. Further changes have been implemented. These include the creation of a new clinical pathway for referral to the liaison psychiatry team to improve detection and referral of patients. A change was made to the clerking booklet to improve documentation of the Abbreviated Mental Test (AMT) scores. This was aligned to awareness via teaching sessions to F1, F2 and CMT Doctors.

Audit: BTS Adult Asthma Audit

- Learning around Patient Experience

The findings from the Trust's participation in this national audit highlighted the need to increase the number of patients receiving specialist review within 4 weeks of admission. A new clinic run by the Asthma Specialist Nurses has commenced, this sees all acute asthma patients within the 4 week target. Additionally, the Trust now uses the 'asthma bundle process' to optimise the management of patients with asthma.

Audit: Fractured Neck of Femur

- Learning around Patient Safety
- Learning around Patient Experience

This audit demonstrated the length of stay for patients has been reduced from 29.3 days to 20.4 days. The trajectory for the number of patients receiving surgery in 36 hours 55.5%; the Trust achieved 85.7% and also increased pre-operative AMT's from 88% to 100%.

Audit: Recording of Child Care Responsibilities

- Learning around Clinical Effectiveness
- Learning around Patient Experience

Using the 'Think Family' approach an audit was carried out to assess whether child care responsibilities and adult patients was being assessed to ensure appropriate action is being taken. Our re-audit identified that there had been a significant improvement in the completion of the social circumstance sections of the patient administration booklet, compliance against the criteria rose from 56% to 74%.

Audit: IV Contrast of Extravasation in Radiology

- Learning around Clinical Effectiveness
- Learning around Patient Experience

Audit was undertaken to assess the occurrence of extravasation in radiology and compliance with policies and processes in relation to this. Against a national average of between 0.2% – 0.9% the Trust had less cases of extravasation at a rate of 0.15%. Following the audit information we offer to patients was improved, the policy was reviewed and our reporting of extravasation incidents increased.

What have we achieved in 2016/17?

A significant number of audits have been presented at the Clinical Audit and Effectiveness Sub-committee which has enabled various staff groups get a better understanding of some of the outcomes and challenges faced from the results of audit. Some of the audits presented include:

- IV Fluid Therapy in Adult Patients in Hospital
- NCEPOD Sepsis
- National Diabetes Audit
- Audit of AMT Compliance in ED & EAU
- National Comparative Audit of Lower GI bleed
- National Audit – UK Parkinsons
- PROMs

In addition to this, the following work has been completed:

- The system for the electronic registration of clinical audits is now embedded and running smoothly. These registrations feed directly into the clinical audit database
- The electronic data collection audit tool is now embedded and is constantly being improved upon. The Trust has achieved over a 98% rate of all audits registered being undertaken by the new electronic method
- Divisions and specialties receive regular reports detailing their clinical audit activity; this enables them to ensure that audits remain on target and to identify promptly and areas which require intervention
- Regular clinical audit training sessions continue to take place with the addition of sessions for new clinical staff, such as junior doctors having easily accessible information for them to be able to progress their audits

What do we aim to achieve in 2017/18?

- The clinical audit intranet site will be further developed and improved upon
- Ensure that medical staff participate in the trust-wide clinical audits
- The trust-wide clinical audits will be reviewed to improve the content and actions which are a consequence of the audits
- Improved engagement with the clinical audit leads will meet regularly to ensure that they understand the role and how they can support their specialties in clinical audit
- Undertake further awareness for staff who need to register audits
- Develop a range of Standard Operation Procedures to support the systems and processes used`

2.2.2 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 2016/17 that were recruited during that period to participate in research approved by the Research Ethics Committee was 1098.

Sherwood Forest Hospitals NHS Foundation Trust is actively involved in clinical research. The Research and Innovation team invest in opportunities to expand the provision of health care to develop efficiencies in service design, innovative practices and new service delivery that will lead to cost effective services that are fit for purpose and improve the outcomes for patients in the future.

Patient recruitment to participate in research is largely from studies adopted on the National Institute for Health Research portfolio with a smaller proportion from non-adopted studies which are mainly conducted for educational qualifications.

Work that commenced during 2015/16 to ensure studies were closed and archived in a timely manner has impacted on the number of studies we now have open as the work continued into the first 6 months of 2016/17. The Trust had hoped to increase the number of studies open and actively recruiting by 20% during 2016/17 but this has not been achieved and there has been a decrease. This is partly due to a further 40 studies being identified as requiring closure and archiving. This work has now become part of usual business and the implementation of the web-based data system (EDGE) ensures study status is captured more accurately.

This is compared to recruitment of 990 patients onto research studies with 823 being recruited for NIHR portfolio studies. Our aim of increasing recruitment by 10% in 2017/18 to our studies has been achieved. 1098 patients have been recruited of which 925 have been NIHR portfolio studies.

The Trust continue to aim to increase the number of patients who have access to research studies as part of their care pathway and over the next 2 years aim to achieve >90% of studies delivering to time and target. This will be supported by the continued implementation of the robust study set up process ensuring study set up includes close working with clinical care teams to provide accurate data as part of the expression of interest and feasibility stages of site selection.

Work has already commenced exploring the possibility of collaborating with external organisations in order to expand the types of research studies available to our local patient population and at the core of an expansion in research activity at the Trust is the development of a dedicated clinical trials unit, opportunities for which will be explored during 2017/18. This would allow the expansion of clinical trials access for patients in the region.

2.2.3 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) established in 2009/10 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.

During 2016/17 Sherwood Forest Hospitals NHS Foundation Trust received payment of circa £1.4 m 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 £4m received in 2015/16 when available CQUIN was 2.5%.

A proportion of Sherwood Forest Hospitals NHS Foundation Trust income in 2016/17 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 2016/17 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-2016**

During 2016/17 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 2016/17 CQUIN predicted year end position. A – **Achieved** PA – **Partially Achieved**

CQUIN scheme	Indicator name	Description	Q1	Q2	Q3	Q4
National	NHS Staff Health and Wellbeing	The introduction of health and wellbeing initiative covering physical activity, mental health and improving access to physiotherapy for people with MSK issues.	A	A	A	A
National	NHS Staff Health and Wellbeing	Provide healthy food for NHS staff, visitors and patients and achieving a step change in the health of the food offered on our premises in 2016/17. This initiative included covers all restaurants, cafes shops and vending machine within the Trust.	A	A	A	A
National	NHS Staff Health and Wellbeing	Achieving an uptake of flu vaccination by frontline clinical staff of 75%.	A	A	A	A
National	Timely identification and treatment of Sepsis in emergency departments	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis and the percentage of patients who present with severe sepsis or septic shock and were administered antibiotics within the appropriate time frame and had an empiric review within three days of the prescribing of antibiotics.	A	A	A	A
National	Antimicrobial Resistence	Total Antibiotic consumption per 1,000 admissions, Total consumption of Carbapenem per 1,000 admissions, Total consumption of piperacillin – tazobactam per 1,000 admissions.	A	A	A	PA
National	Empiric review of antibiotic prescriptions	Empiric review of antibiotic prescriptions. Percentage of antibiotic prescriptions reviewed within 72 hours.	A	A	A	PA
Specialised	Optimal Device Utilisation	To support national work on the control of utilisation and expenditure of high cost devices (Specifically ICDs) and deliver a step change in methodology which will benefit the whole health economy and deliver a harmonisation of pricing and strategy in the merger of Sherwood Forest NHS Foundation Trust and Nottingham university hospitals NHS Trust.	A	A	A	A
Specialised	Pre Term Babies Hypothermia Prevention	The aim of this scheme is the prevention of hypothermia in preterm babies (<34 weeks) by routine monitoring within 1 hour of admission, and by taking corrective action.	A	A	A	A
Specialised	Patient Experience	Undertake an options appraisal and the subsequent creation of a jointly agreed plan to establish, shadow run and implement an Alliance-wide measurement approach to monitoring and reporting on care user involvement in decision making and feeling supported from 1st April 2017. The approach will focus on three key conditions: COPD, diabetes and cardiac failure.	A	A	A	A

2.2.4 Registration with the Care Quality Commission (CQC)

Sherwood Forest Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered'. Sherwood Forest Hospitals has the following conditions on registration, none.

The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2016/17.

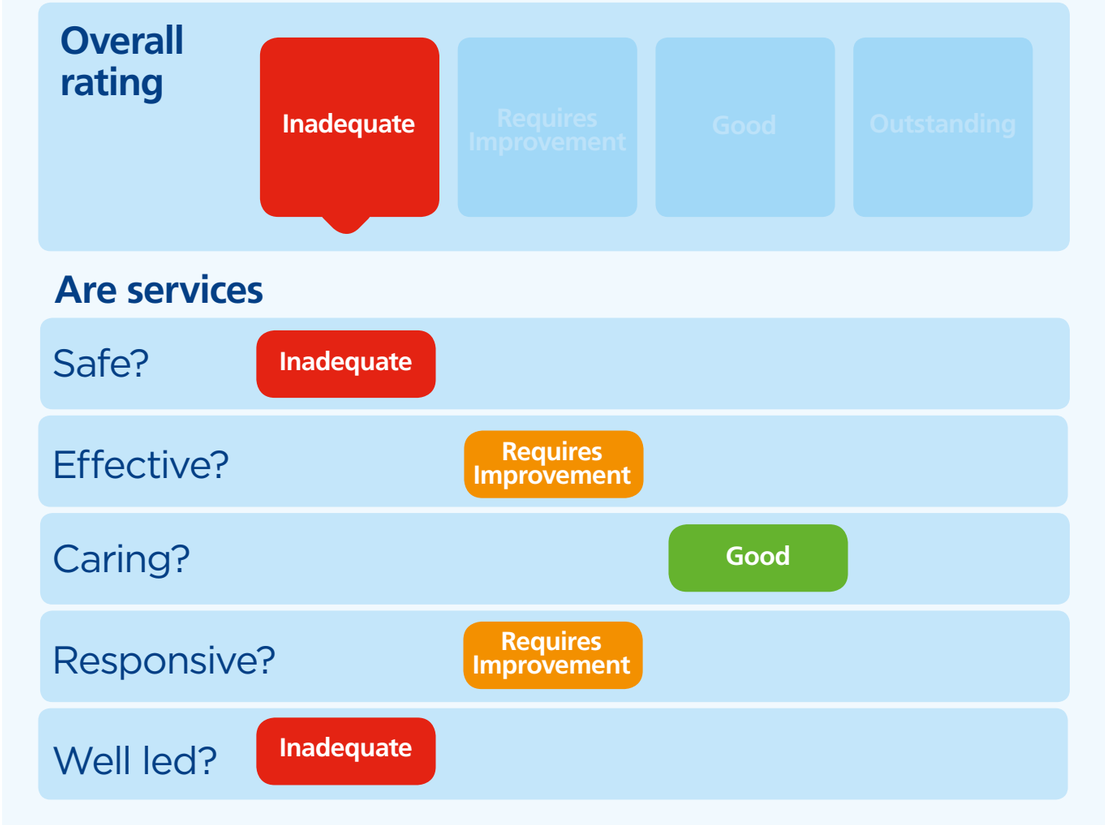
Sherwood Forest Hospitals has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2015/16 the Trust experienced a challenging time in relation to demonstrating the quality of its care. The CQC undertook a comprehensive inspection and carried out an announced inspection visit from the 16th to the 19th June 2015 and three unannounced visits on 7th, 9th and 30th June 2015 using the CQC Comprehensive Inspection regulatory model. Following this full inspection of our services, England's Chief Inspector of Hospitals Professor Sir Mike Richards, recommended that the Trust should remain in special measures and look to develop a long-term partnership.

The full report is available at: **http://www.cqc.org.uk/provider/RK5**

Under the Comprehensive Inspection methodology, the CQC attributes individual ratings to each of the core service areas that the hospital provides; Urgent and Emergency Care, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and outpatients and diagnostic services.

The outcome of the 2015 CQC Inspection is indicated in the grid below:



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. The CQC noted significant progress in the care delivered to our patients in all areas inspected and this was reflected in the Report published in October 2016. 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.

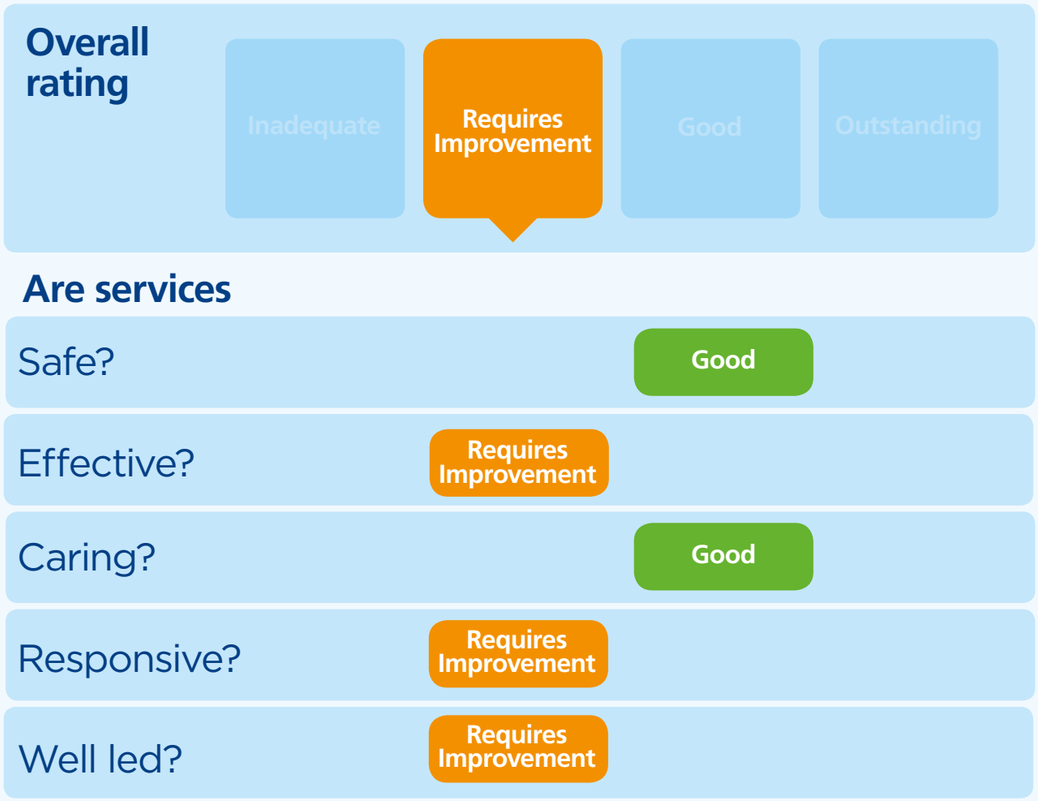
The continuing progress made by the Trust and improvements in the safety and quality of care delivered to our patients noted by CQC throughout 2016 was further validated in the lifting of the regulatory action – namely:

Section 31 – 31st May 2016

Section 10 – 28th July 2016

Section 29a – 14th September 2016

Following the publication of the 2016 Report in October the Trust position is reflected in the grid below:



In conjunction with the improved position as identified by CQC NHS Improvement removed the Trust from Special Measures in November 2016.

A significant contributor to the improvements made across the Trust during 2015/16 was the success of the Quality Improvement Programme. Following the 2015 Inspection a 287-point Action Plan was approved by the Board of Directors in November 2015. The Plan identified 10 key areas of focus that captured all the issues raised from the Keogh Review in 2013 and the CQC Inspections of both 2014 and 2015. The robustness of the plan, the leadership of the Executive Team and the engagement of staff across the organisation resulted in over 95% of the actions being completed within the year with evidence provided to the Board of Directors providing assurance that actions taken were embedded and now encompassed within business as usual processes. The Trust was able to demonstrate that it now has systems and processes in place that would quickly identify and respond if there was deterioration in the safety and quality of care delivered.

The approach and methodology has been applied to the development of the Advancing Quality Programme. The improvement plan will propel the Trust forward on its committed journey to outstanding.

2.2.5 Data Quality 2016/17

Data quality influences all aspects of the delivery of patient care. It crosses internal and external organisational boundaries and is the responsibility of everyone involved in delivering and supporting care. The decision making of all clinical staff, support services, managers, executives and the Trust Board requires timely access to high quality information to effect.

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.

Sherwood Forest Hospital NHS Foundation Trust requires that its data collection is at all times, accurate, valid, timely, complete and relevant. Improving the accuracy of all patient based information is a key priority for the Board of the Trust. Failure to address these issues could have serious implications for both patients safety and may result in loss of income for the Trust.

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.

(i) Development of a Corporate Data Quality Validation Policy - Achieved

Validation encompasses the processes that are required to ensure that the information being recorded is of good quality. These processes deal with data that is being added to continuously and also can be used to improve the quality of historical data.

It is imperative that regular validation processes and data checks/audits are undertaken on data being recorded to assess its completeness, accuracy, relevance, accessibility and timeliness.

Such processes are likely to include, checking for duplicate or missing data, checking for deceased patients, validating waiting lists, ensuring that national definitions and coding standards are adopted, and NHS number is used and validated.

Patient data is collected and process by multiple staff across the organisation and therefore the data quality may affect and be affected by a wide range of staff and activities.

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.

The Trust intends to take the following further actions to improve:

- 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

(ii) Based on the Audit Commissions four standards framework we have further defined management arrangements to support further improvements and secure the quality and accuracy of our data - Achieved

Audit Commissions four standards are:

- Governance and Leadership
- Policies and Procedures
- Systems and Processes
- People and skills

Strengthening these areas will provide the Trust with the key building blocks required to consistently deliver high quality data and ensure that the organisation is in the position to successfully support future system developments. Improvements made include:

- Reviewed and updated the senior accountability/strategic responsibility for data quality
- Reviewed and updated the operational and management arrangements for data quality
- Consistently reviewed and updated the work plan of the Data Quality team to ensure that it supports/delivers corporate objectives
- Developed a measurable set of data quality metrics to translate corporate data quality objectives. Production of a real-time data quality dashboard to track progress and inform next steps

The Trust intends to take the following further actions to improve:

- Provide consistent feedback to the Board and SFH staff to highlight issues identified through the DATIX incident, near miss and risk register relating to data quality
- Review current Data Quality risks, outcomes and any lessons learnt from addressing these issues. To inform further training requirements

(iii) Facilitate monthly SFH Data Quality Group meetings - Achieved

(iv) Attend monthly Data Quality Improvement Group meetings in collaboration with the CCG's to promote data quality and discuss issues pertaining to both Primary and Secondary care - Achieved

The Trust intends to take the following further actions to improve:

- To continue facilitate the Data Quality Group Meetings to inform the revised Data Quality Plan for 2017/18

(v) Data Quality Training - Achieved

We reviewed all system based and operational Data Quality training material (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 as a pre requisite to obtaining access to the system.

We introduced a Training Plan for 2017/18 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 will deliver a new starter package including; DQ Generic Training, RTT Generic Training, Role Based Data Quality and RTT Training.

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.

(vi) Development of a Data Quality Internal Audit Programme - Achieved

The Data Quality team have developed and agreed a schedule of targeted audits that are undertaken throughout the year. The results from these audits are disseminated and discussed at monthly Divisional and Governance meetings and the Data Quality Group. The Data Quality team have undertaken audit spot checks and observational audits in response to emerging themes and issues.

The Data Quality team have utilised the Meridian Audit Tool as endorsed by the Trust Audit Department to design and facilitate the on-going audit plan. This currently addresses data quality in Admitted patient care, Outpatient activity and the Referral to Treatment National Waiting Time target.

The Trust intends to take the following further actions to improve:

- To expand the current audit programme to include other data quality metrics

(vii) Development of robust communication channels to inform good data quality practices - Achieved

Good communication is an important factor in the effective implementation of the 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 [Access Policy] 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 Audit Committee (e.g. tracking progress on Data Quality Improvement Plan actions)
- Dedicated Data Quality and Clinical Coding support provided to all five Divisions (and Service Lines as appropriate)

The Trust intends to take the following further actions to improve:

- To create a monthly newsletter to be circulated with the Trust Staff bulletin so that all staff have access to information provided by the Data Quality team not just those staff that work in administrative roles.

Good communication is an important factor in the effective implementation of the Data Quality Strategy

(viii) Data Quality Improvement KPIs

To provide assurance that the Trust's data is reliable, in 2016 a project commenced utilising the Cymbio Process Analytics software bespoke data quality dashboards to address these issues. Thus was discontinued early 2017 in favour of an in-house solution.

The Trust intends to take the following further actions to improve:

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

(ix) PTL Data Quality Validation - Achieved

In response to the Trust's ability to provide assurance that the RTT Waiting time target data is robust work was completed to update the PTL during 2016.

The new PTL has been incorporated into Trust reporting from May 2016 and have further developed the report to allow Divisional Teams to interrogate their RTT data in real time through the use of self-service reports together with a PTL validation dashboard to monitor progress against the 92% RTT incomplete performance target.

The Trust intends to take the following further actions to improve:

- Routinely audit a random sample of validated pathways as part of the audit schedule
- Produce and implement an RTT Strategy

(x) Data Quality kite mark policy - Achieved

Scope and test the methodology for introducing a data quality Kite Mark system to support the Board/Executive team's assessment of performance KPI's (Single Oversight Framework/SOF).

