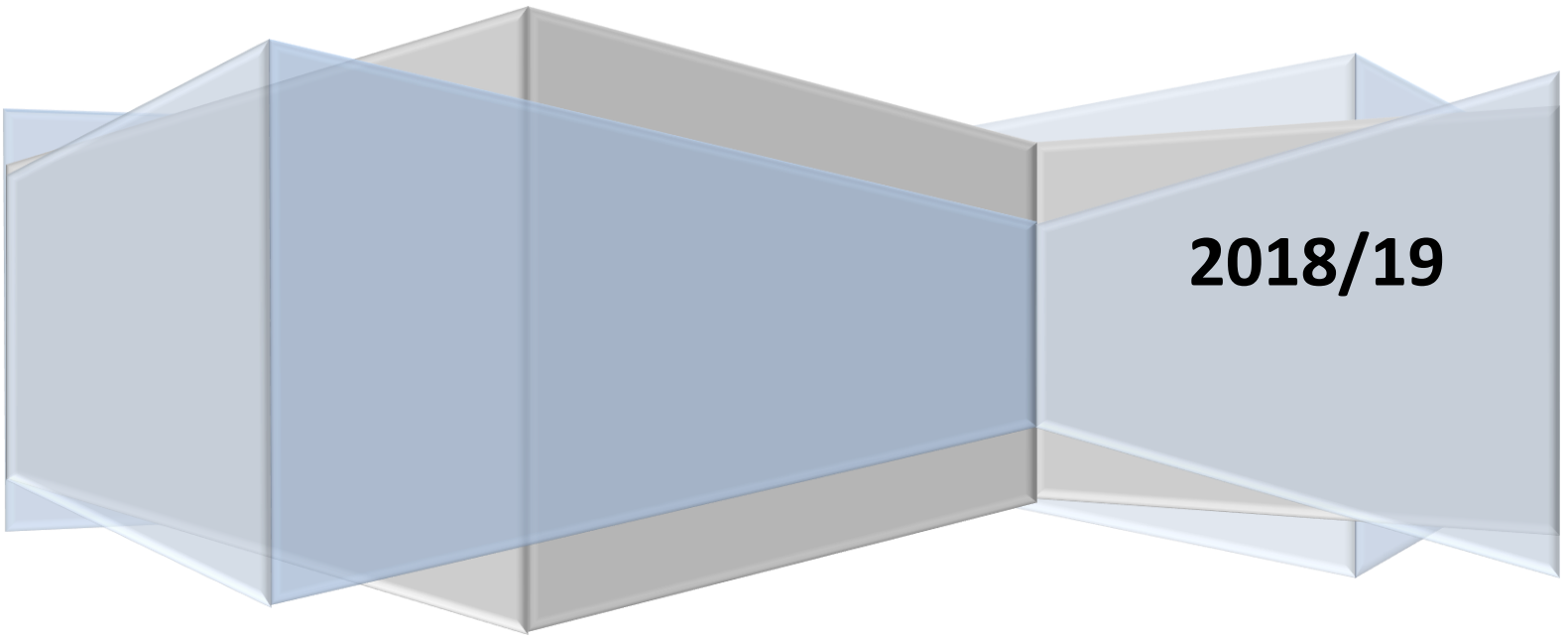
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2018/19

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule7, paragraph 25(4)(a) of the National Health Service Act 2006

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Performance Report

Statement from the Chair

The year 2018-19 was one of continued progress for Sherwood Forest Hospitals NHS Foundation Trust in terms of performance, strategy and leadership. I would like to thank all staff and volunteers across King's Mill, Newark and Mansfield Community Hospitals for contributing to a positive year.
Most significantly in terms of performance we were delighted that in August 2018, the CQC announced we were now rated as 'Good' overall, and 'Outstanding' for care in the most recent inspection of our services. The CQC also identified many teams and services they rated as outstanding. We have come a long way, and the progress is testament to a great deal of hard work, commitment and compassion.

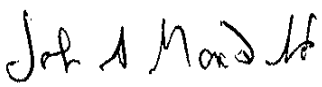
It is undeniable that like all parts of the NHS we continue to face significant challenges as an organisation, including volume of attendances, financial pressures and supporting the health and care needs of an increasingly elderly population. Colleagues have responded well to these challenges, but it is clear that as part of a system we cannot continue to keep doing things the way we always have.

With that in mind we have done a lot of work this year in helping to embed system-wide approaches to health and social care, sharing responsibility for the health and wellbeing of our communities and increasingly utilising the shared resource we have to deliver care. We continue to be committed to playing a leading role in the Nottingham and Nottinghamshire Integrated Care System.

The principles of system-wide care, and wellbeing of our communities has also informed a lot of the thinking that has gone into our new five-year Trust strategy which was launched in April 2019. Thank you to all of our partners and stakeholders that have contributed to this important piece of work.

We have seen two new Non-Executive Directors join the Trust this year, Barbara Brady, and Manjeet Gill. I am pleased we now have a fully substantive Board of Directors. In my role as Chair I would also like to thank the ongoing support from our dedicated team of Governors who continue to play an important role in engaging with and representing the voice of our communities. I would also like to recognise the immense contribution that our Community Involvement team and our 650 team of volunteers play in the day to day running of the Trust.

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