The data contained within the SOF must be a true reflection of the Trust's Performance and therefore must be judged on its reliability and quality as explicitly assessed using a visual indicator. Work has been undertaken to develop and embed the tool into the SOF.

2.2.6 Information Governance Assessment Report

The Sherwood Forest Hospitals NHS Foundation Trust Information Governance toolkit Assessment Report overall score for 2016/2017 was 82% and was graded as green, or 'satisfactory'. This reflects the continual refinement and rigour of the requirements each year.

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 (2016-2017)	Published	0	0	23	22	45	82%	Satisfactory	n/a	n/a

All Information Governance (IG) related serious incidents are reported via the IG Toolkit, which in turn reports them to the Information Commissioner (ICO). The Trust reported three IG level two serious incidents during 2016/17, two of which have been investigated and closed and one which is still currently being investigated.

We aim to maintain the standard for 2017/18 by developing and building on the actions below:

- Maintain Information Governance as a mandatory training requirement for all staff
- Continue undertaking a formalised programme of information asset risk assessment, ensuring each division provides assurance for their information assets and that these are reviewed and maintained with responsible officers
- For each information asset, the owner is required to report on progress against the toolkit requirement on an annual basis to the Senior Information Risk Owner (SIRO)
- The Trust continues to have one lead for each standard responsible for the identification, collation and uploading of the evidence required for the toolkit
- Internal and external information flows for the Trust reviewed on an annual basis
- To review the current Publication scheme and ensure this is kept up to date
- To develop a Cyber Security Strategy and raise the awareness of Cyber Risks to employees of the Trust

The Trust received 446 Freedom of Information requests in 2016/17 with the majority of the requests continuing to be from journalists. The themes requested tend to reflect current news items and are sent to all Trusts across the country, in search of outliers or to build a national picture with information and statistics. Over the past twelve months the main trends have been related to Trust spend; in particular locum, temporary and agency staffing costs and regular requests reflecting news stories including cyber security and figures related to super bug infections within the Trust.

2.2.7 Clinical Coding Audit

Sherwood Forest Hospitals was not subject to the Payment by Results Clinical coding audit during 2016/17 by the Audit Commission.

Sherwood Forest Hospitals NHS Foundation Trust has a dedicated team of qualified & trainee clinical coders that are responsible for coding roughly 90,000 inpatient activity for 2016-17. Coded activity data is submitted to Secondary User Services (SUS) which is used to support Commissioning, Healthcare development, Improving NHS Resourcing Efficiency.

Data Quality Audit, focused on clinical coding, is a crucial part of a robust assurance framework required to support the provision of statistically meaningful coded data to facilitate the information that is used for various reasons as specified above.

The Trust has undertaken, as part of the Information Governance Standard 505 an audit of 200 finished consultant episodes (December 2016) to assess the accuracy of clinical coding. The results indicate an error rate of less than five percent regarding correct; primary and secondary diagnoses, primary and secondary procedures and the results provide assurance that the Trust has a consistently high accuracy rate within this area.

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
IGT level 3 requirement	>=95%	>=90%	>=95%	>=90%
IGT level 2 requirement	>=90%	>=80%	>=90%	>=80%
SFH Trust	93%	98.14%	91.60%	92.52%

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

HSMR & Clinical Coding; Trust mortality measured through HSMR for the period of 2016-17 has been below 100. This is the result of work from clinicians to reduce mortality and improved recording of co-morbidities and also due to improvements made by the Trust's coders in identifying co-morbidities when coding the patient's healthcare record. (Co-morbidities of a patient are one of the most significant aspects that affect risk of dying). This has led to an increase in our figure for expected deaths, meaning that the ratio of crude to expected death has reduced.

Clinical engagement & coding validation: Evidence of improved clinical engagement, in order to improve the accuracy of coded data includes coding queries via email, one to one meeting with the clinician, teaching session including observing the procedures. Validation of sepsis as a diagnosis is in place, in order to prevent incorrect recording of sepsis and meet the national targets for sepsis. Work is in progress to establish a process of coding validation of deceased patients.

2.3 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. These are detailed in the table at Appendix 3. Details relating to the progress against some of these indicators are included in this section.

2.3.1 Patient Reported Outcome Measures (PROMs)

Patient reported outcome measures (PROMs) are a means of collecting information regarding the effectiveness of care delivered by the NHS as perceived by the patients themselves utilising pre and postoperative surveys to calculate health gains. PROMs have been collected by providers of NHS care since 2009 and currently include four clinical procedures:

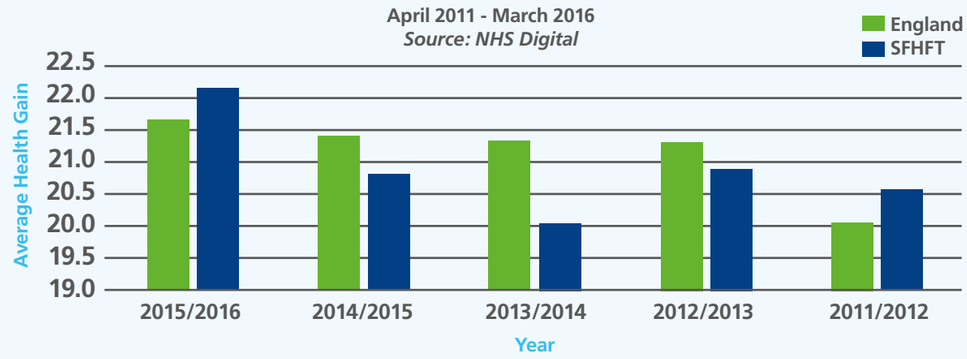
- **Hip replacement**
- **Knee replacement**
- **Groin hernia**
- **Varicose veins**

For 2016/17 we aimed to focus on improvement in our Hip and Knee scores as they were below the National average:

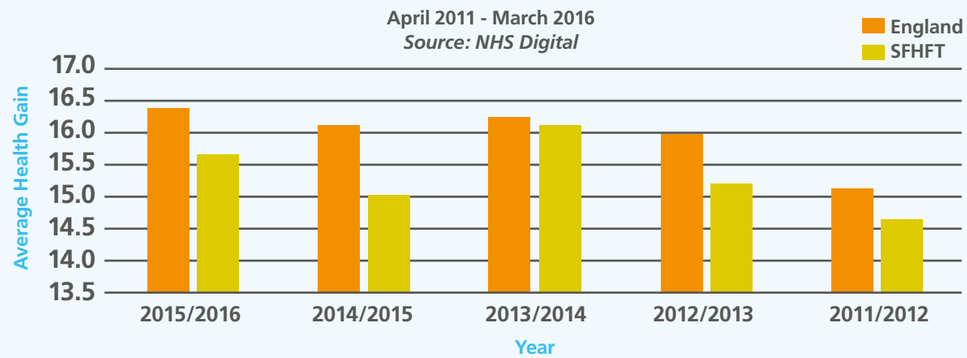
- To implement a Hip and Knee School - All hip and knee replacement patients attend Pre -operative Hip and Knee School, to be given information regarding their procedure as well as the opportunity to practice exercises and use of aids with expert support. The school also allows patients to be assessed for their OT needs and requirements.
- Orthopaedic Outreach - 100% of hip and knee replacement patients have access to the Orthopaedic Outreach Team for up to 10 days post-operatively.
- FLO - Flo Telehealth provides the opportunity for 12 month post-op follow ups to be undertaken virtually, reducing unnecessary OPD attendances for the patient and creating additional capacity for the Trust. In addition Flo Telehealth takes into account patients recorded functional outcomes in the decision making process.
- Audit of patients reporting deterioration – this is planned as a research project for one of our Trainee registrars in conjunction with the Nurse Specialist. We plan to bring the patients into clinic to discuss their questionnaire and report on the findings.

The graphs below (Graph 4 and 5) charts the results of the Oxford Hip Score and Oxford Knee Score outcome measurement tools and demonstrate an improvement in hip replacements and in knee replacements. The 2015/16 figures are based on provisional data which was published 10th November 2016.

Graph 4- Oxford Hip Score



Graph 5- Oxford Knee Score

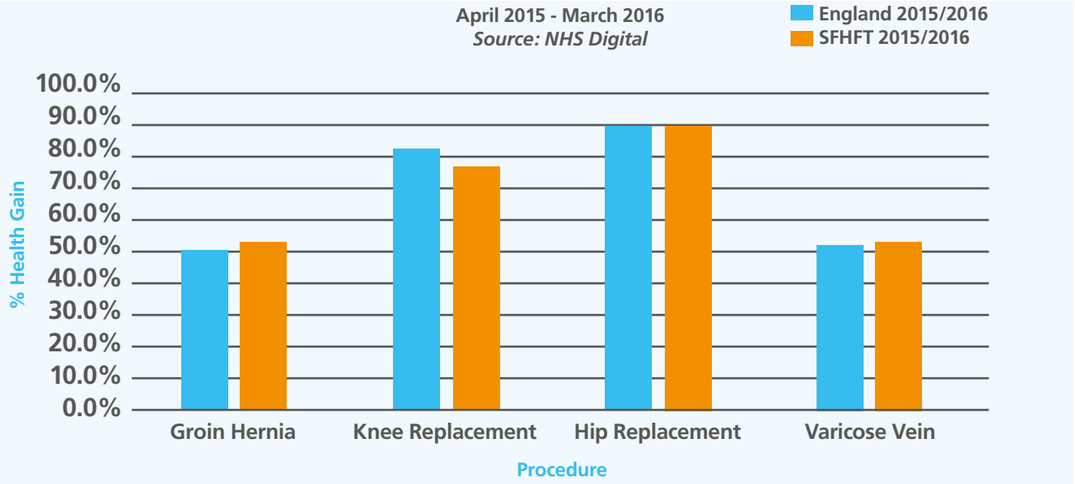


From October 2015 the Vascular Service at the Trust has been provided entirely by Nottingham University Hospital (NUH) consultants. The service comprises outpatient clinics at King's Mill Hospital and Newark Hospital sites, day case lists and inpatient work at King's Mill Hospital relating to patients who are repatriated post-surgery from NUH. Services are delivered Monday to Friday.

One stop clinics have been developed at the Trust which improves services for patients and streamline patient pathways by ensuring patients receive their outpatient appointment and diagnostic test on the same visit to the hospital.

The adjusted health gains are illustrated in graph 6 which represents the most up-to-date information available to the Trust at the time of printing:

Graph 6- PROMs Improved Health Gain



There is evidence of robust mechanisms in place to collect this data both from an internal and external perspective. As evidenced within the above table, the Trust adjusted health gains for groin hernia, varicose veins and hip replacements are comparable to those reported nationally.

In response to these results, further work and audits will be undertaken to ascertain how we can improve the knee scores to above the national average.

2.3.2 The Trust's responsiveness to the personal needs of patients

Patient experience scores are collated nationally via the National Patient Survey programme as a means of capturing their views regarding the care they have received. National surveys are mandated across:

- **Out patient service**
- **In patient services**
- **Emergency departments**
- **Maternity Services**
- **Cancer Care**
- **Children and Young People**

The Trust has reviewed its process to improve learning from these surveys and embed improvements. Reports from all surveys are shared through the Trust's Governance Committee structures with action plans shared at Patient safety and Quality Board and Quality Committee. Where the surveys cannot provide sufficient detail the Trust has commissioned additional focused surveys.

The Trust has implemented a new external provider to collect and collate Friends and Family Test (FFT) data in a number of medians to ensure we continue to capture all eligible patients. The provider Meridian Optimum provide the Nursing Metrics therefore this has ensured the FFT feedback can be aligned and incorporated into this data to identify trends and themes of patient experience along with staffing levels, and ward audits. Recommendation rates through the NET promoter score have always been positive within the Trust. However a programme of work has been undertaken to provide a selection of different solutions including; paper, text messaging, QR codes and instant electronic surveys through mobile technology to improve response rates.

Venous Thromboembolism

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).

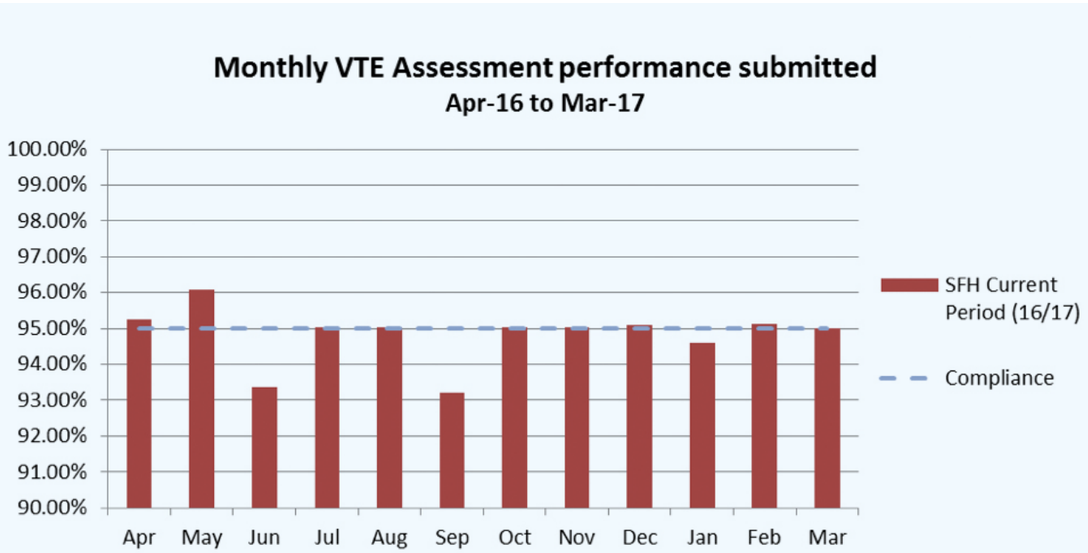
The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical and surgical care. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. 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. During 2016/17 the following target was agreed regarding the management of VTE:

- 95% of all patients will undergo a VTE risk assessment
- 100% of cases of hospital acquired thrombosis (HAT) will have a root cause analysis (RCA) performed

During the reporting period April 2016 – March 2017, compliance with 95% of all patients undergoing a VTE risk assessment was achieved for 9 of the 12 months within this period. For the 3 months where this was not achieved, compliance was at, or close to, 93.2% and 94.6% (June 93.93%, September 93.20% and January 94.60%) as evidenced in the following graph (graph 7). Compliance was not achieved during these 3 months 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 introduction of Nerve Centre during 2017 provides an opportunity to develop an electronic risk assessment form. It is anticipated that this will improve compliance by introducing a prompt for the completion of the risk assessment in real time and be fully auditable to support ongoing monitoring. Graph 7 – Monthy VTE assessment rate.



Clostridium difficile Infection

Sherwood Forest Hospitals has continued to see a reduction in Clostridium difficile (C.difficile) acquisition rates across its acute service since 2007; Prevention of infection focuses on interventions such as hand hygiene, environmental cleaning and antimicrobial stewardship.

C.difficile is a major cause of diarrhoeal infection in healthcare. This spore forming organism is difficult to control, remaining for months on equipment and in the hospital environment. It commonly affects the frail elderly and particularly those patients with complex co-morbidities or who have been treated with antibiotics. Whilst antimicrobial stewardship reduces patient susceptibility and choice of disinfectant can play a role in controlling C.difficile, it is well recognised that staff training in the identification and management of C.difficile together with meticulous cleaning of patient equipment and the patient's immediate environment is a necessity in preventing outbreaks and cross infection.

The Infection Prevention and Control Team (IPCT) have implemented changes since 2015 and have worked to embed the improvements in practice to help prevent the 'avoidable infection' and possible 'lapses in care' as defined by NHS England. In recognition of the achievements made through partnership working in this area the team are nominated finalist in the National Patient Safety Awards 2017.

What did we aim to achieve in 2016/2017?

C.difficile infection was acknowledged as a problem that impacted upon the whole health economy. The partnership working with colleagues from primary care commenced during 2014/15 has continued with a number of actions completed including:

- A review to identify any common themes identified across organisations within the whole healthcare economy
- All relevant learning shared between the local infection prevention teams
- Ensure that Trust attributable cases in the reporting period remain below 48

During 2016/17 there were zero cases of Clostridium difficile transmissions within the Trust

How are we performing against this target?

At the end of 2014/2015 Sherwood Forest Hospitals had reported 67 cases of C.difficile, in 2015/2016 this had reduced to 45 as shown in graph 9, light grey line, Table 2 provide further information regarding C.difficile rates (per 100,000 bed days) including a comparison of monthly rates from the preceding 4 years. During, 2016/2017 the final numbers of C.difficile cases identified is 28 which is set by Public Health England.

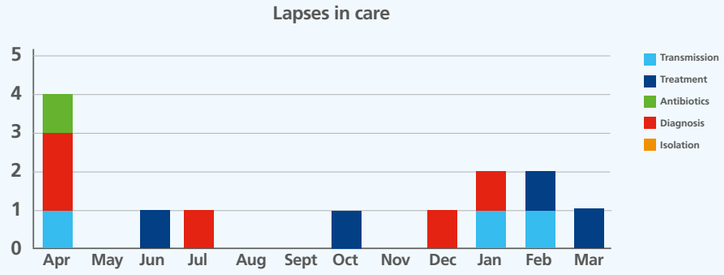
During 2016/2017 there have been zero cases genetically linked suggesting that there has been Zero direct transmission within the Trust. C.difficile is a complex organism and will continue to require aggressive monitoring and response during times when the organisation has high levels of activity.

The Trust recognised that greater emphasis on C.difficile management was required and several interventions were implemented:

Patient Management is a core element of improving patient outcomes following a diagnosis of C.difficile infection and reducing the risk of onward transmission. Patient care is closely monitored by the infection prevention team.

- 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 occurs 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 C.difficile patients identified post 72 hours.



Education and Training:

- All educational programmes were adjusted to incorporate methods of how to prevent and control C.difficile
- An appropriate patient story was incorporated to highlight both the severity of C.difficile and the importance of good patient care
- Regular information was provided to all divisional governance forums

Cleanliness: The standard of cleaning is fundamental in reducing the risks of transferring C.difficile. This year the IPCT worked 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 ward decant and deep clean process put in place during 2015/2016 continued to reduce the environmental microbial load and therefore reduce the risk of cross infection
- Process and responsibilities for environmental cleaning and chemical changes and review novel cleaning technology, including ultra violet cleaning has evolved

Auditing: This is an important part of both monitoring existing practice and driving improvements in those areas required. The existing audit system was inefficient, time consuming and ineffective.

- The IPCT performs standardised audits, providing photographic evidence of issues identified; detailed specific immediate feedback and education at time of audit has been provided
- The process of utilising the incident reporting system to drive accountability and ownership of the cleanliness issues within clinical areas has been introduced and actions monitored as part of governance processes
- An improvement trend in compliance with both environmental and equipment cleanliness has been noted
- In April 2015, a stool proforma was introduced to direct staff when and when not to send samples, since April 2016 compliance has been consistently between 79% and 82%. In addition all samples that are rejected have been monitored and the teams informed. Further revision of internal procedures to further improve compliance is being undertaken

Graph 9 – Cumulative totals of C.difficile

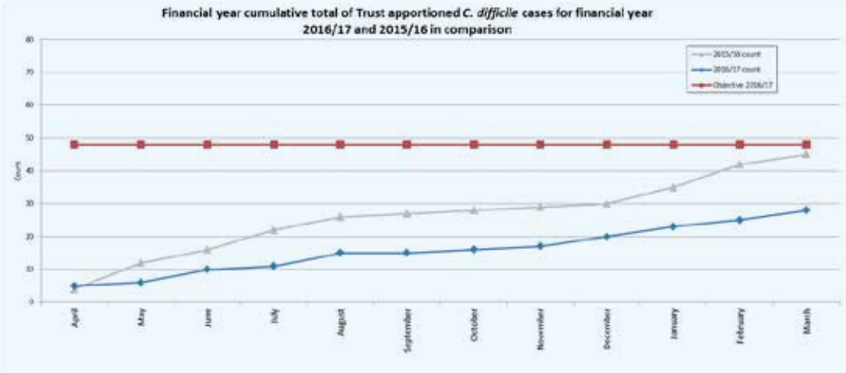


Table 2 C.difficile Rates per 100,000 bed days

Period	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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	0.00	5.5	5.4	15.7	14.9	11.4	16.0

Monitoring and reporting

All cases of C.difficile infections within Sherwood Forest hospitals have undergone a root cause analysis (RCA) to establish the underlying reasons why the patients have succumbed to the infection. 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 2017/18 remains at 48 cases; 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.

2.3.4 Patient Safety Incidents

Sherwood Forests Hospital 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 Hospital compared with other non-specialist acute providers:

Table 3 - Level of patient safety reporting

	Sherwood Forest Hospital			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 April – 30th Sept 2015	3657	3604	32.61	38.25
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	Not yet reported	Not yet reported	Not yet reported

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.

In terms of severity, 80% of all patient safety incidents reported between April and September 2016 were graded 'No harm', which was above the national average of 78%. National data for October 2016 to March 2017 has not yet been published by the NRLS.

The length of time it takes to complete an incident investigation reduced substantially during the first half of 2016/17, from an average of 20 days in April 2016 to 14 days in September as a result of concerted efforts made across the Trust.

The number of Serious Incidents (SIs) reported within the Trust reduced considerably in 2016/17, averaging around 2 per month compared with the previous year when the average was just over 5 per month. This is a positive indicator of the improvements in patient safety that have been and continue to be made within the Trust.

A basic user guide to incident reporting on the Datix system is provided to all new starters as well as being published on the Trust intranet. A Good Governance Training and Education Programme will be rolled out in 2017/18 to provide a wide range of classroom based and e-learning packages that will be made available to all staff in order to further raise awareness and understanding of the value and importance of incident reporting and investigation in supporting the Trust to manage risk.

The Trust has also continued to invest in all aspects of Datix system development 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 has included the introduction of automatic feedback to incident reporters on conclusion of an investigation, providing details of lessons learned in the course of the investigation. The Patient Safety Culture Programme has also focussed on improving staff confidence in the incident reporting process. The introduction of Nerve centre will ensure that all clinical staff will have individual devices, providing further opportunities for reporting near miss events and Incidents.

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 incident management systems. This enables constant monitoring of Duty of Candour and enables the Trust to demonstrate the Duty is consistently being met.

During October 2016 a review was undertaken by the Trust internal auditor to provide independent assurance on the Trust's arrangements for implementing the statutory Duty of Candour and resulted in an opinion of "Significant Assurance".

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 Trust's previous Quality Improvement Plan which included all our patient safety improvements plans and in particular the Trust's 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.

Part 3 - Other information

3.1 Our quality priorities

The following section provides an overview of the Trust's quality priority performance during 2016/17. 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 2016/17 were:

1. **Reduce mortality as measured by hospital standardised mortality ratio.**
2. **Recognise and respond effectively to deteriorating patients. (See part 2)**
3. **To improve the safe use of medicines. (See part 2)**

The information in the table to the right 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.

	2016/17 Additional Quality Priorities
Improving the safety of our patients	To reduce the number of C.difficile cases reported (See part 2)
	Reduce harm from falls
	To reduce the number of urinary tract infections (UTIs)
Improving the effectiveness of clinical care	Hospital length of stay
	Improve the discharge information for acute kidney injury (AKI) diagnosis and treatment in hospital
	To improve the experience of patients who are coming to their end of life
Improving patient expereince	Improve the experience of care for dementia patients and their carers
	Ensure that our complaints system and processes are robust, responsive and support organisational learning
	Safeguarding

The following sections describe our 2016/17 Quality Priorities in detail.

3.2 Safety – Reduce harm from falls

Falls and falls related injuries are a major cause of disability and the leading cause of mortality due to injury in older people in the UK. People aged 65 and older have the highest risk of falling, with 30% of people over 65 and 50% of people over 80 falling at least once a year (NICE 2013). Of those falls around 30% result in injury such as a fracture, head trauma or soft tissue trauma, which can lead to hypothermia, pressure ulcer development, infection and impaired rehabilitation. Experiencing a fall can also have a significant psychological impact on the individual, such as an increased fear of falling, loss of confidence and independence, or subsequent isolation and depression. It should also be recognised that very often patients and their families feel anxiety and anger when a fall occurs leading to complaints.

Falls are also associated with increased length of stay and may precipitate admission into long-term care.

Sherwood Forest Hospitals NHS Foundation Trust is committed to reducing, as far as possible, the number of patients in our care who suffer a fall or fall-related injury. The Trust acknowledges that the risk of patient falls occurring can never be entirely removed, and that in order to achieve successful rehabilitation some patients who are recovering from an acute illness may go through a period of increased risk of falls, as they are encouraged to regain their independence and autonomy. Reducing harm from falls has been a quality priority for the Trust since 2015.

What did we achieve during 2015/6?

- Reduced the number of inpatients falling in hospital with harm
- Reduced the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital
- Delivered a safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice

What did we aim to achieve during 2016/7?

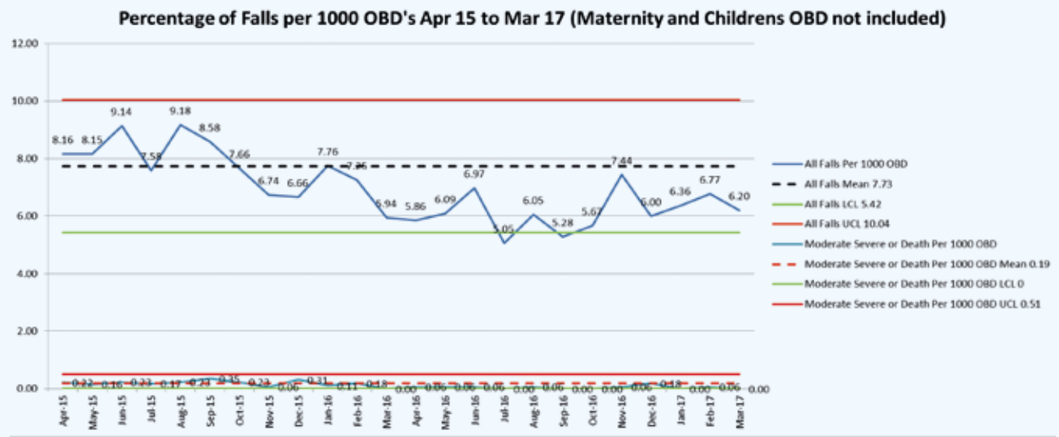
- To reduce the number of inpatients falling in hospital against an agreed trajectory to less than the national average of 6.63 per 1000 occupied bed days
- To deliver a safety improvement programme utilising best practice both from a local and national perspective
- Work in collaboration with Alliance partners to reduce harms from falls
- To review the impact of the redeveloped enhanced patient care tool

Sherwood Forest Hospitals NHS Foundation Trust is committed to reducing, as far as possible, the number of patients in our care who suffer a fall or fall-related injury

How are we performing against this target?

Graph 10 below shows the percentage of falls calculated by the occupied bed days (OBD) as per the National Audit of Inpatient Falls criteria. The Trust continues to drive improvements by education and innovations.

Graph 10 – Percentage Falls per 1000 OBD's



The Trust continues to demonstrate a reducing percentage of falls per 1000 bed days compared to the equivalent point 24 months previously. Noting the fluctuations with this the Trust is focused on embedding improvements to see another step change in reducing the amount of falls. The Trust figure for March is 2017 is 6.20. The National average is currently 6.63.

Over the past 12 months the Trust Safety Improvement Programme has involved national networking, educational events and data analysis identifying trends the Falls Lead Nurse has developed new ways of working that will aim to reduce harm from falls. Highlights from the programme have included:

- The Falls Lead Nurse held a multi-disciplinary health promotion day in the outpatient area. Information and demonstrations were available around the importance of exercise and falls prevention. Promoting engagement by patients and families to help themselves in reducing falls has been a key focus with a simple visual information sheet now available.

A variety of Trust and alliance wide educational events have taken place including falls champions sessions and a joint falls and dementia seminar.

The Falls Lead Nurse developed a roving educational trolley for Frontline Falls. The trolley contains information relating to falls prevention and enables on the spot education and was sighted as an example of good practice by NHS Improvement Director of Nursing. The Falls Grab Box launched in 2016 was also commended and nominated for a National Fab Stuff NHS "Piccalilley" Award, and the team attended an event at the London 02.

A new Falls Care plan was developed which includes both a falls prevention plan and a post fall risk assessment. The care plan enables care to be individualised. By using both best practice and NICE recommendations the care plan guides staff to make appropriate assessments.

Following successful implementation of the **"Patient Station Not Nurses Station"** mobile workstations on Woodland Ward, staff is now visibly engaged with patients in the bay. As part of **Back to the Floor** clinical work the Falls Lead Nurse supported in those areas that had shown a higher falls rate to enable an assurance visit and bespoke educational requirements.

The Falls Lead Nurse has undertaken a deep dive analysis together with night time assurance visits learning from analysis identified a theme concerning patients who could not locate or did not use the call bell when advised. Written and visual Call Don't Fall signage has been developed and implemented.

Work was developed which identified the agreed individual ward targets for the reduction of level 2-5 harms and also repeat fallers. This will help drive accountability and ownership of falls prevention at ward level.

A review of the Enhanced Patient Care guidelines has been undertaken. This has been revised making them clearer and easier for the registered nurse to follow; this is supported with a care plan and risk assessment booklet.

The Trust has developed the concept of the Virtual Ward and has employed HCAs into staffing rotas which enabled Trust staff to support for "Enhanced Patient Care".

Better Together Programme Alliance Work 2016/7

The Better Together Alliance Group has continued to drive improvements by the sharing of good practice and develop interventions relevant to reducing falls in Mid Notts. Sherwood Forest Hospitals is the sponsor for the Better Together falls transformation agenda. A gap analysis has been undertaken to assess the degree to which the falls pathway has been delivered across the Alliance together with specific work programmes to improve patient outcomes.

The Trust contributed to the work with Nottinghamshire Fire and Rescue Service in order to explore how their Safe and Well Visit could include falls safety. As a result several recommendations are being piloted by the Persons at Risk Team.

The Falls Lead Nurse contributed to the production of a health education video to be used in care Homes and Sherwood Forest Hospitals which highlights to patients and carers the importance of regular activity. This was an opportunity for the Trust to move forward the Move **More Often Message** highlighting the importance of exercise.

Monitoring, measurement and reporting

During 2016/17 performance has been reported through the Falls Prevention Group. The terms of reference and membership have been reviewed for this group and it is now jointly chaired by the Consultant lead for falls and the Deputy Chief Nurse.

The Falls Prevention Group will operationally lead the implementation of the Falls Prevention and Falls Care Strategy 2017/18. 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. Additionally the Deputy Chief Nurse will chair a quarterly Harm Free Care meeting with the Divisional Heads of Nursing to review progress and improvement and ensure systems are in place to challenge and improve poor practice.

The Falls Lead Nurse compiles a monthly report which provides data with narrative to highlight any themes and current actions taken in response. This is shared with wards and departments.

What do we aim to achieve in 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.

3.3 Safety - To reduce the number of Urinary Tract Infections (UTIs)

Urinary Tract Infections (UTIs) are acknowledged as being the most frequently suffered bacterial infection across all health care communities with a reported prevalence of asymptomatic bacteriuria of 15%–50%. Within hospitals it is one of the most common causes of a health care associated infection (HCAI) and is frequently, but not exclusively, associated with a urinary catheter.

Frequently with Catheter Associated Urinary Tract infections (CAUTI), an invasive device, in this case a urinary catheter, can increase the risk and severity of the infection. CAUTI's have serious implications for the patients' safety and quality of care; increasing the length of hospital stay, increased fear and anxiety on the patient and patients family and can result in increased mortality and for this reason are one of the four harms nationally monitored through the Safety Thermometer. In addition CAUTI's are responsible for many potentially avoidable admissions to the Trust. Improvements need to involve the collaboration of all stakeholders involved in the care of this group of patients.

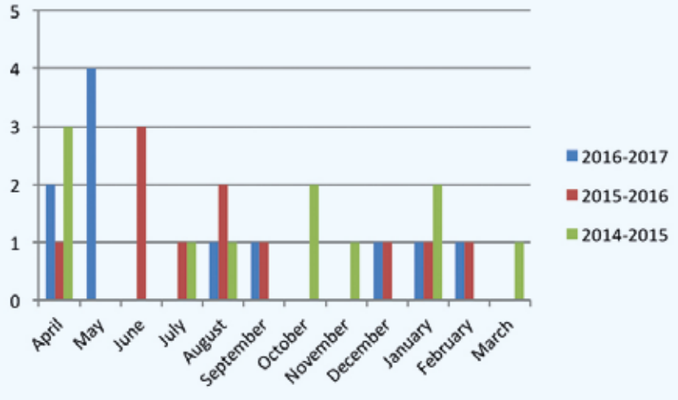
CAUTI poses a significant clinical risk to both patients and have a high impact in financial terms. A simple UTI can cost approximately £1400, whereas a CAUTI related blood stream infection can cost around £20,000 per case.

Table 4 identifies the prevalence of UTIs in Sherwood Forest Hospitals over a period of 10 years, recorded as part of the national point prevalence survey. It demonstrates as a result of continuous improvement there has been a systematic reduction in UTIs.

Table 4: National Point Prevalence Survey of HCAI Results

HAI site	2006	2011	2016
Urinary Tract Infections	22.4%	17.2%	12.5%

Graph 11 – annual cases of CAUTI



What did we aim to achieve in 2016/17?

To reduce to less than 5 the number of CAUTIs

How have we performed against this target?

Reducing CAUTI's Bacteraemias relies on multiple factors, primarily the appropriateness of using an indwelling catheter and if present the safe management of that catheter. Therefore the interventions implemented were to address all aspects of the patient's urinary catheter journey; from reducing the risk of insertion to its swift removal.

Within 5 months there had been 8 cases. However, following full implementation of the integrated closed system in September 2016 there have only been 3 cases bringing the total to 11. Graph 11 details the case of CAUTI since 2014.

Monitoring and reporting

The Infection Prevention and Control Team (IPCT) monitor urinary catheter compliance in a number of ways. The electronic audit tool introduced during 2015/16 has enabled the audit process to be extended from a quarterly review to monthly monitoring and is reported through the Infection Prevention and Control Committee then to Patient safety & Quality Board.

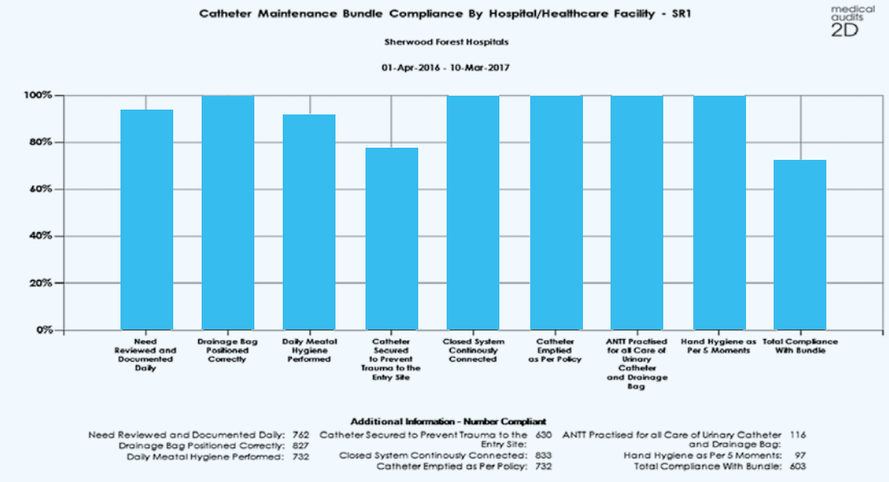
Compliance is monitored against the HOUDINI protocol and the catheter care pathway. Sherwood Forest's own pathway replicates the national recommendations and all 80 of the observation audits compliance was 100%.

The HOUDINI acronym lists the clinical indications when it is appropriate for the continued use of a catheter.

- H **Haematuria** (only requires catheter if in clot retention)
- O **Obstruction/Retention**
- U **Urology surgery**
- D **Damaged skin** (open sacral or perineal wound in an incontinent patient)
- I **Input/output, fluid monitoring**
- N **Nursing care end of life/comfort care**
- I **Immobility, due to physical constraint e.g. unstable fracture and unable to use bottles/bedpans**

The IPC team also performed audits against good practice for the management and maintenance of catheters. (Graph 12) During the past year the IPC team have undertaken over 800 catheter management audits. The main areas for focused improvement related to the fixation of the urinary catheter. These devices have now been included within the new catheter packs and there has been an improvement in fixation which can be directly associated with the reducing infection rates.

Graph 12 – Urinary Catheter bundle compliance



All CAUTI related blood stream infections undergo a full root cause The main themes identified with the initial 8 CAUTI bloodstream infections related to lack of fixation devices being in place, prolonged catheterisation for monitoring purposes and unclear documentation. The second half of the year has not identified these themes as an issue.

What do we aim to achieve in 2017/18?

The Quality Priorities for 2016/2017 revolved specifically around the continuing reduction of C.difficile infection and bacteraemia caused by a catheter associated urinary tract infection. These two aspects continue to be priorities, and many of the measures taken will continue in practice and are becoming embedded within care. However to achieve further significant reductions the aspects needed to be stripped back to the core themes that continue to cause infections and these have formed the basis of the 3 SMART objectives for 2017/2018. Antimicrobial prescribing is an acknowledged driver for C.difficile infections and antimicrobial resistance and Eschericia coli is acknowledged as being the most frequent organism causing CAUTI. The priority to reduce surgical site infections was developed in response to a focus from Public Health England. Measurement, monitoring and reporting of this quality priority will be through the Infection Prevention & Control Committee through to Patient Safety and Quality Board.

- **Ensure 90% of all antimicrobials are reviewed with a clear plan documented in the medical notes/ medication chart within 72 hours.** The increase in antimicrobial resistance has led to increased pressure on existing antibiotics and greater challenges in treating patients. Inappropriate use of antimicrobials increases the risk to patients of colonisation and infection with resistant organisms and subsequent transmission to other patients
  - The national CQUIN launched in 2016/17 aimed to address this by mandating an empiric review of antibiotic prescriptions within 72 hours. Guidance published by PHE – Start Smart Then Focus details key components of a strong antimicrobial stewardship programme. It recommends that providers should develop an action plan and monitor adherence to Start Smart Then Focus principles regularly in all clinical areas

  Since the launch of the audit the percentage of antibiotic prescriptions with evidence of review within 72 hours has improved but we aim to achieve 90% or above continuously.

- **10% reduction of post 48 hour Escherichia coliform (E.Coli) bacteraemia associated with urinary tract infection using the 2016/2017 rate as a benchmark.** One of the most frequently diagnosed bacteraemia is caused by the E.coli bacteria. During 2012/2013 enhanced surveillance in 35 hospitals confirmed that the urogenital tract was the most commonly reported source of infection (51.2% of cases) with prior treatment for a urinary tract infection being the largest independent effect associated with this infection source

  The requirement to reduce the numbers overall of E.coli bacteraemia has been identified within measures set by NHS England. To achieve this reduction, a multi-agency approach will be required and a specific focus to ensure:
  - That the primary source of the bacteraemia is prevented, the urogenital tract is kept healthy and free from infection by promoting adequate hydration, effective hygiene and reduced duration of indwelling catheters, that the primary source of infection is identified promptly through timely sampling
  - That the primary source of infection is effectively treated with appropriate antimicrobials
  - To promote learning and improve patient outcomes
- **Reducing the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark.** During 2016 the Trust became outliers nationally in the numbers of surgical site infections reported to Public Health England (PHE) Surgical Site Surveillance Service. The Surgical site infections (SSI) reported fulfilled the stringent criteria laid down by the PHE and the surveillance is continuous. Success in this priority will ensure positive patient outcomes and support the clinical teams to reduce readmission rates within their speciality

  The Trust completes the national reporting programme which occurs 3 months in arrears; whilst provisional data will be available; though the fully validated data will not be available on a quarter by quarter to enable national benchmarking. Monitoring will be undertaken by IPCT who will provide internal information monthly.

3.4 Safety - Patient Safety Culture Programme

In June last year we launched our Patient Safety Culture programme, which was developed in partnership with Nottingham University Hospitals to improve patient safety by fostering a safety culture where staff across the multidisciplinary team work together to identify, celebrate and share good practice and have a constant and active awareness of the potential for things to go wrong.

This programme built on the Trust's previous Quality Improvement Plan which included all our patient safety improvements plans, and the domains relating to Patient Safety were set out within 3 headings of 'Governance', 'Patient Safety' and 'Staff Engagement'

Improvements had already been made by staff to support a patient safety culture, for example the work on sepsis, medical engagement and a new governance structure.

As part of the programme, a new patient safety culture team was introduced to support ward staff to make improvements and recognise where improvements needed to be made.

The objective of the programme has been to develop a systematic approach from which to create an open culture where all staff understands 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.

The programme included inviting every member of ward staff to lend their voice to a survey that captured what staff on the front line felt and thought about patient safety in their specific areas, creating a safe environment for staff to share their stories on how it feels to work here and to support staff in identifying and leading improvements in their area.

Phase I of the programme has encouraged staff to think differently about the way that they talk about and deliver safe patient care. As part of this, ward staff have been identifying and leading on patient safety initiatives and action plans relevant to their area.

Keeping our patients safe is a priority for everyone and staff, visitors and patients have been involved in shaping this initiative.

One of the outcomes so far has been that we have been able to develop a ward specific 'footprint' of safety culture described by staff in terms of patient safety, teamwork, resilience, attitude to errors and perceptions of local and senior management.

What do we aim to achieve in 2017/18?

The Trust considers the safety culture programme critical to improving the quality and safety of our care and has therefore identified this programme as one of our quality priorities for 2107/18. The Trust will continue to build on this work to enhance our overall Patient Safety Culture and to support this we plan to:

- Implement Schwartz Rounding to maximise and facilitate learning opportunities for the wider organisation
- To reinvigorate and update the 'Sign Up to Safety' Campaign
- Introduce Patient Safety Conversations (PSC) to promote an open culture to discuss with staff about how we can make patients safer

Our safety culture programme has been critical in improving the quality and safety of the care we provide

3.5 Effectiveness – Reduce Hospital length of stay

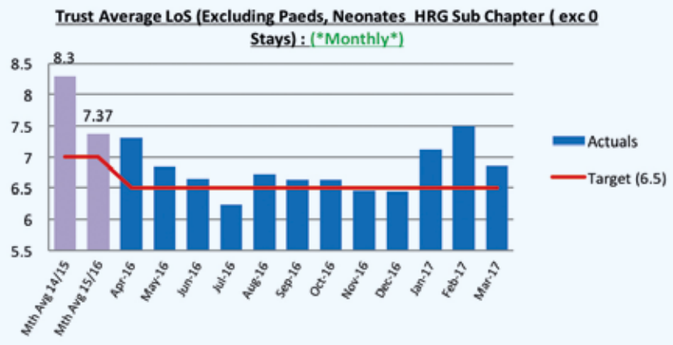
What did we aim to achieve in 2016/2017?

- To reduce average length of stay for general and acute patients

How are we performing against this target?

Table 5 demonstrates that as at the 31st March 2017 the Trust had managed to reduce its average Length of Stay to 6.85 days, although there have been months when the Length of Stay has been below our target.

Table 5 – Average Length of Stay



Reducing length of stay is primarily driven through two work streams. The first Workstream centres on the Emergency Department and the Emergency Assessment Unit and has as its objective to ensure as many patients as possible are safely cared for in the same day as attendance. We are utilising the nationally recommended Ambulatory Care pathways where it is safe and appropriate to do so. By working as a multi-disciplinary and multi-agency team that includes primary, community and social care colleagues, the number of patients who have a zero day LOS has increased from 1,280 in April 2016 to 1,677 in March 2017. Whilst we remain slightly above the peer group average in our emergency readmission rate for 0-30 days, we have reduced the gap.

In April 2016 we were at 8.51% and our peers were at 7.84% and in December 2016 we had reduced our readmission rate to 7.91% with the peers reducing to 7.74%. We reduced our rate by 0.6% and our peers had reduced by 0.1%.

The second work stream has focussed on introducing Red to Green days as part of the Board Rounds and ensuring the SAFER bundle is fully implemented on all wards, but specifically our adult acute wards. We are continuing to plan discharges better through our board rounds and have seen a reduction in the average number of patients with a Delayed Transfers of Care from 46 in April 2016 to 29 patients in March 2017.

Specific specialities, including rehabilitation and haematology, have received additional support to reduce LOS as average LOS significantly exceeded that of the national average. These LOS have improved during 2016/17.

SPECIALITY	AVERAGE LOS FOR APRIL 2016	AVERAGE LOS FOR JANUARY 2017
Rehabilitation	38.97	36.03
Haematology	12.27	5.14

Focus during the final quarter of 2016/17 has been to reduce the number of patients whose LOS has exceeded 10 days, whilst ensuring each patient has a safe and sensible discharge plan, and externally with community and social care partners to enable a whole system approach for patients whose discharge is more complex.

Monitoring and reporting

There is a daily report on the number of patients whose length of stay exceeds 7, 10 and 20 days that is circulated widely to ward clinical teams and managers. Together with weekly ward flow metrics and a fortnightly LOS meeting, teams have information which supports quality patient care and the delivery of this quality priority.

What do we aim to achieve in 2017/18?

This priority has been amended in 2017/18 to improve the quality of discharge. This will be monitored through the discharge work programme.

3.6 Effectiveness – Improve discharge information for Acute Kidney Injury, diagnosis and treatment in hospital

Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected. Due to the increasing age and acuity of patients under our care AKI is becoming a much more common condition and as such must be responded to and treated appropriately. Without quick treatment, abnormal levels of salts and chemicals can build up in the body, which affects the ability of other organs to work properly. If the kidneys shut down completely, this may require temporary support from a dialysis machine, or lead to death.

What did we aim to achieve in 2016/17?

Improve the discharge information for acute kidney injury (AKI) diagnosis and treatment in hospital.

How are we performing against this target?

During 2016/17 the Trust has worked closely with Nottingham University Hospitals Consultant Renal team and colleagues and through this collaboration has been part of the East Midlands Strategic Clinical Network. The network has facilitated the production of sick day rules leaflets for patients at high risk of Acute Kidney Injury (AKI) across the East Midlands. This strategy is endorsed by the NICE AKI clinical guideline. This information has been made available to patients both at discharge and within outpatient settings.

Additionally, a mortality alert in relation to AKI was received and an audit carried out on 50 sets of case notes of the identified deceased patients. In all cases the patients were elderly and AKI was one of a number of comorbidities that had contributed to but not caused their death.

Monitoring and Reporting

Monitoring of this priority has been through the Deteriorating Patient Group and the final report was presented to the Mortality Surveillance Group with assurance given to the Patient Safety Quality Board. Acute Kidney Injury is a standing agenda item for the Deteriorating Patient Group and although the Trust does not have a substantive Renal Physician to lead on this work there is a strong collaborative arrangement in place with colleagues from Nottingham University Hospitals.

What do we aim to achieve in 2017/18?

Incorporate the improvements in the discharge information for AKI into the Trust's Deteriorating Patient quality priority.

3.7 Effectiveness - Reduce mortality as measured by Hospital Standardised Mortality Ratio (Key Priority 1 for 2016/17)

Mortality rates are a key indicator of quality of care. They help us understand the risks of hospital treatments for individual patients, changes in the patterns of disease over time and can point to improvements needed to reduce the likelihood of death. Whilst our mortality measured through HSMR continues to improve the Trust recognises the significance of this indicator and as such it remains a key area of focus.

The hospital standardised mortality ratio (HSMR) considers deaths in a 'basket' of conditions that cover 80% of deaths occurring in hospital. Standardised mortality rates are a way of allowing comparison between hospitals. By comparing risk factors (e.g. age, number of co-morbidities) in the local population against those for the whole of England, an expected number of deaths can be calculated. Comparison of the actual and expected deaths gives a ratio so that any number above 100 indicates that more patients have died whist undergoing inpatient care in the hospital than was expected. The ratio varies from one month to the next and a number within a specified range will indicate whether the Trust falls outside or within the expected norm. Elevated ratios above 100 are likely to indicate an excess of deaths related to clinical issues and may be deemed avoidable and as such an in-depth understanding of local data is required.

As outlined above HSMR is defined by measuring crude mortality against expected mortality. The crude mortality rate looks at the absolute number of deaths that occur in a hospital in any given year and then compares that against the number of people admitted for care in that hospital for the same time period. The measure is affected directly by the number of admissions and does not allow for the type of patient admitted or their associated risk of death. The total number of deaths within the hospital varies from year to year and is influenced by seasonal changes such as summer v winter and outbreaks of specific conditions such as flu.

In addition to measuring HSMR the Trust is also measured against the summary hospital mortality index (SHMI). SHMI covers all hospital deaths, including those that occurred outside of the hospital within 30 days of discharge.

What did we aim to achieve in 2016/2017?

- Ensure that global and specific HSMR results fall within the expected range
- To have an embedded mortality reporting system visible from service to Board
- To eliminate the difference in weekend and weekday mortality as measured by HSMR

How are we performing against these targets?

The graph 13 indicates the performance of the Trust in relation to both SHMI and HSMR. The table shows the downward trend indicating that our mortality is below the expected normal level. Although overall crude mortality has reduced and is less erratic the most recent data shows a sharp increase but this is likely to be attributable to seasonal variation and can be expected for winter periods.

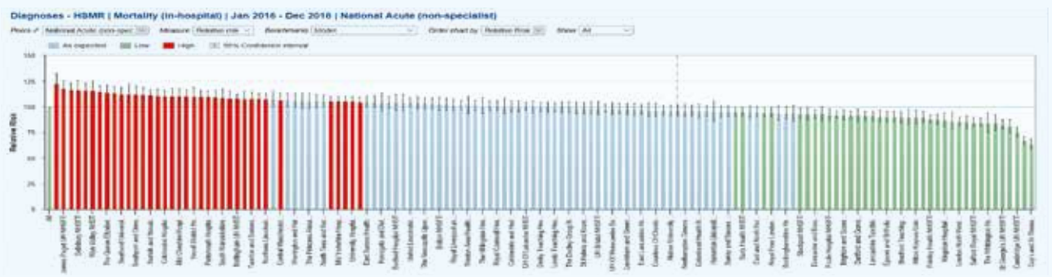
We are now among the best performing Trusts in the country with regard to mortality rates

Graph 13 – Trust Mortality trend

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Series1	120.70	122.35	128.70	107.85	109.78	93.50	93.11	107.77	99.66	104.67	86.18	87.14	89.50	95.66	102.08	89.74	95.08	89.86	114.74	97.62	102.26	103.54	92.08	93.91	107.06
Rolling 12 Month HSMR	115.17	115.00	116.20	115.87	116.04	115.08	113.63	112.81	110.97	110.71	107.95	105.64	102.44	99.90	97.78	95.81	94.66	94.47	96.08	95.24	95.54	95.73	96.15	96.71	98.53
SHMI	104.6	104.6	101.5	101.5	101.5	102.1	102.1	102.1	101.9	101.9	101.9	99.1	99.1	99.1	95.9	95.9	95.9	95	95	95	95.15	95.15	95.15		
Crude Mortality SFH	4.47%	4.39%	4.08%	3.34%	2.77%	2.81%	2.56%	2.99%	2.72%	2.92%	2.46%	2.81%	3.26%	3.42%	3.15%	2.81%	2.38%	2.12%	2.84%	2.56%	2.65%	2.74%	2.61%	3.18%	3.98%

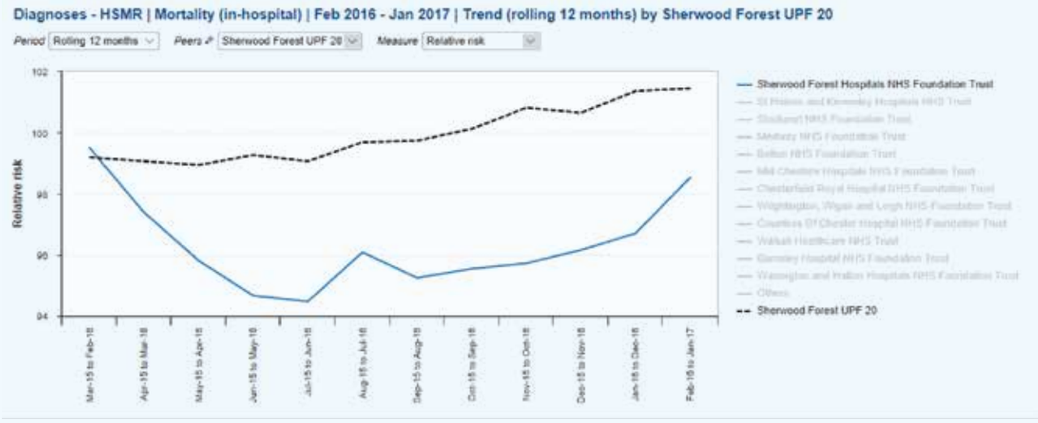
The dotted line on graph 14 confirms that the Trust is now in the lowest 3rd of Trusts nationally. This is a significant shift in position from 2013 when, as a Keogh trust was deemed to be the worst performing in the country.

Graph 14 - Trust national mortality position



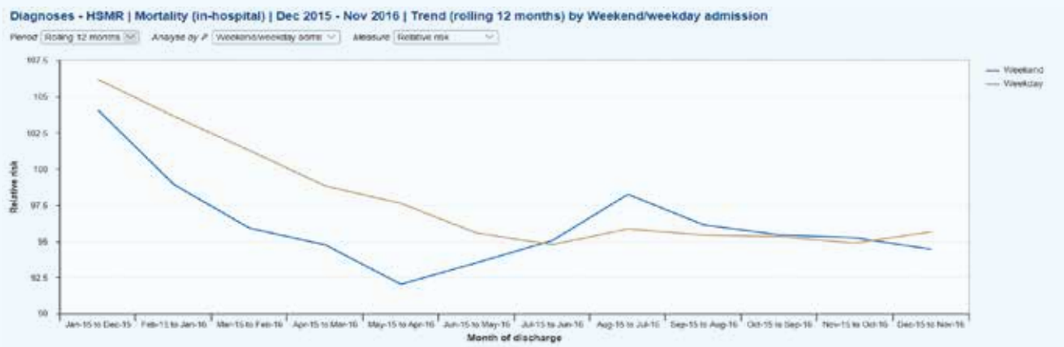
As well as the national comparator the Trust has selected a peer group of 20 Acute Hospitals with a comparable demographic and case mix to further demonstrate the progress and sustained performance that has been achieved. Graph 15 indicates that the reduction in mortality relative risk is significantly below the peer group average.

Graph 15 - Trust Rolling Mortality trend



As articulated below in graph 16 the weekend mortality has now aligned with the weekday mortality demonstrating that the interventions put in place in 2015/16 have been sustained below the 100 figure with both indicators averaging in the region of 96.

Graph 16 – weekend and weekday mortality rate



What do we aim to achieve in 2017/18?

The Trust has a well-established Mortality Surveillance Group that meets monthly chaired by the Medical Director. Each Division is represented and provide a monthly update on their mortality reviews.

The Group used the external data provided by Dr Foster in a much more intelligent and focussed was interrogating each mortality alert to determine required improvements and changes in practice required.

There is clear evidence that the Mortality Surveillance Group is integrated with the wider Trust Governance Structure with robust reporting structures in place at Divisional and Local level. There are clear criteria for a more in-depth mortality review to be presented to the Mortality Surveillance Group for those cases where avoidable factors have been identified, the Coroner has accepted a case for Inquest or the deceased patient has recognised Mental Health or Learning Disability needs.

Although the Trust will continue to monitor and respond to HSMR intelligence the focus for 2017/18 will be the learning and improvements in patient care following both expected and unexpected deaths.

A framework is in place to respond to the 'Learning from Deaths' guidance that was launched by NHS improvement in March 2017. Training is currently underway to ensure that clinical teams have the required skills and competencies to undertake comprehensive assessments of the quality of care delivered to patients prior to their death and apply the Structured Judgement Review Methodology to identify avoidable factors and elicit any learning.

The aim for the coming year will be to demonstrate tangible improvements to care delivery and a deeper understanding of the various components that contribute to the overall experience of death, not only for the patient but their families and carers. How staff involve and interact with carers and families will be an important element of our work. How we manage and respond to mortality is a programme within the Trust 'Advancing Quality' Improvement Plan, however, continued improvements in this quality priority will be monitored and reported through the Trust wide Mortality Surveillance group which reports to Patient Safety and Quality Board.

3.8 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. People are affected by the death in many ways especially the loss of a member of their family or a friend.

More people are living longer often with many long term conditions. Older people especially can become frail, and are more likely to be affected by an illness or accidents which they may not recover from. Increasing age and frailty will increase the numbers of deaths approximately 10-20% within the next 15 years.

Becoming more confident to talk about our beliefs about dying and our needs for achieving comfort and dignity is essential and 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.

The Trust aspires to improve the standard of care and be one of the best, following national guidance and learning from local people's experiences; understanding the priorities for care of the patient and those important to them. The Trust promotes a positive culture of care that has compassion and kindness at its heart which is delivered by good teamwork and communication. This helps provide an individualised care plan to reduce their symptoms and support the patient at the right time and in the right place. Where possible we try and respond to patients wishes. This might include care at home or admission into a hospice or care home.

What did we set out to achieve during 2016/17?

Whilst 4 End of Life Care areas were monitored and reported on against this quality priority, there were many other areas where there was a focus for improvement, during this 2016/17, to ensure we delivered high quality care.

- Embed the role of End of Life champions ensuring champions have the right skills and knowledge to enhance End of Life care.
- Working in collaboration with partners to increase the number of patients who die in their preferred place of care.
- To ensure that patients are discharged safely and effectively, underpinned by robust communication with care planning principles in place.
- Evidence of specific end of life training in place.

How are we performing against this target?

The lead nurse for End of Life has worked with clinical teams to embed the role of End of Life Champion. An extensive training and development programme has been put in place during 2016/17 enabling champions to feel confident in supporting improvements in the care of people at the End of their lives.

Throughout the year we have continued to monitor the number of hospital deaths and measure Preferred Place of Care (PPC) and worked in collaboration with partners to increase the number of patients who die in their preferred place of care. The data is currently only available to the end of quarter 3. This identifies there were a total of 949 deaths in hospital. The summary of Preferred Place of Care is as follows:

- There were a total of 328 patients that were referred to the Integrated
- Discharge Advisory Team for facilitation of their discharge to PPC
- Out of these 328 patients we achieved PPC for 278 (85%)
- 259 of 278 patients (93%) PPC was not in hospital and died in their PPC
- 18 of 328 patients (6%) chose hospital as their PPC
- Out of 328 patient's referred 45 (14%) did not achieve their preferred place of care because they died before discharge could be effected

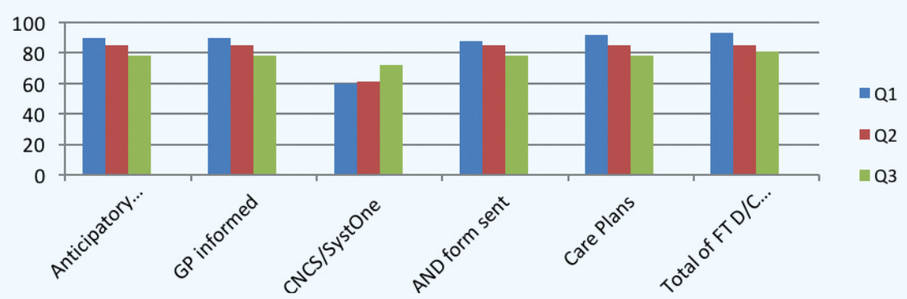
The most common reasons for not achieving an effective discharge to the patients Preferred Place of Care was family choice of appropriate destination or ability to manage at home; patients suddenly deteriorated before discharge was achieved; and patients were unable to be discharged due to care home 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 6 and graph 17 shows achievement of the monitored indicators for people who had fast track discharges during 2016/17.

Table 6 – Indicators in place on fast track discharge

Number (%) of people with this indicator in place on discharge	Monitored discharge indicator
253 (97%)	Patients had Anticipatory Medications prescribed
253 (97%)	GPs/Healthcare Professionals were communicated
251 (96%)	Had an Allow Natural Death in place
255 (98%)	Patients were discharged with a care plan in place
193 (74%)	Patients were registered on the GP GSF register/ SystmOne EPaCCs IT system

Graph 17 – Processes to ensure a safe and effective discharge



Rationale for not achieving 100% compliance is continuously monitored and reviewed with improvement plans in place. However, 24 patients were discharged out of area, where SystmOne/EPaCCS is not in use. Therefore this can account for 9% of patients where it was not possible to share information with GP's via this route.

The standard turnaround time for processing a Fast Track Continuing Care discharge should be no longer than 3 days. For 126 patients, discharge was delayed over 3 days, the common themes were:

- Delay due to family/patient choice
- Delay due to Care Home availability
- Care Home assessments being performed
- Delays in care packages/night sitters being set up or available
- Agree and process funding for care packages
- TTO's not being prescribed timely

In response to the findings during the year a number of actions and improvements have been taken:

- Clinical cases and audit findings were presented at a number of educational meetings with medical staff. This helped to raise awareness of issues and identify staff learning needs.
- Continued to share data with the Mid Nottinghamshire Alliance Team and work closely to influence changes
- Continued to meet with Continuing Health Care to address funding, care package and care home availability issues

Allow a Natural Death or Do Not Attempt Cardio-Pulmonary Resuscitation Orders; there are consistency high levels of compliance which exceeded the Trust local standards in the documentation of this decision ensuring the presence of a consultant endorsement and evidence of patient and family involvement. The Trust is well placed to update local clinical practice and policy to reflect new national guidance which will be implemented in 2017. This new standard is expected to strengthen the quality of the discussion and decision making process between staff and patients and those close to them.

Last Days of Life in Hospital Audit; The Trust participated in the national auditing process submitting returns in 2015-16 which were subsequently reported in the last Quality Account. In 2016-17 there was no national audit commissioned for the care of the dying in hospital. During this year we have reconsidered our audit plan to improve the process and involve front line staff more. Changes to this internal clinical audit plan were influenced by the learning from an external peer review. Building on these positive results we focussed on areas for improvement.

National Audit - Key local areas for improvement; during this year we have continued to address these areas by improving the knowledge and skills of staff, ensuring up to date guidance is available and improve systems of assessment and documentation.

Clinical Assisted Hydration and Nutrition; There is a requirement for further involvement of and support for relatives in decisions relating to clinical assisted hydration and nutrition. The Trust does however perform better than the national average in this area.

Needs of the families and others; although the report demonstrates a positive comparison to national data, the actual result is lower than we expected for support of the people most important to the patient. Again the Trust does however perform better than the national average in this area.

Specialist Palliative Care (SPC); the national audit reflects on-going local commitment to enhance the current SPC Hospital Support Service. Access to these specialist services remains a national problem.

Good progress has been made with delivering training throughout the year and we have achieved the planned training in line with the annual Training Programme 2016/17.

Mandatory Update: Between the 1st April and 31st December 2016 1641 staff, which included Nursing/OPD, Health Care Assistants (HCA)/Advance Nurse Practitioners, Qualified Therapy & Assistants and Chaplaincy completed and passed the End of Life Care workbook on the Mandatory Update. The current compliance as at 31st December 2016 of permanent staff is 92% nursing, 89% HCA, 89% AHP, 72% Midwifes.

Induction Training; Between 1st April and 31st December 2016 a total of 253 nurse, midwives and Allied Healthcare Professionals attended the End of Life Care session on induction training. 120 junior doctors attended the End of Life Care table during their induction training held on 3rd August 2016.

End of Life Care Foundation Course: A two and a half day Foundation Programme was developed following the training needs analysis and commenced in April 2016. Ten courses have so far been delivered throughout this year. The focused training was initially set up to support the end of life care champions and clinical Nurse Specialists but these courses are now available to registered nurses or allied healthcare professionals with a specific interest in end of life care. Currently a total of 40 (96%) CNS's and 29 (100%) champions have attended the whole or elements of the course.

End of Life Care Preceptorship study day; this study day was initially developed to support the International Registered Nurses new to the Trust to provide a wider overview of end of life care. Due to the popularity and positive feedback from the Practice Development Team, it was suggested it be widened out to all preceptorship nurses. Four End of Life Care study days were delivered throughout the year, with 37 Registered Nurses in attendance.

End of Life Care module for Health Care Assistants to support the BTEC modules; during quarter 3 a half day session on End of Life Care including Care after Death introduced to support HCA's undertaking the BTEC Module or as a stand-alone study session. Ten HCA's have attended the two sessions held so far. Future sessions are planned in the New Year and are already fully booked.

End of Life Care Champions Update and Education Days; the purpose of these sessions is to provide ward champions with the opportunity to update their knowledge and skills through participatory and shared learning. 4 half day sessions have been held throughout the year with 50% attendance at each one.

During 2016/17 the Trust has sought further assurance to ensure quality of care. This has included:

A Bereavement survey - Between 1st April and 31st December 2016 90 questionnaires were returned.

Overall the survey showed significant and consistent improvements throughout the year, particularly in the following areas - doctors and nurses listening to both patients and relatives; treating patients and family's with dignity and respect in a sensitive manner; providing adequate pain control and emotional support; meeting spiritual and religious needs Areas identified where we are required to improve are controlling other symptoms better; communicating and explaining 'what to expect in the final days' to relatives and providing written information to support the conversation.

General Palliative and End of Life Care Committee

The Terms of Reference of the General Palliative and End of Life Care Committee were updated during this year with important changes seen with the inclusion of a Non-Executive Director of this Trust Board as part of its membership. The Trust now is fully compliant to the national organisational audit standards set out in the 2015-16 audit. The Patient Experience Team are now integral members contributing to this committee and the sub-group that monitors and acts on incidents, concerns, complaints. During this year the Patient Experience Team took over the management responsibility for the Bereavement Centre and has overseen significant improvements in the administration relating to deaths and the support for the bereaved.

External Peer Review

This independent clinical led review was commissioned as part of the Quality Improvement Plan agreed with the CQC. The findings were reported to the Trust Board. This report confirmed that the Trust had made significant improvement and had high levels of clinical leadership, strategy, governance and clinical outcomes. It supported the CQC findings where actions were already identified to address important improvements in Training and Education and the service arrangements of the Hospital Support Specialist Palliative Care Service.

Internal Audit

A follow-up review was completed to examine the extent to which the seven actions that were outstanding as a result of our End of Life Care Audit have been implemented. The findings from internal audit indicated that significant progress has been made against the agreed actions.

Partnership Work

The End of Life Care Team attended 3 workshops with the Mid Nottinghamshire Alliance Team Better Together Programme working to establish priorities within end of life care that require improvement.

The Lead Nurse for End of Life Care and Lead Clinician have attended the quarterly Mansfield & Ashfield and Newark & Sherwood CCG's End of Life Group and Nottinghamshire Strategic Advisory Group meetings throughout the year, in order to improve communication, share good practice and identify risks/concerns. The End of Life Care Team attend and actively contribute to the Nottinghamshire Strategic Advisory Group. This helps set consistent professional standards and facilitate cross boundary working.

During 2016/17 the Trust has sought further assurance to ensure quality of care

Monitoring and reporting

Building on the strengthened quality governance of the General Palliative and End of Life Care Strategy Group we have had effective systems to monitor and report on improvements. Specific improvement requirements of the Quality Improvement Plan were reported through this process.

Other areas we have focussed our efforts on include:

- Continued partnership working primarily with primary care and community based services, to ensure patients are achieving their Preferred Place of Care/Death and implementation of the Electronic Palliative Care Coordination System (EPaCCS)
- Continued to monitor and sustain safe and effective discharges
- Worked with Mid Nottinghamshire End of Life Care Group to develop a joint End of Life Care Strategy
- Conduct a training needs analysis, to understand the knowledge and skills on end of life care of medical and non-medical staff, and their further training requirements
- The End of Life Care Team have undertaken on-going local audits of patients deaths to monitor the quality, safety and effectiveness of the care delivered, completion and usage of appropriate documentation and to establish improvements required

What we aim to achieve in 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 we will focus on:

- 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 EPaCCS including to pilot cross boundary working

3.9 Patient Experience – Improve the experience of care for dementia patients and their carers

What did we aim to achieve in 2016/17?

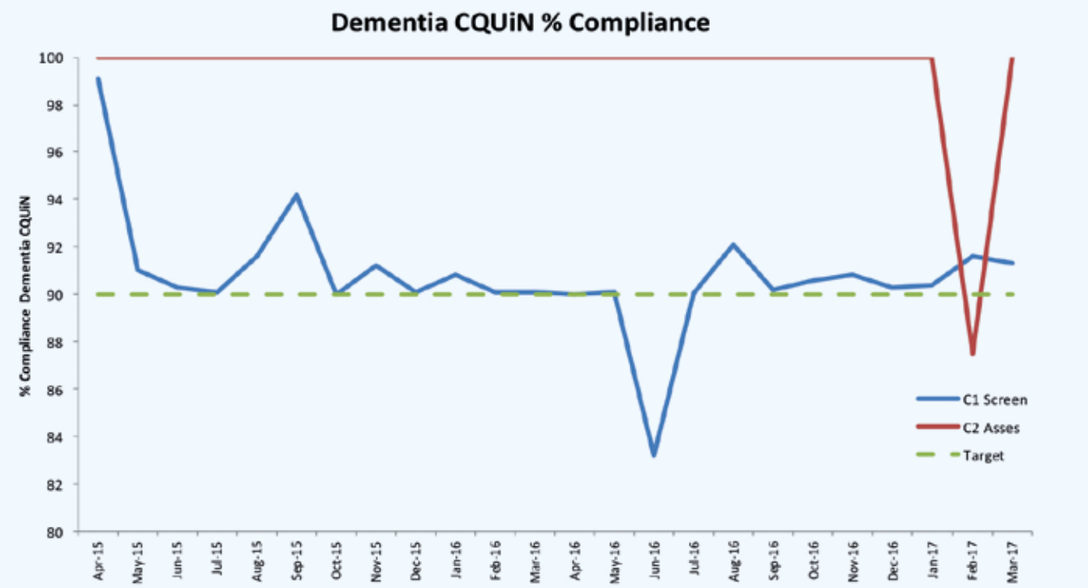
Dementia continues to be a key Trust priority to ensure that people who are living with dementia, and people who care for them, are cared for effectively when accessing our services. For 2016/2017 we planned:

- To find, assess, refer and inform (FARI) all patients over the age of 75 admitted to hospital for emergency, unplanned care
- The provision of a dementia training programme
- To enhance the provision of support to carers

How are we performing against this target?

Meeting the national find, assess, refer and inform target remains challenging, primarily because the Trust is using a paper based system. With the introduction of Nervecentre in 2017, the Trust expects to move to an electronic referral process. Graph 18 shows the performance against the Dementia FARI score since April 2015.

Graph 18 – Trust FARI score since April 2015



An extensive range of training continued to be delivered to a diverse range of carers and stakeholders as identified in table 7 below

Table 7 – Uptake of Training

Training Opportunity	Stakeholders captured
Orientation – Dementia Awareness (Tier 1)	707
Contemporary Issues (Tier 2)	75
Dementia Champions	21
Mandatory training	2409
Members Event	16

Based on learning for the patient and carer experience surveys undertaken in 2015/16, the Trust has diversified and increased the range of support to carers. Examples of this include:

Engagement with Voluntary Services; Within Sherwood Forest Hospitals we typically only see people who are living with dementia and their carers for a relatively short spell in their dementia journey and it is vital that we can provide information about other services that are available for support with dementia care outside of the Trust. Within the Mansfield/ Ashfield and Newark/Sherwood areas there are a number of organisations who provide support for people who are living with dementia and their carers. Links have been made with national and local groups and they have been involved in events that have been organised by staff at SFHFT, for example, Dementia Champions up-date and a dementia event for librarians across Nottinghamshire.

Sherwood Forest Hospitals has been a member of Dementia Action Alliance (DAA) since 2013; DAA exists to enable 'organisations across England to connect, share best practice and take action on dementia', and helps to promote dementia-friendly communities building relationships with organisations who can support our work.

Carer Feedback; Processes and opportunities to increase feedback from carers have been, and continue to be, reviewed. When complaints are received via the Patient Experience Team, these are investigated and appropriate actions taken to address the issues raised. Informal feedback has been received through the locally-based support groups and where possible incorporated into our care and services. On occasion service carers would like are beyond the scope of what could be available through the Trust. An example is the proposal of provision of day-care and respite services, and the proposer has been advised to discuss this idea with the CCG.

The Ashfield and Mansfield DAA will be consulting with citizens regarding their experiences of dementia support and care within the area, and one of the questions relates to experience of healthcare. Any information that is supplied will be analysed to see whether it can be used to shape provision of care within SFHT.

Dementia Care plan; A revised dementia care plan has been introduced. This builds on the information in the 'This is Me' document that can be used to facilitate person-centred dementia care. The care plan also provides information on the V.I.P'S (Brooker) model of person-centred dementia care to remind staff of important considerations when planning care for someone who is living with dementia.

Information from the Alzheimer's Society, carers, and from discussions with staff who work closely with people who are living with dementia, informed development of the care plan.

The 'This is Me' document is nationally recognised as a tool to enhance person-centred care in health, 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. Education and training with champions has improved use of these documents. However, further improvements are planned for 2017/18 to compliment use of the revised dementia care plan.

National recognition will take time and effective communication strategies to enable us to 'show-case' our achievements both locally and on a national scale. King's Mill Hospital is participating in the VOICE study that is being conducted by researchers at the University of Nottingham. This involves developing communication skills that staff can use when interacting with people who are living with dementia. Evaluation of the research will enable the investigators to develop a national training package. Participation in research raises awareness of emerging initiatives in dementia care promotes care that is at the frontier of modern dementia care.

Monitoring and reporting for sustained improvement

Understanding how we are performing is a critical part of improving our practice. Wards and departments regularly audit the care they deliver. Questions have now been included in the nursing metrics focus on two important areas:

- Do people present with the 'This is Me' document and, if not, is this given to them?
- Are people with dementia identified through the use of the Forget-Me-Not magnet on the care and comfort boards and is the Forget-Me-Not sticker used on notes?

These questions were introduced in March 2017 and responses will be monitored to determine how clinical teams, people living with dementia and their carers can be supported and how improvements can be made.

Appointment of a substantive Specialist Dementia Nurse in July 2016 helped to ensure that previous developments are sustained and improved in line with national guidelines and good practice evidence. Performance regarding dementia screening, assessment and referral are reported to the Safeguarding Board on a quarterly basis.

Understanding how we are performing is a critical part of improving our practice.

What do we aim to achieve in 2017/18

Increase the numbers of staff accessing dementia training. A success during late 2016 was implementation of Tier 2 dementia training that should be undertaken by staff who have regular contact with people who are living with dementia. We are required biannually to report the numbers of staff who have completed this to Health Education East Midlands. We estimate that there are potentially 2500 staff who need to access this level of dementia training, so it will take time for these staff to be able to complete this. In the meantime, all new staff receive dementia awareness as part of their orientation and staff receive a yearly dementia up-date as part of their mandatory training. The Alzheimer's Society Dementia Friends Awareness is available on request and other bespoke training sessions are also being held when requested.

Explore how adaptations can make specific areas throughout the Trust more dementia friendly. Areas that are currently keen to develop this include: the Emergency Department, Operating Theatres and Ward 12. These works will also align to the Trust's PLACE environmental plan. For example providing appropriate clocks within the clinical areas that don't currently have them, ensuring that there is appropriate signage throughout the clinical areas, and providing handrails at Newark.

The Dementia Champions were re-launched in December 2016 with a clear role profile. This is a growing network that meets quarterly and there have been two meetings to date. Champions come from all sectors of the Trust's workforce and support the Specialist Dementia Nurse through raising awareness of good dementia care and implementing best practice within their respective environments.

Working in partnership with carers continues to be a priority. Nationally 'John's Campaign' focuses specifically on working closely with the carers of people who are living with dementia when they come into hospital; the Trust is exploring implementation of this within the Trust.

3.10 Patient Experience – Ensure our complaints systems and processes are robust, responsive and support organisational learning

Complaints are a very important source of information about our patients, relatives and carers views regarding the quality of the services we provide in our hospitals.

What did we aim to achieve in 2016/17?

- Improve the quality of complaint responses and achieve the internal trust target response rate of 90%
- Embed the learning from complaints and triangulate themes with other governance intelligence, including claims and incidents

How are we performing against this target?

The quality of our complaint responses is measured through a variety of ways. We have continued to embed the robust systems established during 2016/17 providing central complaints management and a single lead contact from the start through to the final response for a complaint via the Patient Experience Team. Complainants have commented positively to this approach which has proven successful in ensuring complaints are thoroughly investigated to ensure learning is captured within agreed timescales.

We endeavour to respond as swiftly as possible when any issues are raised in accordance with the trust complaints and concerns policy and procedure, which is noticeable from the decrease in the annual figures for complaints and concerns 2016/17 in comparison to 2015/16.

The Trust continues to manage concerns and complaints in accordance with the Trust's Complaints and Concern Policy; all complaints are verbally acknowledged in the first instance to ensure the Patient Experience Lead has an understanding of the concerns and expectations as a result of the complaint investigation. All complaints are formally acknowledged by writing within 3 working days, which includes complaints received in writing or electronically, such as by email. We continually strive to improve final responses and offer early meetings to understand concerns and achieve local resolution of complaints.

Should complainants remain unhappy following our investigations and final response; we will review the complaint to identify if any further action or investigation can take place in an attempt to resolve the complaint. This year we re-opened 5% of complaint cases.

We continue to exceed the internal target of 90% compliance within 25 working days or agreed timescales. Table 8 shows the Trust's performance during 2016/17.

Table 8 – Complaint response

Division	No. received	No. responded in 25 days	No. responded over 25 days with agreed revised timescales	% responded within 25 days	No. reopened -complaints
Emergency/ Urgent Care	92	86	*6	93%	3
Surgery	114	104	*10	91%	2
Women's and Children's	53	49	*4	92%	0
Medicine	103	93	*10	90%	14
Diagnostic & Rehabilitation	12	12	0	100%	0
Corporate	3	3	0	100%	0
Totals	**377**	**347**	**30**	**94%**	**19**

*linked to Serious Investigations and /or Local Resolution Meetings
A total of 8 complaint cases have led to a letter of claim/proceedings served to the trust and are currently being handled by the NHS Litigation Authority.

Parliamentary Health Service Ombudsman (PHSO)

We aim to resolve all complaints to the complainants' satisfaction by conducting thorough investigations and providing a comprehensive response as well as offering complainants the opportunity to discuss further concerns with us. However, we are not always able to achieve a resolution, which satisfies the complainant. Under the NHS complaints system, complainants dissatisfied with responses received from us have the right to ask the Parliamentary Health Service Ombudsman (PHSO) for an independent review of their case.

Nationally referrals and investigations taken on by the PHSO have increased, and during 2016/17 the PHSO received 9 of applications relating to the Trust. The outcomes of these are detailed in table 9 below.

The decrease in re-opened complaints and referrals to the PHSO indicates the quality of complaint responses, and the attempts made to resolve complaints locally with the support of medical and nursing staff and the quality of responses has improved, in addition, the timely response.

We aim to resolve all complaints to the complainants' satisfaction by conducting thorough investigations and providing a comprehensive response as well as offering complainants the opportunity to discuss further concerns with us

Table 9 - PHSO applications received and outcome.

	2015/16	2016/2017
PHSO received applications	7	9
Upheld	0	0
Partially Upheld	2	0
Not Upheld	3	4
Not investigated	2	1
Awaiting outcome	0	4

Monitoring and Reporting

The Divisional Patient Experience Leads and Head of Patient Experience work closely with divisions to provide expert advice and support throughout the complaint management; this includes co-ordination of investigations, local resolution meetings and sharing of reports related in serious investigations in accordance with the statutory Duty of Candour. This has proven successfully in engagement with the medical and nursing staff to ensure a responsive and detailed investigation report is achieved in a timely manner, with staff fully understand the importance and value of addressing complainants concerns to provide assurances and explain any learning and actions as a result of the investigation when appropriate.

Patient Experience dashboards have been introduced by the Head of Patient Experience to provide real-time feedback including complaints, concerns and compliments to identify trends and hotspots to all relevant managers.

Patient stories and cases are feedback at governance meetings for learning and highlight areas of good practice. This has supported the triangulation of themes and trends within division and wider organisational learning.

The introduction of action plans as a result of all upheld /or partially upheld complaints supports implementing improvements to services as a result of the complaints investigation. The actions are tracked by the patient experience team and in 2017/18; this progress will be reported to Board.

The Division's complaints performance is reported and monitored at the monthly Patient Safety and Quality Board, and discussed at monthly divisional governance meetings.

A weekly tracker of all open complaint cases is available for divisions to provide a summary of the complaint caseload, which has supported the trust to exceed the internal target of 90% throughout the year.

What do we aim to achieve in 2017/18?

We are continually striving to make further improvements within our complaints management and learning processes, and incorporate this feedback with the other patient experience mechanisms within the trust to understand the quality of care we provide to our patients.

A number of the agreed actions for 2017/18 are as follows:

- Introduction of Internal Peer Review of complaints based on the Patient Association guidance to scrutinise the management of our complaints, reviewing four to five randomly selected complaints files on a quarterly basis. The feedback provided by the panel is used for reflection, learning and improvement.
- Re-establish the Patient Experience Group, which paused due to the proposed merger of trusts. The group will provide a platform to triangulate patient experience including, Friends and Family Test, NHS Choices, National Patient Surveys and indicators agreed in the new patient experience and engagement strategy. The membership will include internal and external stakeholders including trust governors, Healthwatch and Clinical Commissioners.
- Launch a Learning Week, a trust wide event to showcase the learning from governance functions, including claims, incidents, complaints, coroners and serious investigations.
- Throughout 2016/17 we have continued to focus not only on the experience of the patient, also the experience of the complainant within our complaints process, understanding how they have felt throughout the journey. We have introduced a complainant satisfaction survey which is sent with the consent of the complainant following the closure of a complaint, and plan to expand this to a text messaging service in 2017/18 to increase response rates, and provide further feedback.

We have been focusing on the experience of the patient or complainant to understand how they felt throughout their journey

- Evidence an improvement in the identification, management and delivery of safe personalised care of patients with Mental Health conditions.

How are we performing against this target?

The safeguarding training Level 2 / 3targets were achieved as identified in Table 10 below.

3.11 Patient Experience – Safeguarding

What did we aim to achieve in 2016/17?

- To ensure that safeguarding training (Level 2 / 3) targets are achieved
- To ensure that Mental Capacity Assessment (MCA) and Best Interest systems and processes are embedded within clinical practice
- To further embed the recently implemented safeguarding champion model

Table 10 – Percentage completion of level 2 and 3 Safeguarding training.

Activity	Q1 2016-2017	Q2 2016-2017	Q3 2016-2017	Q4 2016-2017
SG Adults	96%	97% ↑	96% ↓	97% ↑
SG Children Level 1	95%	96% ↑	97% ↑	98% ↑
SG Children Level 2	85%	89% ↑	90% ↑	89% ↓
SG Children Level 3	77%	79% ↑	78% ↓	69% ↓

Safeguarding Children Level 2 Training; This mandatory safeguarding training for nursing, midwifery and therapy staff for 2016/17 is achieved by completion of a workbook, submitted prior to the face-to-face element of the update day. The workbook is based on the NSCB information leaflet 'Indicators of Possible Child Abuse' and has a pass mark of 80%.

The compliance rate for 2016/2017 is currently at 89%, which is just below the Trust target of 90%. The workbook has been reviewed and amended to an E.learning package for 2017/2018, which incorporates practice changes and updates from lessons learnt from serious case reviews.

Safeguarding Children Level 3 Training; Level 3 safeguarding training is mandatory for all staff that has regular contact with children – this includes ED and MIU staff, integrated sexual health service, as well as those within Children's Services. This training can be undertaken in a variety of ways and is clearly displayed for staff on the training pathway. Currently staff groups requiring this level of training must undertake a total of 6 hours training over a 3 year period to be complaint.

Compliance for Level 3 Safeguarding children training over 2016/2017 is at 69%, which is below the Trust target, however there have been some difficulties in the reporting of this training, which has led to inaccuracy within the figures.

To overcome these difficulties we have changed the way staff gains compliance. From April 2017, staff will be required to evidence they have attended a full day Level 3 safeguarding children training every 3 years. This competency will be achieved via staff attending the full day in house 'Think Family' training, provided by the Safeguarding team or via external multi agency Level 3 training.

Safeguarding Adult Training; This has not previously been reported on within levels, however moving forward in 2017/2018 this will be aligned with Safeguarding Children's levels. This will provide assurance within the SAAF and the Care Act 2014.

To ensure that Mental Capacity Assessment (MCA) and Best Interest systems and processes are embedded within clinical practice; this work is on-going. The main work for safeguarding adults including Learning Disabilities has been to continue to embed Mental Capacity Assessment (MCA) and best interest systems and processes within clinical practice; and for safeguarding children it has been based on embedding robust safeguarding supervision and 'the voice of the child' in all assessments.

Safeguarding teams have redefined safeguarding training strategy to ensure training links with multi-agency training; aim is to improve quality of e.g. referrals to MASH. MCA/DOLs training has been revised and how to best embed into clinical practice through electronic app, prompt cards, 360 degree audits, safeguarding team visibility onwards, and this includes Learning Disability awareness within clinical areas. Revised both adults and children's training safeguarding level 3 and introduced a 'Think Family Day'

To further embed the recently implemented safeguarding champion model; the safeguarding champion model continues to be developed across the adult and children divisions, with forums supporting adult champions and children champions through group and one to one supervision.

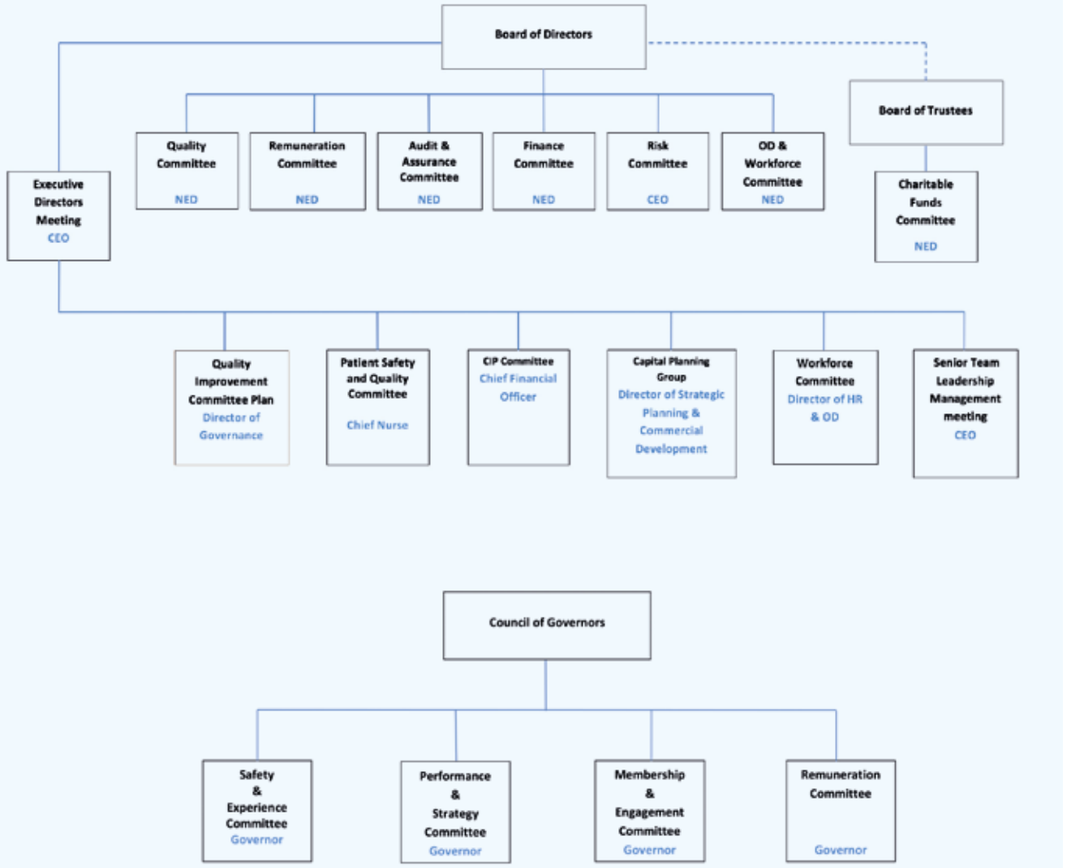
Evidence an improvement in the identification, management and delivery of safe personalised care of patients with Mental Health conditions; this work is on-going and will form part of the safeguarding strategic work plan for 2017/2018, led by the Head of Safeguarding. There is current work underway in partnership with the Rapid Response Liaison Team, looking at Mental Health Act service improvement. This will determine action plans and priorities for 2017/2018.

What do we aim to achieve in 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 Committee.

- 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. We continue 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.

Appendix 1 - Trust Committee Structure



Appendix 2 - Mandatory Key Performance Indicators

Indicators identified within the Risk Assessment Framework and Single Oversight Framework for 2016/17	Target	Performance	
		Yr2015/16	Yr2016/17
Maximum time of 18 weeks from point of referral to treatment in aggregate – arithmetic average for Yr2015/16	18 weeks 92%	92.03%	92.63%
A&E clinical quality: total time in A&E dept. (% <4hour wait)	4 Hours > 95%	94.43%	94.51%
Cancer 2 week wait: all cancers	93%	95.20%	95.9%
Cancer 2 week wait: breast symptomatic	93%	95.60%	96.6%
Cancer 31 day wait: from diagnosis to first treatment	96%	98.40%	97.8%
Cancer 31 day wait: for subsequent treatment – surgery	94%	99.00%	100.0%
Cancer 31 day wait: for subsequent treatment –drugs	98%	99.70%	98.9%
Cancer 62 day wait: urgent referral to treatment	85%	84.00%	83.6%
Cancer 62 day wait: for first treatment – screening	90%	96.40%	89.2%
C. difficile – meeting the C. difficile objective	Local targets	45	28
Infection prevention control: MRSA bacteraemia (no. of cases attributed to Trust)	0	1	0
Access to healthcare for people with LD	Compliant	Compliant	Compliant
Data completeness: community services: referral to treatment information	50%	96.67%	96.55%
Referral information	50%	54.80%	56.70%
Treatment activity information	50%	77.63%	76.84%

Appendix 3 - Monitored Core Indicators

1. Mortality (NHS Digital)

	Previous period (Oct 2014 – Sep15)	Current period (Oct 15-Sept 16)	National Performance			Comment
			Average	Highest	Lowest	
(a)Summary Hospital level Mortality Indicator (SHMI) value	**1.019**	**0.9515**	**1.003**	**0.639**	**1.164**	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons as this is the latest data available on the NHS digital website. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data, and so the quality of its services by continued work between clinical staff and clinical coders to improve our coding.
(b)SHMI banding	**2**	**2**	*	**3**	**1**	
(c) Percentage of patients deaths with palliative care coded at diagnosis or speciality level	**13.9**	**15.6**	**29.6**	**56.3**	**0.4**	The Sherwood Forest Hospitals Trust considers that this percentage is as described for the following reasons. We ensure that review by our specialist palliative care team is clearly evidenced in the patient record to ensure correct coding. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this percentage , and so the quality of its services by Increasing our rate of palliative care coding by ensuring accurate record keeping when patients receive palliative care at the Trust and ensuring the liaison between Trust clinical staff and clinical coders continues.

* DATA NOT AVAILABLE ON NHS DIGITAL WEBSITE

Appendix 3 - Monitored Core Indicators (Continued)

2. Patient Related Outcome Measures (PROMs); Adjusted Average Health Gain (NHS Digital)

	Previous period (2014/15)	Current period (2015/16)	National Performance			Comment
			Average	Highest	Lowest	
(i) Groin Hernia Surgery	**53.5%**	**54.2%**	**50.9%**	*	*	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; It is the latest available on NHS Digital website. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data, and so the quality of its services by focussing on pre and post-operative patient information and care.
(i) Varicose Vein Surgery	**50.7%**	**53.8%**	**52.3%**	*	*	
(ii) Hip Replacement Surgery	**89.9%**	**89.2%**	**89.7%**	*	*	
(iii) Knee Replacement surgery	**77.2%**	**77%**	**81.6%**	*	*	

* DATA NOT AVAILABLE ON NHS DIGITAL WEBSITE

3. Percentage Readmissions to hospital within 28 days

	Previous period (Apr 15-Mar 16)	Current period (Apr 16-Dec 16)	National Performance			Comment
			Average	Highest	Lowest	
(i) Patients aged 0 or over 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	**7.63%**	**8.44%**	**7.39%**	**Not available**	**Not available**	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; this is the most current data available on HED. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this percentage, and so the quality of its services by continuing to review readmissions on a regular basis and undertake a programme of work which addressed specific causes for readmission.

Appendix 3 - Monitored Core Indicators (Continued)

4. Responsiveness to the personal needs of patients

	Previous period (Apr 16-Mar 17)	Current period (April 16-Feb 17)	National Performance			Comment
			Average	Highest	Lowest	
Trust's responsiveness to the personal needs of its patients	**97.35**	**97.45**	**95.87**	**99.97**	**74.2**	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; Information from the patient surveys is triangulated against the themes and trends identified by the patient experience team though their work and conversations with patients, relative and service users. This includes the analysis of complaints, concerns and compliments. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data, and so the quality of its services by improving the learning process from our surveys, specifically how the information is analysed and shared following collation by our externally commissioned provider and undertaking additional local surveys to provide additional detailed patient experience information. Focus has taken to improve the response rate to FFT and patient surveys and ensure that comprehensive feedback is provided to areas so the information can be used.

Appendix 3 - Monitored Core Indicators (Continued)

5. Staff who would recommend the Trust as a provider of care to their family and friends

	Previous period (2015/16)	Current period (2016/17)	National Performance Average (Median) for acute Trusts			Comment
			Average	Highest	Lowest	
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family and friends	**73.4%**	**86.3%**	****79.9**	****100**	****46.6**	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; The Trust has adhered to the national guidance for conducting the Staff, Friends and Family test. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this percentage, and so the quality of its services by continuously driving improvements in patient safety and quality and ensuring staff are aware of improvements.

**** NATIONAL DATA ONLY UP TO END OF Q2**

6. Venous thromboembolism (VTE) risk assessment

	Previous period (Apr 15-Mar 16)	Current period (Apr 16-Mar 17)	National Performance			Comment
			Average	Highest	Lowest	
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	**94.89**	**94.82**	*****95.62**	*****100**	*****74.11**	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; the Trust has robust screening systems and processes in place to identify patients at risk. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data, and so the quality of its services by continuously monitoring performance against this indicator and implementing an electronic risk assessment form through NerveCenter in 2017.

***** DATA ONLY TO DECEMBER 2016**

Appendix 3 - Monitored Core Indicators (Continued)

7. C.difficile (NHS Digital)

	Previous period (Apr 16-Mar 17)	Current period (April 16-Feb 17)	National Performance			Comment
			Average	Highest	Lowest	
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the Reporting period	**19.31**	**12.55**	*	*	*	Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: C.difficile rates are reported internally to the Infection Control Committee and subject to governance reviews and reported externally to Public Health England, in line with national reporting requirements. The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data and so the quality of its services by C.difficile will remain a priority closely monitored through existing governance processes. We will continue to actively embed the actions taken since. Will deliver on the 2016/17 actions identified in root cause analysis processes. We will embed and ensure the improvements in cleaning and effective management of patients with an infection caused by C.difficile are sustained. We will improve the monitoring and management of source infections such as urinary tract infections and chest infections. Emphasis on antimicrobial stewardship in line with the national standard - to reduce antibiotic consumption and encourage a multidisciplinary focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours.

* DATA NOT AVAILABLE ON NHS DIGITAL WEBSITE

Appendix 3 - Monitored Core Indicators (Continued)

8. Patient safety Indicators

	Previous period (Apr 15-Mar 16)	Current period (Apr 16-Sept 16)	National Performance (Acute Teaching Providers)			Comment
			Average	Highest	Lowest	
Rate of patient safety incidents reported per 1,000 bed days	**33.62**	**32.82**	**46.55**	*	*	The Sherwood Forest Hospitals Trust considers that this data is as described for the following reasons; it is the latest national data available The Sherwood Forest Hospitals Trust intends to take the following actions to improve this data, and so the quality of its services by; Incident reporting awareness training is included in the induction programme for all new members of nursing staff, and a basic user guide to reporting is provided to all new starters as well as being published on the Trust intranet. A Good Governance Training and Education Programme will be rolled out in 2017/18 to provide a wider range of classroom based and e-learning packages that will be made available to all staff. The Trust has continued to invest in all aspects of Datix system.
Number of patient safety incidents that resulted in severe harm or death	**17**	*				

* DATA NOT AVAILABLE ON NHS DIGITAL WEBSITE

Annex 1 – Statements from Commissioners, Health Scrutiny Committee and Governors.

This section includes the statements from our stakeholders about the Trust's quality performance during 2016/17 following review by Stakeholders

Statement from Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Groups (CCGs) – 3rd May 2017

Sherwood Forest Hospitals Foundation Trust implemented significant change during 2016/17 leading to quality improvements across the organisation. Improvements in their safety culture, management of sepsis, reduction in C Difficile and mortality rates are examples of where demonstrable change has been sustained.

The Trust was congratulated by the Mid Nottinghamshire Clinical Commissioning Groups for their focus and pace in delivering the required changes along the resulting removal of Special Measures status.

The Trust has also been a high achiever in meeting the NHS England A+E four hour wait target during the year despite significant winter pressures and will have an annual rate of over 94.5% (against a 95% target). Collaborative working, within the Mid Nottinghamshire Alliance by the organisation, has contributed to wider improvement to services for our population.

Statement from Healthwatch – 19th May 2017

As the independent watchdog for health and social care in the County, we work to ensure that patient and carer voices are heard by providers and commissioners. We are grateful to be given the opportunity to view and comment on the Quality Account.

Healthwatch Nottinghamshire has a constructive relationship with SFHT with the CEO sitting on the Oversight Group. This is tasked with ensuring that the Quality Improvement Plan, developed in response to the CQC Report, is implemented and that improvements are embedded. We are satisfied that robust processes have been put in place to maximise the potential for positive change; acknowledging systemic challenges, in relation for example, to recruitment and retention of key clinical staff.

Healthwatch Nottinghamshire would like to highlight a number of recognised successes presented in the Account and to seek assurance and guidance from the Trust in addressing under performance and the areas of concern that remain.

Successes

During 2016/17 the Trust achieved many of their quality priorities and we wish to recognise the following:

Overall improvement in scores from Staff Friends and Family responses.

Achieving zero medication-related never-events.

Consistently reaching all quarterly Commissioning for Quality and Innovation indicators throughout the year.

Continuing to exceed the internal target of 90% compliance to patient complaints within 25 working days.

We are particularly impressed with the Trust's continued improvement regarding Sepsis performance. We commend the Trust on their advance from being one of the worst performing trusts in the country, to being classed in the 25% best performing during the course of the year.

Healthwatch Nottinghamshire are pleased to have entered into agreement in principle regarding an updated Information Sharing Protocol with the Trust. We have also welcomed the opportunities for our Chair and Chief Executive to meet with the Trust's Interim Chief Executive, in order for Healthwatch Nottinghamshire to ensure patient and carer voices are heard.

Improvements/Concerns

Healthwatch Nottinghamshire believes that patient engagement is an important element and with regards patient experience, we were disappointed to see very brief information about how patient feedback is collected. The National audits for 2017/2018 are very staff-centric with little focus on patient experience. We would like to see more emphasis on patient feedback in the future.

Presentation of the Quality Account

The structure of the Quality Account as a whole is not easy to navigate for the reader. Although the draft of the documents we saw has explanation and contextual information, it would be beneficial to reduce the amount of jargon to make the document more accessible to members of the public. We were pleased that the Trust included a glossary of terms to help in this regard.

Comments received by Healthwatch Nottinghamshire

During 2016/17 we collected 264 experiences about services that the Trust provides (see the dashboard overleaf for an overview of our data). All of our data is thematically coded and we used 76 codes in total – 38 of which were positive and 38 were negative. Almost two thirds (66%) of all comments that came into Healthwatch Nottinghamshire about the Trust are positive. It is important to note that, in contrast, only 41% of experiences that came directly to Healthwatch were negative. We can clearly see that over half experiences that are not shared directly with us are positive, and this highlights the need for the Trust to continue working with us to ensure that patient experiences from many sources are considered when improving services and patient experience. We are pleased that our data show positive interaction with staff, with a third of all experiences talking about the compassionate care of staff.

Actions / Recommendations

Healthwatch Nottinghamshire seeks clarification on the following:

1. Further details on how the Trust plans to provide safe services outside core hours, as identified as Key Priority 1 for 2017/18.

2. More priority given to patient engagement and experiences going forward.

Healthwatch welcomes improvements in a number of the priority areas set for 2016/17, but we also recognise the challenges still faced by the Trust. We look forward to seeing further improvements in 2017/18. We will continue to work with the Trust, to monitor any issues which arise, and ensure that we represent the views of local people.

Sherwood Forest Hospitals
1st April – 31st December 2016

healthwatch Nottinghamshire

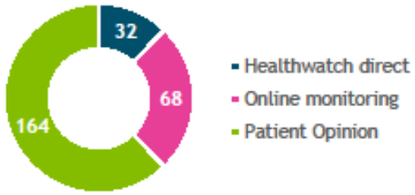
Experiences collected

264 Experiences collected

3 Identifiable services reviewed

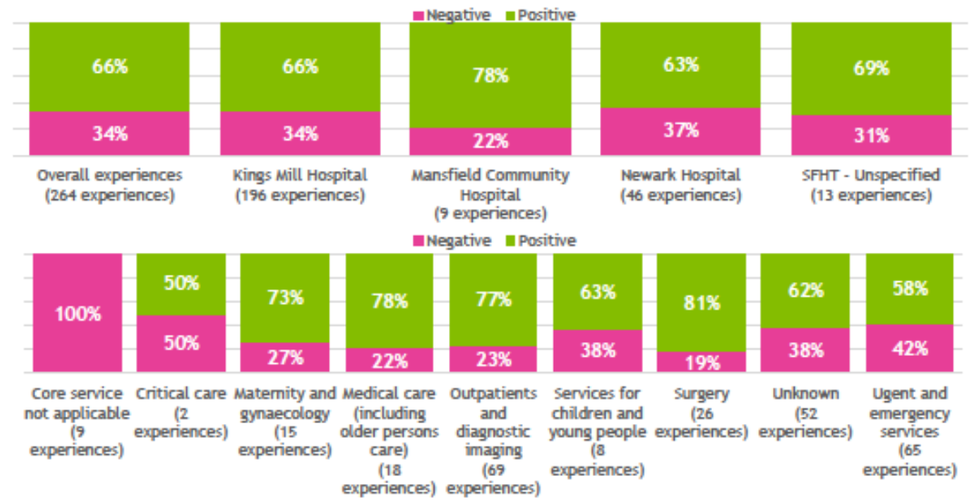
Note: this does not include experiences collected through ongoing Question of the Moment or Insight Projects

Source of experiences and sentiment

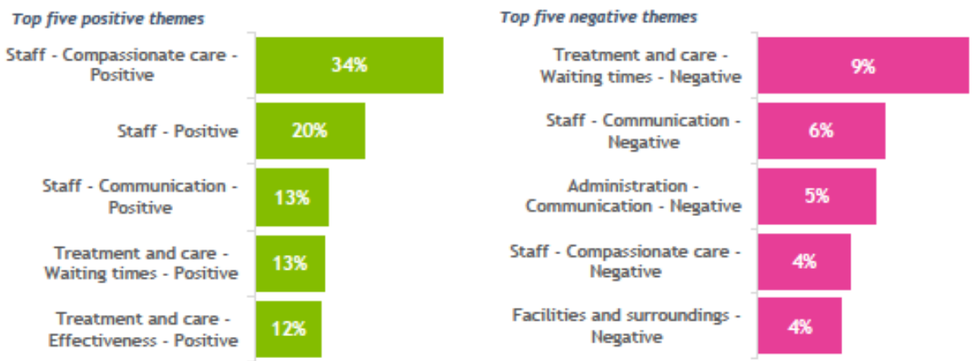


Source	Number	Negative	Positive
Healthwatch direct	32	59%	41%
Patient Opinion	164	24%	76%
Online monitoring	68	44%	56%
Information sharing	0	0%	0%
All sources	264	34%	66%

Services and sentiment



Themes of reviews



Annex 2 – Statement of Directors' responsibilities for the Quality Report

The quality report must include a statement of directors' responsibilities, in the following form of words:

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 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to 25th May 2017
  - papers relating to Quality reported to the board over the period April 2016 to 24th May 2017
  - feedback from commissioners dated 3rd May 2017
  - feedback from the Overview and Scrutiny Committee (Due to the local election it was Nottinghamshire County Council identified they were not able to provide a statement)
  - feedback from Healthwatch dated 19th May 2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, - final annual report is not yet published
  - the latest national patient survey – the full results are expected in July 2017
  - the national staff survey 7th March 2017
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 25th May 2017
  - CQC inspection report dated October 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, and
- The Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: **25 May 2017** Chairman:

Date: **25 May 2017** 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 Auditor's Report to the Council of Governors

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ON THE 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 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

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 criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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 is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 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:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 3 May 2017;
- feedback from Healthwatch, dated 19 May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national staff survey, March 2017;
- Care Quality Commission inspection report, 9 November 2016; and
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2017.

Independent Auditor's Report to the Council of Governors *(continued)*

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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 the 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 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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, except 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'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller 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 affect 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 of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Sherwood Forest Hospitals NHS Foundation Trust.

Independent Auditors Report to the Council of Governors *(continued)*

Basis for qualified conclusion

A&E Indicator

Our testing of the calculation of the 4 hours A&E indicator found that we were unable to corroborate the "stop time" recorded by the Trust in 51% of the cases tested, as the Trust were either unable to retrieve the patient file, or the "clock stop" time was not recorded within the patient file. In 26% of cases tested we were unable to agree the "clock stop" to the time recorded within the patient file as there were inconsistencies between the two times.

18 Week Referral to Treatment Indicator

Our testing of the calculation of the 18 week referral to treatment indicator identified 20% of the cases tested to supporting data did not corroborate the start or stop times recorded by the Trust.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP.

KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

30 May 2017

Sherwood Forest Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the Accounts

These accounts, for the year ended 31 March 2017, 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 .....

Name **Peter Herring**
Job title **Chief Executive Officer**
Date **25 May 2017**

Statement of Comprehensive Income

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3	237,963	226,463
Other operating income	4	57,476	37,613
Total operating income from continuing operations		**295,439**	**264,076**
Operating expenses	5, 7	(367,274)	(272,141)
Operating surplus/(deficit) from continuing operations		**(71,835)**	**(8,065)**
Finance income	9	28	37
Finance expenses	10	(19,208)	(18,452)
PDC dividends payable		-	-
Net finance costs		**(19,180)**	**(18,415)**
Gains/(losses) of disposal of non-current assets	11	(137)	(51)
Surplus/(deficit) for the year from continuing operations		**(91,152)**	**(26,531)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	13	**-**	**-**
Surplus/(deficit) for the year		**(91,152)**	**(26,531)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(2,796)	-
Revaluations	16	-	2,111
Other recognised gains and losses		-	-
Other reserve movements		-	-
Total comprehensive income/(expense) for the period		**(93,948)**	**(24,420)**

The above deficit includes impairments and costs relating to Long Term Partnership (LTP) costs as detailed below.

Surplus/(deficit) for the year as stated above		**(91,152)**	**(26,531)**
Reversal of impairment	6	(202)	(32,635)
Impairment	6	42,281	4,120
LTP SFH		1,426	550
LTP (NUH)		11,216	1,318
LTP (Other)		-	180
Surplus / (deficit) from continuing operations excluding the impact of impairments and LTP		**(36,431)**	**(52,998)**

The notes on pages 182 to 218 form part of these accounts and are cross-referenced accordingly.

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	13	4,505	5,335
Property, plant and equipment	14	226,297	271,856
Trade and other receivables	19	593	652
Other financial assets	21	-	-
Other assets	20	-	-
Total non-current assets		**231,395**	**277,843**
Current assets			
Inventories	18	3,377	3,239
Trade and other receivables	19	21,796	14,159
Other financial assets	21	-	-
Non-current assets for sale and assets in disposal groups	22	-	-
Cash and cash equivalents	23	3,899	1,456
Total current assets		**29,072**	**18,854**
Current liabilities			
Trade and other payables	24	(32,335)	(30,492)
Other liabilities	26	(561)	(6,810)
Borrowings	27	(7,191)	(6,348)
Other financial liabilities	25	-	-
Provisions	28	(1,061)	(703)
Liabilities in disposal groups	22	-	-
Total current liabilities		**(41,148)**	**(44,353)**
Total assets less current liabilities		**219,319**	**252,344**
Non-current liabilities			
Trade and other payables	24	(975)	(1,567)
Other liabilities	26	-	-
Borrowings	27	(452,345)	(392,930)
Other financial liabilities	25	-	-
Provisions	28	(863)	(389)
Total non-current liabilities		**(454,183)**	**(394,886)**
Total assets employed		**(234,864)**	**(142,542)**
Financed by			
Public dividend capital		146,139	144,513
Revaluation reserve		11,942	14,949
Income and expenditure reserve		(392,945)	(302,004)
Total taxpayers' equity		**(234,864)**	**(142,542)**

The financial statements contained within the annual accounts were approved by the Board and signed on its behalf by:

Name **Peter Herring**
Position **Chief Executive Officer**
Date **25 May 2017**

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' and others' equity at 1 April 2016 - brought forward	**144,513**	**14,949**	**(302,004)**	**(142,542)**
Surplus/(deficit) for the year	-	-	(91,152)	**(91,152)**
Other transfers between reserves	-	(211)	211	**-**
Impairments	-	(2,796)	-	**(2,796)**
Revaluations	-	-	-	**-**
Public dividend capital received	1,626	-	-	**1,626**
Public dividend capital repaid	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2017	**146,139**	**11,942**	**(392,945)**	**(234,864)**

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**144,136**	**13,005**	**(275,640)**	**(118,499)**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2015 - restated	**144,136**	**13,005**	**(275,640)**	**(118,499)**
At start of period for new FTs	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	(26,531)	**(26,531)**
Other transfers between reserves	-	(167)	167	**-**
Impairments	-	-	-	**-**
Revaluations	-	2,111	-	**2,111**
Public dividend capital received	377	-	-	**377**
Public dividend capital repaid	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2016	**144,513**	**14,949**	**(302,004)**	**(142,542)**

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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(71,835)	(8,065)
Non-cash income and expense:			
Depreciation and amortisation	5.1	10,428	9,460
Net impairments	6	42,079	(28,515)
Income recognised in respect of capital donations	4	(140)	(547)
(Increase)/decrease in receivables and other assets		(7,579)	(3,522)
(Increase)/decrease in inventories		(138)	(233)
Increase/(decrease) in payables and other liabilities		(5,941)	4,474
Increase/(decrease) in provisions		832	(137)
Net cash generated from/(used in) operating activities		**(32,294)**	**(27,085)**
Cash flows from investing activities			
Interest received		29	36
Purchase of intangible assets		(665)	(2,310)
Purchase of property, plant, equipment and investment property		(7,381)	(6,208)
Sales of property, plant, equipment and investment property		78	-
Receipt of cash donations to purchase capital assets		-	547
Net cash generated from/(used in) investing activities		**(7,939)**	**(7,935)**
Cash flows from financing activities			
Public dividend capital received		1,626	377
Movement on loans from the Department of Health		66,233	59,487
Movement on other loans		-	-
Capital element of PFI, LIFT and other service concession payments		(5,975)	(5,680)
Interest paid on PFI, LIFT and other service concession obligations		(17,210)	(17,541)
Other interest paid		(1,998)	(911)
Net cash generated from/(used in) financing activities		**42,676**	**35,732**
Increase/(decrease) in cash and cash equivalents		**2,443**	**712**
Cash and cash equivalents at 1 April		**1,456**	**744**
Cash and cash equivalents at 31 March	23.1	**3,899**	**1,456**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going concern

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 2016/17 we are reporting a deficit of (£91.15m) including costs associated with Long Term Partnership (LTP) with Nottingham University Hospitals NHS Trust (NUH) and the impact of impairments on the valuation of buildings. Removing these costs, which were £12.64m relating to LTP and £42.08m relating to impairments, we are reporting a deficit of (£36.43m). This is favourable to the plan by £4.77m excluding LTP, £8.01m including LTP. To support this financial position we have received £42.96m of revenue support term loans and has utilised a further £18.31m in working capital facility (WCF). £5.33m was also received to support the capital expenditure of £8.98m. In March 2017 all WCF loans were converted to revenue support term loans which attract a more favourable rate of interest, and in year repayments of £0.37m were made against existing capital loans.

NHS Improvement has set a control total of a maximum deficit of (£37.62m) in 2017/18, which includes receipt of £8.81m of Sustainability and Transformation funding (STF). To qualify for this funding the Trust must deliver its financial plan and the ED 4 hour wait target. To support this deficit and to repay PFI debt and previous capital loans we will require £43.56m of cash support (£37.92m revenue and £5.64m capital). NHS Improvement is aware of the need for cash support and the value has formally been notified via the submission of the two year financial plan on 23rd December 2017, and updated plan submitted 12 April 2017. This has not formally been agreed, however planning guidance states that if control totals are agreed revenue financial via term loans will be available to deficit organisations.

Discussions with NHS Improvement has indicated that cash will be available, with specific details to be agreed although at present it is assumed that this will be in the form of revenue term support loans, as per planning guidance issued by NHS Improvement

Notes to the Accounts

The Trust Board agreed a financial plan that would deliver the control total on 31st March 2017. Included within this is assumed cost improvement programme (CIP) delivery of £14.46m. Development and delivery of the CIP programme includes dedicated support from a CIP Director 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.

These accounts have been prepared on a going concern basis.

Judgements, estimates and assumptions

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.

Note 1.1 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidatedas the balances are not deemed material, however,the revenue and capital grants are reflected in the accounts.
The Trust has no interests in other entities.

Note 1.2 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.
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.

Notes to the Accounts

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments 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. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1. 4 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 1.5 Trust Specific Context

Post Balance Sheet events
The Trust is not aware of any events since the close of the accounting period, which would affect the position reported or the Trust's assessment of its going concern basis.

Third Party Assets
The Trust held £1k (£1k in 2015/16) as cash in hand or at bank at 31 March 2017 on behalf of patients or other third parties.

Related party transactions
Sherwood Forest Hospitals NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Sherwood Forest Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent entity. A detailed schedule of income and expenditure is shown in **note 37.**

The Trust has also received revenue and capital payments from Sherwood Forest Hospitals General Charitable Fund for which the Trust is the corporate Trustee. Sherwood Forest Hospitals General Charitable Fund purchased goods and services for the Trust during the financial year, and also provided purchases for patients and staff at Sherwood Forest Hospitals. The administration of the Charity is carried out by the Trust, and during the financial year the Trust charged the Charity for this service.

The Audited Accounts / Summary Financial Statements of the Funds Held on Trust are available separately.

Notes to the Accounts

Recognition
Property, plant and equipment is capitalised where:

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

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

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. 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’.

Notes to the Accounts

Impairments
In accordance with the *DH 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 income 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.

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

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be 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.

Donated, government grant and other 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.

Notes to the Accounts

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

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 FT 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 1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised.

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

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

Notes to the Accounts

Note 1.7 Intangible assets cont

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

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 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS 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.

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.

Notes to the Accounts

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below. All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

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

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

Classification and measurement
Financial assets are categorised as 'fair value through income and expenditure', 'loans and receivables' or 'available-for-sale financial assets'. Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. 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.

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.

Notes to the Accounts

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices and/or independent appraisals.

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 directly in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Note 1.11 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation 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
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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 Provisions

The NHS foundation 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
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is £122.52m (2015/16 £106.32m) but this is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling
The NHS foundation 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 the NHS Litigation Authority 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.

Notes to the Accounts

Note 1.13 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 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, 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 1.14 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 trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation 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 (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 1.15 Value added tax

Most of the activities of the NHS foundation 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 1.16 Corporation tax

No liability for corporate tax has been recognised or incurred when applying current legislation.

Note 1.17 Foreign exchange

The functional and presentational currencies of the trust are 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 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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*.

Notes to the Accounts

Note 1.19 Cash and cash

Cash is cash in hand and deposits with any financial institution repayable without any 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 convertable to known amounts of cash with insignificant risk of change in value.

Note 1.20 Losses and special

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 NHS foundation trusts 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 2016/17.

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 : early adoption is not therefore permitted.*
IFRS 14 Regulatory Deferral Accounts	*Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH 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 : 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: early adoption is not therefore permitted.*

Note 1.24 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

In-year a revaluation was undertaken by the 'Valuation Agency Office' of the land and building assets of the Trust under the modern equivalent cost valuation method and the movements in market value reflected in the financial position. The basis of the valuation excluded VAT from all PFI assets to reflect the underlying nature of the transaction where VAT is a pass through cost.

As part of the year end process, estimates have been made regarding outstanding income, expenditure and provisions. No estimates have been made regarding land and buildings as these have all been revalued in year. The Trust is not aware of any material uncertainty within these estimates which would impact on the figures disclosed within the primary statements and notes to the accounts.

Note 2 Operating Segments

Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare.

The Trust is split into 5 clinical divisions, Urgent Care, Medicine, Surgery, Women's and Childrens 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.

Notes to the Accounts

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17 £000	2015/16 £000
Acute services		
Elective income	38,029	36,189
Non elective income	73,588	71,379
Outpatient income	46,967	45,453
A & E income	14,646	13,324
Other NHS clinical income	63,762	59,058
All services		
Additional income for delivery of healthcare services	-	-
Private patient income	119	117
Other clinical income	852	943
Total income from activities	**237,963**	**226,463**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2016/17 £000**	**2015/16 £000**
CCGs and NHS England	233,886	222,541
Local authorities	2,738	2,745
Department of Health	-	-
Other NHS foundation trusts	343	-
NHS trusts	25	20
NHS other	-	57
Non-NHS: private patients	119	117
Non-NHS: overseas patients (chargeable to patient)	41	40
NHS injury scheme (was RTA)	811	943
Non NHS: other	-	-
Additional income for delivery of healthcare services	-	-
Total income from activities	**237,963**	**226,463**
Of which:		
Related to continuing operations	237,963	226,463
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 22.94% to reflect expected rates of collection. (21.99% 2015/16)

Notes to the Accounts

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17 £000	2015/16 £000
Income recognised this year	41	40
Cash payments received in-year	13	7
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2016/17 £000	2015/16 £000
Research and development	741	956
Education and training	11,651	11,456
Receipt of capital grants and donations	140	547
Charitable and other contributions to expenditure	365	257
Non-patient care services to other bodies	6,871	5,477
Support from the Department of Health for mergers	-	-
Sustainability and Transformation Fund income	15,004	-
Rental revenue from operating leases	1,478	1,967
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	-	-
Other income	21,226	16,953
Total other operating income	**57,476**	**37,613**
Of which:		
Related to continuing operations	57,476	37,613
Related to discontinued operations	-	-

Sustainability and Transformation Fund income relates to income received for meeting agreed operational and financial targets.

The largest items in other income relate to recharges arising from the Public Finance Initiative schemes (PFI) £4.2m, and the locally hosted Health Informatic Services £6.25m which provides I.T. services to local CCG and GP practices.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, 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:

	2016/17 £000	2015/16 £000
Income from services designated (or grandfathered) as commissioner requested services	237,963	226,463
Income from services not designated as commissioner requested services	(930)	(1,060)
Total	**237,033**	**225,403**

Note 4.2 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.

Notes to the Accounts

Note 5.1 Operating expenses

	2016/17 £000	2015/16 £000
Services from NHS foundation trusts	276	380
Services from NHS trusts	307	435
Services from CCGs and NHS England	58	164
Services from other NHS bodies	1	5
Purchase of healthcare from non NHS bodies	1,657	1,124
Purchase of social care	-	-
Employee expenses - executive directors	1,658	1,231
Remuneration of non-executive directors	144	153
Employee expenses - staff	194,333	184,221
Supplies and services - clinical	25,378	25,117
Supplies and services - general	1,555	1,640
Establishment	3,089	2,896
Research and development	-	-
Transport	677	326
Premises	19,715	16,984
Increase/(decrease) in provision for impairment of receivables	370	220
Increase/(decrease) in other provisions	1,031	-
Change in provisions discount rate(s)	-	-
Inventories written down	-	-
Drug costs	21,747	21,321
Rentals under operating leases	401	474
Depreciation on property, plant and equipment	8,933	8,299
Amortisation on intangible assets	1,495	1,161
Net impairments	42,079	(28,515)
Audit fees payable to the external auditor		
audit services- statutory audit	62	69
other auditor remuneration (external auditor only)	7	34
Clinical negligence	8,919	7,731
Legal fees	209	393
Consultancy costs	720	2,822
Internal audit costs	157	136
Training, courses and conferences	805	714
Patient travel	-	-
Car parking & security	-	164
Redundancy	-	-
Early retirements	52	52
Hospitality	151	198
Publishing	-	-
Insurance	-	-
Other services, eg external payroll	-	-
Grossing up consortium arrangements	-	-
Losses, ex gratia & special payments	70	7
Other*	31,218	22,185
Total	**367,274**	**272,141**
Of which:		
Related to continuing operations	367,274	272,141
Related to discontinued operations	-	-

*Other income includes the PFI operating expense charge of £20.8m and Long Term Partnership costs with Nottingham University Hospitals £11.2m..

Notes to the Accounts

Note 5.2 Other auditor remuneration

	2016/17 £000	2015/16 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	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	-	34
Total	**7**	**34**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £0.5m (2015/16: £0.5m).

Note 6 Impairment of assets

	2016/17 £000	2015/16 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price (Including impact of VAT as detailed below)	42,079	(28,515)
Other	-	-
Total net impairments charged to operating surplus / deficit	**42,079**	**(28,515)**
Impairments charged to the revaluation reserve	2,796	-
Total net impairments	**44,875**	**(28,515)**

Impairments during the period arose from:	2016/17 £000	2015/16 £000
Reversal of previous impairment	(202)	32,635
Impairment charged to operating expenditure due to changes in market value	8,365	
Impairment charged to operating expenditure relating to in year valuation movement PFI assets excluding VAT	33,916	(4,120)
Impairments charged to the revaluation reserve	2,796	
Impact on Retained (Deficit) for the year	44,875	28,515

The Trust approved a change in the method of valuation in year to remove VAT. This change was adopted as it reflects the commercial nature of the Private Finance Initiative.

Notes to the Accounts

Note 7 Employee benefits

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**137,365**	135,784
Social security costs	**13,178**	10,360
Employer's contributions to NHS pensions	**16,228**	16,029
Pension cost - other	**-**	-
Other post employment benefits	**-**	-
Other employment benefits	**-**	-
Termination benefits	**-**	-
Temporary staff (including agency)	**29,576**	23,607
Total gross staff costs	**196,347**	**185,780**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**196,347**	**185,780**
Of which		
Costs capitalised as part of assets	297	276

Note 7.1 Retirements due to ill-health

During 2016/17 there were 7 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £437k (£233k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration The aggregate amounts payable to directors were:	2016/17 Total £000	2015/16 Total £000
Salary	1588	1,130
Taxable benefits	2	13
Performance related bonuses		-
Employer's pension contributions	68	88
Total	**1,658**	**1,231**

Further details of directors' remuneration can be found in the remuneration report.

Notes to the Accounts

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.

	2016/17 £000	2015/16 £000
Operating lease revenue		
Minimum lease receipts	-	-
Contingent rent	1,478	1,967
Other	-	-
Total	**1,478**	**1,967**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease receipts due:		
- not later than one year;	1,365	1,321
- later than one year and not later than five years;	4,901	4,742
- later than five years.	835	1,311
Total	**7,101**	**7,374**

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 FT is the lessee.

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	401	474
Contingent rents	-	-
Less sublease payments received	-	-
Total	**401**	**474**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	253	249
- later than one year and not later than five years;	278	480
- later than five years.	-	-
Total	**531**	**729**

Notes to the Accounts

Note 9 Finance income

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

	2016/17 £000	2015/16 £000
Interest on bank accounts	28	37
Total	**28**	**37**

Note 10.1 Finance expenditure

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

	2016/17 £000	2015/16 £000
Interest expense:		
Loans from the Department of Health	1,997	911
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	17,211	17,541
Total interest expense	**19,208**	**18,452**
Other finance costs	-	-
Total	**19,208**	**18,452**

Note 10.2 The late payment of commercial debts (interest) Act 1998

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

	2016/17 £000	2015/16 £000
Profit on disposal of non-current assets	78	-
Loss on disposal of non-current assets	(215)	(51)
Net profit/(loss) on disposal of non-current assets	**(137)**	**(51)**

Note 12 Corporation tax

No liability for corporation tax has been recognised or incurred when applying current legislation

Notes to the Accounts

Note 13.1 Intangible assets - 2016/17

	2016/17	2015/16
	Software licences	Software licences
	£000	£000
Valuation/gross cost at 1 April - brought forward	**12,356**	**10,046**
Valuation/gross cost at start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Additions	665	**2,310**
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Revaluations	-	-
Transfers to/ from assets held for sale	-	-
Disposals / derecognition	-	-
Gross cost at 31 March	**13,021**	**12,356**
Amortisation at 1 April - brought forward	**7,021**	**5,860**
Amortisation at start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Provided during the year	1,495	**1,161**
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Revaluations	-	-
Transfers to/ from assets held for sale	-	-
Disposals / derecognition	-	-
Amortisation at 31 March	**8,516**	**7,021**
Net book value at 31 March 2017	**4,505**	
Net book value at 1 April 2016		**5,335**

Notes to the Accounts

Note 14.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**17,191**	**239,749**	**1,496**	**-**	**30,885**	**-**	**7,395**	**294**	**297,010**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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**
Reclassifications	-	(5,577)	-	-	-	-	-	-	**(5,577)**
Revaluations	-	-	-	-	-	-	-	-	**-**
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 - brought forward	**-**	**-**	**-**	**-**	**19,775**	**-**	**5,168**	**211**	**25,154**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	5,577	-	-	2,475	-	866	15	**8,933**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	(5,577)	-	-	-	-	-	-	**(5,577)**
Revaluations	-	-	-	-	-	-	-	-	**-**
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 14.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**17,191**	**239,749**	**1,496**	**-**	**30,885**	**-**	**7,395**	**294**	**297,010**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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**
Reclassifications	-	(5,577)	-	-	-	-	-	-	**(5,577)**
Revaluations	-	-	-	-	-	-	-	-	**-**
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 - brought forward	**-**	**-**	**-**	**-**	**19,775**	**-**	**5,168**	**211**	**25,154**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	5,577	-	-	2,475	-	866	15	**8,933**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	(5,577)	-	-	-	-	-	-	**(5,577)**
Revaluations	-	-	-	-	-	-	-	-	**-**
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**

Notes to the Accounts

Note 14.2 Property, plant and equipment - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	**17,341**	**211,236**	**1,339**	**-**	**29,496**	**-**	**6,800**	**294**	**266,506**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2015 - restated	**17,341**	**211,236**	**1,339**	**-**	**29,496**	**-**	**6,800**	**294**	**266,506**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	2,841	157	-	2,079	-	602	-	**5,679**
Impairments	-	(4,120)	-	-	-	-	-	-	**(4,120)**
Reversals of impairments	-	32,635	-	-	-	-	-	-	**32,635**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	2,253	-	-	-	-	-	-	**2,253**
Disposals / derecognition	(150)	(5,096)	-	-	(690)	-	(7)	-	**(5,943)**
Valuation/gross cost at 31 March 2016	**17,191**	**239,749**	**1,496**	**-**	**30,885**	**-**	**7,395**	**294**	**297,010**
Accumulated depreciation at 1 April 2015 - as previously stated	**-**	**-**	**-**	**-**	**18,099**	**-**	**4,317**	**189**	**22,605**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2015 - restated	**-**	**-**	**-**	**-**	**18,099**	**-**	**4,317**	**189**	**22,605**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,090	14	-	2,315	-	858	22	**8,299**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	150	6	(14)	-	-	-	-	-	**142**
Disposals / derecognition	(150)	(5,096)	-	-	(639)	-	(7)	-	**(5,892)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**19,775**	**-**	**5,168**	**211**	**25,154**
Net book value at 31 March 2016	**17,191**	**239,749**	**1,496**	**-**	**11,110**	**-**	**2,227**	**83**	**271,856**
Net book value at 1 April 2015	**17,341**	**211,236**	**1,339**	**-**	**11,397**	**-**	**2,483**	**105**	**243,901**

Note 14.3 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned	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**
Government granted	-	-	-	-	-	-	-	-	**-**
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 14.4 Property, plant and equipment financing - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016									
Owned	17,191	11,322	-	-	9,697	-	2,216	67	**40,493**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	227,167	-	-	-	-	-	-	**227,167**
PFI residual interests	-	-	1,496	-	-	-	-	-	**1,496**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	-	1,260	-	-	1,413	-	11	16	**2,700**
NBV total at 31 March 2016	**17,191**	**239,749**	**1,496**	**-**	**11,110**	**-**	**2,227**	**83**	**271,856**

Notes to the Accounts

Note 15 Donations of property, plant and equipment

The trust received donations during the year of £460k . (2015/16 £547k). No restrictions were placed on these donations of which £140k funded the purchase of capital assets.

Note 16 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 2017.

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.

The Trust approved a change in the method of valuation in year to remove VAT. This change was adopted as it reflects the commercial nature of the Private Finance Initiative. There were no other changes to the method of calculation adopted during the year. Details of the impact of this change have been reflected in note 6.

Notes to the Accounts

Note 18 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	1,178	1,243
Work In progress	-	-
Consumables	2,126	1,908
Energy	73	88
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**3,377**	**3,239**

Inventories recognised in expenses for the year were £25,554k (2015/16: £25,216k). Write-down of inventories recognised as expenses for the year were £0k (2015/16: £0k).

Notes to the Accounts

Note 19.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	17,738	7,137
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,398	1,509
Capital receivables	-	-
Provision for impaired receivables	(439)	(159)
Deposits and advances	-	-
Prepayments (non-PFI)	1,154	2,868
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	74	173
Interest receivable	-	1
VAT receivable	1,179	1,576
Other receivables	692	1,054
Total current trade and other receivables	**21,796**	**14,159**
Non-current		
Trade receivables due from NHS bodies	-	-
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,120	1,086
Capital receivables	-	-
Provision for impaired receivables	(590)	(500)
Deposits and advances	-	-
Prepayments (non-PFI)	63	66
Accrued income	-	-
Other receivables	-	-
Total non-current trade and other receivables	**593**	**652**

Notes to the Accounts

Note 19.2 Provision for impairment of receivables

	2016/17 £000	2015/16 £000
At 1 April as previously stated	**659**	**439**
Prior period adjustments	-	-
At 1 April - restated	**659**	**439**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	370	243
Amounts utilised	-	-
Unused amounts reversed	-	(23)
At 31 March	**1,029**	**659**

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 19.3 Analysis of financial assets

	31 March 2017		31 March 2016	
	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	28	-	30	-
30-60 Days	42	-	22	-
60-90 days	12	-	12	-
90- 180 days	80	-	95	-
Over 180 days	867	-	500	-
Total	**1,029**	**-**	**659**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,539	-	3,950	-
30-60 Days	583	-	1,133	-
60-90 days	195	-	1,114	-
90- 180 days	548	-	981	-
Over 180 days	1,502	-	2,175	-
Total	**5,367**	**-**	**9,353**	**-**

Note 20 Other assets

The Trust did not hold any other assets in either the current or previous periods.

Note 21 Other financial assets

The Trust did not hold any other financial assets in either the current or previous periods.

Note 22 Non-current assets for sale and assets in disposal groups

The Trust did not hold any non-current assets for sale and assets in disposal groups, in either the current or previous periods.

Notes to the Accounts

Note 23.1 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.

	2016/17 £000	2015/16 £000
At 1 April	**1,456**	**744**
Prior period adjustments	-	-
Net change in year	2,443	712
At 31 March	**3,899**	**1,456**
Broken down into:		
Cash at commercial banks and in hand	5	5
Cash with the Government Banking Service	3,894	1,451
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**3,899**	**1,456**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,899**	**1,456**

Note 23.2 Third party assets held by the NHS foundation 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 (2015/16 £1k). This has been excluded from the cash and cash equivalents figure reported in the accounts.

Notes to the Accounts

Note 24 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
Receipts in advance	63	-
NHS trade payables	6,545	6,925
Amounts due to other related parties	-	-
Other trade payables	8,645	6,251
Capital payables	2,813	1,870
Social security costs	1,900	1,492
VAT payable	-	-
Other taxes payable	1,527	1,489
Other payables	2,897	2,636
Accruals	7,945	9,829
PDC dividend payable	-	-
Total current trade and other payables	**32,335**	**30,492**
Non-current		
Receipts in advance	-	-
NHS trade payables	975	1,235
Amounts due to other related parties	-	332
Other trade payables	-	-
Total non-current trade and other payables	**975**	**1,567**

Note 25 Other financial liabilities

There were nil (2015/16 nil) current and non current liabilities as at 31 March.

Notes to the Accounts

Note 26 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	561	6,810
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	**561**	**6,810**

There were no non-curent Other liabilities

Note 27 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health	906	373
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	6,285	5,975
Total current borrowings	**7,191**	**6,348**
Non-current		
Loans from the Department of Health	131,028	65,328
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI, LIFT or other service concession contracts	321,317	327,602
Total non-current borrowings	**452,345**	**392,930**

Notes to the Accounts

Note 28.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other legal claims	Equal Pay (including Agenda for Change)	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	**377**	**124**	**525**	**66**	**1,092**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	**-**
Arising during the year	69	122	200	657	**1,048**
Utilised during the year	(48)	(135)	(11)	(5)	**(199)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	(17)	-	-	**(17)**
Unwinding of discount	-	-	-	-	**-**
At 31 March 2017	**398**	**94**	**714**	**718**	**1,924**
Expected timing of cash flows:					
- not later than one year;	48	94	714	205	**1,061**
- later than one year and not later than five years;	190	-	-	-	**190**
- later than five years.	160	-	-	513	**673**
Total	**398**	**94**	**714**	**718**	**1,924**

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 previously reclaimed lease car and Option to Tax VAT.

All cash flows reflect the expected or known date of payment .

Notes to the Accounts

Note 28.2 Clinical negligence liabilities

At 31 March 2017, £122,520k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2016: £106,322k).

Note 29 Contingent assets and liabilities

	31 March 2017	31 March 2016
	£000	£000
Value of contingent liabilities		
NHS Litigation Authority legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(79)	(79)
Gross value of contingent liabilities	**(79)**	**(79)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(79)**	**(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 30 Contractual capital commitments

	31 March 2017	31 March 2016
	£000	£000
Property, plant and equipment	2,693	353
Intangible assets	114	166
Total	**2,807**	**519**

Notes to the Accounts

Note 31 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.

As referenced in Note 1.6 the annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme applied to the opening lease liability for the period and is recognised in finance costs.

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.

Notes to the Accounts

Note 31.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2017 £000	31 March 2016 £000
Gross PFI, LIFT or other service concession liabilities	**603,219**	**626,485**
Of which liabilities are due		
- not later than one year;	23,266	23,266
- later than one year and not later than five years;	93,065	93,065
- later than five years.	486,888	510,154
Finance charges allocated to future periods	(275,617)	(292,908)
Net PFI, LIFT or other service concession arrangement obligation	**327,602**	**333,577**
- not later than one year;	6,285	5,975
- later than one year and not later than five years;	28,579	27,168
- later than five years.	292,738	300,434

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2017 £000	31 March 2016 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,784,366	1,935,409
Of which liabilities are due:		
- not later than one year;	47,907	46,538
- later than one year and not later than five years;	208,192	200,272
- later than five years.	1,528,267	1,688,599

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2016/17:

	31 March 2017 £000	31 March 2016 £000
Unitary payment payable to service concession operator	44,021	42,836
Consisting of:		
- Interest charge	17,211	17,541
- Repayment of finance lease liability	5,975	5,680
- Service element and other charges to operating expenditure	20,835	19,615
Total amount paid to service concession operator	**44,021**	**42,836**

Notes to the Accounts

Note 32 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 2017:

	2017	2016
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	115	106
arrangements:		
- not later than one year;	162	162
- later than one year and not later than five years;	704	704
- later than five years.	3,512	3,674
Total	**4,378**	**4,540**

Notes to the Accounts

Note 33 Financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	20,518	-	-	-	**20,518**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	-	-	-	-	**-**
Total at 31 March 2017	**20,518**	**-**	**-**	**-**	**20,518**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	12,181	-	-	-	**12,181**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	1,456	-	-	-	**1,456**
Total at 31 March 2016	**13,637**	**-**	**-**	**-**	**13,637**

Note 33.1 Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	131,934	-	**131,934**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	327,602	-	**327,602**
Trade and other payables excluding non financial liabilities	30,497	-	**30,497**
Other financial liabilities	-	-	**-**
Provisions under contract	1,924	-	**1,924**
Total at 31 March 2017	**491,957**	**-**	**491,957**

Notes to the Accounts

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	65,701	-	**65,701**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	333,577	-	**333,577**
Trade and other payables excluding non financial liabilities	27,553	-	**27,553**
Other financial liabilities	-	-	**-**
Provisions under contract	1,092	-	**1,092**
Total at 31 March 2016	**427,923**	**-**	**427,923**

Note 33.2 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 £000
In one year or less	32,416	28,580
In more than one year but not more than two years	23,314	23,315
In more than two years but not more than five years	224,283	158,609
In more than five years	211,944	23,315
Total	**491,957**	**233,819**

Note 33.3 Fair values of financial assets at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other receivables excluding non financial assets	593	593
Other investments	-	-
Other	-	-
Total	**593**	**593**

Note 33.4 Fair values of financial liabilities at 31 March 2017

	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	975	975
Provisions under contract	863	863
Loans	-	-
Other	-	-
Total	**1,838**	**1,838**

Notes to the Accounts

Note 34 Losses and special payments

	2016/17 Total number of cases Number	2016/17 Total value of cases £000	2015/16 Total number of cases Number	2015/16 Total value of cases £000
Losses				
Cash losses	27	6	4	1
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	359	13	222	4
Stores losses and damage to property	1	43	-	-
Total losses	**387**	**62**	**226**	**5**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	1	1	1	15
Special severence payments	-	-	-	-
Ex-gratia payments	26	6	26	7
Total special payments	**27**	**7**	**27**	**22**
Total losses and special payments	**414**	**69**	**253**	**27**
Compensation payments received				

Note 35 Prior period adjustments

No prior year adjustments have been made under IAS8 to the comparative information except for minor presentation changes due to alignment with the Government Accounting Manual. The primary movement relates to the impact of impairements which are now shown in expenditure in current and comparative figures.

Note 36 Events after the reporting date

There are no non-adjusting event after the reporting period which affect the finanical information and disclosures made in these accounts.

Notes to the Accounts

Note 37 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	119,331	549	2,950	1,261
Newark & Sherwood CCG	61,712	44	1,339	439
NHS ENGLAND	33,883	7	9,214	0
Hardwick CCG	14,929	0	581	40
HEALTH EDUCATION ENGLAND	11,662	112	83	17
Southern Derbyshire CCG	6,875	0	233	0
Nottingham North & East CCG	5,907	271	170	8
NHS PROPERTY SERVICES	4,563	3,652	474	64
Rushcliffe CCG	3,919	420	1	10
NOTTINGHAM UNIVERSITY HOSPS	3,540	13,712	439	4,928
NOTTINGHAMSHIRE COUNTY COUNCIL	2,470	190	299	0
Nottingham Health Care NHS Foundation Trust	2,055	1,677	353	253
Lincolnshire West CCG	2,542	0	325	0
Nottingham City CCG	3,312	176	2	121
Nottingham West CCG	1,829	137	160	33
NHS litigation Services	0	8,919	43	0
NHS Pensions Scheme	0	16,228	0	2,223
HM Revenue & Customs (Tax/NI)	0	13,178	0	3,427

The Department of Health as the parent department for all Foundation Trusts.

The Trust also has a relationship with Sherwood Forest Hospitals General Charitable Fund, where income

The Trust made payments of £11.9k and £9k to Unique Health and Concept HR Ltd in respect of placement fees for which respectively the Chief Executive and Director of Human Resources are named Directors.

Auditor's Statement – Consolidation Schedules

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INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated FTC1 to FTC38 excluding FTC8a and FTC8b of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2017, which have been prepared by the Chief Financial Officer and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

KPMG LLP

KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

30 May 2017

KPMG Independent Assurance Report

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Independent auditor's report

to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust only

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2017 set out on pages 1 to 44. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of the Trust's income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Financial statements as a whole	£4.3m (2015/16:£3.8m) 1.5% (2015/16: 1.5%) of total income from operations	
Risks of material misstatement		**vs 2015/16**
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS income	◀▶

2. Emphasis of matter – Going concern

In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosures made in Note 1 to the financial statements concerning the ability of the Trust to continue as a going concern.

The Trust has incurred a significant deficit at 31 March 2017 of £91.15 million including the impact of impairments. In addition, the Trust has agreed a planned budget deficit with NHS Improvement of £37.6 million for 2017/18. The plan includes a cost improvement programme of £14.5 million. The Trust will also require a significant injection of revenue and capital loan support of £43.6 million to fund its revenue and capital plans for 2017/18.

These matters, along with other matters, explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern.

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2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows:

The risk		Our response
Operating income (£295.4 million; 2015-16: £264.1 million) *Refer to page 8 of the financial statements (accounting policy) and pages 18 and 19 of the financial statements (financial disclosures).*	**Recognition of NHS and non-NHS income** Of the Trust's reported total income, £233.9 million (2015/16, £222.5 million) came from Clinical Commissioning Groups (CCG) and NHS England. Two CCGs make up 79% of the Trust's income from patient care activities. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income achievement. In 2016/17 the Trust has received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £10.1m of core transformation funding. The full year-end STF amount was £15 million, the difference representing £3.6 million incentive STF and £1.2 million bonus STF, following the Trust exceeding its agreed budget deficit as at 31 March 2017. An agreement of balances exercise is undertaken between NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. The Trust reported total other operating income of £57.5 million (2015/16: £37.6 million) from other activities, primarily education and training, research and development, or other activities. Much of this income is contracted from NHS and non-NHS bodies under contracts that indicate when income will be received; on delivery, milestones, or periodically. There is a greater risk that the income has not been recognised under the accruals basis, and instead on a cash basis. Some sources of income require independent confirmations which can impact the amount of the income the Group will actually receive.	Our procedures included: — **Agreement of balances:** We assessed the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £250,000 we obtained evidence to support the Trust's reported income figure; — **Contract agreement:** For the three largest commissioners of the Trust's activity we agreed that signed contracts were in place;. — **Contract variations:** We investigated a sample of contract variations for commissioners and sought explanations from management; — **Contract disputes:** We discussed with Trust staff and reviewed income variances resulting from the agreement of balances exercise and confirmed whether the Trust is in formal dispute or arbitration in relation to any material income balances and examined the supporting correspondence, including if appropriate any legal advice given, in relation to the expected outcome as recorded within the financial statements; — **Provision for impairment of receivables:** We confirmed the basis upon which any provisions for debt have been made, including the completeness and accuracy of the aged receivables analysis. We tested the assumptions taking into account both past performance and any circumstances specific to the year ended 31 March 2017; — **Completeness of income:** We have performed testing over a sample of income received before and after 31 March 2017 to support the completeness assertion over income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period; and — **Sustainability and Transformation Fund (STF) income:** We assessed the Trust's reporting and accounting for STF income received from the Department of Health and agreeing the amounts recognised to supporting documentation.

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2. Our assessment of risks of material misstatement (cont.)

	The risk	Our response
Property, plant and equipment (£226.3 million; 2015/16: £271.9 million) *Refer to page 10 of the financial statements (accounting policy) and pages 26 to 29 (financial disclosures).*	**Valuation of land and buildings** Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. Assets may also lose value if they are no longer able to derive as much future benefit from their use as anticipated. Valuation is completed by an external expert engaged by the Trust using construction indices and so accurate records of the current estate are required to inform the valuation. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. During 2016/17 a desktop valuation was completed.	Our procedures included: — **Review of valuation:** We assessed the Trust's valuation report and considered the revaluation basis used and its appropriateness (including the assumptions regarding the treatment of VAT); — **Assessment of external valuer:** We assessed the expertise of the valuer commissioned by the Trust to perform the revaluation exercise by ensuring that the valuer was appropriately qualified. We obtained the instructions provided to the valuer and assessed the independence and objectivity of the valuer and the terms under which they were engaged by management; — **Asset data used by the valuer:** We considered the information provided to, and used by the valuer, and undertook testing to ensure both its completeness and accuracy. We tested a sample of floor area measurements back to the Trust's property database, and agreed the listing of assets used by the valuer back to the Trust's Fixed Asset Register; — **Management adjustments;** We tested whether any amendments were made by management to the information received from the valuer before being incorporated into the financial statements by reconciling the valuation report to the financial statements; — **Impairment review:** We considered management's assessment of any need for an impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; and — **PFI disclosures**: We assessed the PFI related disclosures against the requirements of IFRIC 12, SIC 29 and the Group Accounting Manual 2016/17.

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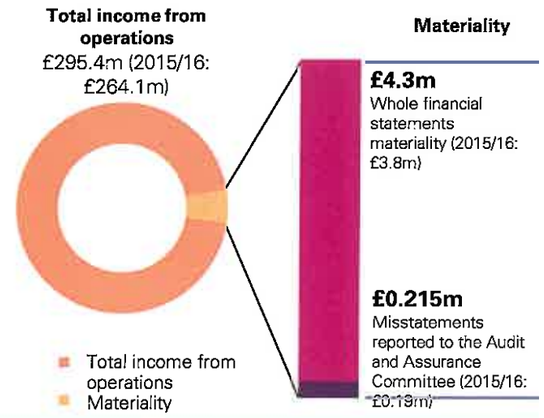
4. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £4.3 million (2015/16: £3.8 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1.5%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit and Assurance Committee any corrected and uncorrected identified misstatements exceeding £215,000 (2015/16: £190,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.



5. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

— the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and

— the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

6. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or

— the Audit Committee's commentary of the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

In addition we are required to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

7. Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report by exception if we are not satisfied that the Trust has put in place proper arrangements to secure value for money in its use of resources for the relevant period.

During 2016/17 the Trust was operating under a section 106 enforcement undertaking and an additional licence condition imposed under section 111. Specifically:

— Monitor imposed a Section 106 condition upon the Trust in April 2015 because of concerns over its financial governance and the sustainability of the long term financial plan, as well as the worsening financial position; and

— Monitor also imposed a Section 111 condition on the Trust in April 2015, requiring the Trust to ensure that it has in place sufficient and effective management and clinical leadership capacity and capability.

On 4 April 2017 NHS Improvement removed the Section 106 condition. The Trust continues to have in place a Section 111 enforcement undertaking.

As at 31 March 2017 the Trust has reported a £91.15 million deficit including the impact of impairments. The Trust required £61.27 million of revenue support borrowings in year.

With exception of the matters reported above, we are satisfied that in all other material respects the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017;

KPMG Independent Assurance Report

8. We have completed our audit

We certify that we have completed the audit of the accounts of Sherwood Forest Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities within the Annual Report the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, 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 on our risk assessment, we undertook such work as we considered necessary.

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This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body, for our audit work, for this report or for the opinions we have formed.

Andrew Bostock for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
15 Canada Square, Canary Wharf, London, E14 5GL

30 May 2017

Dedicated to Outstanding care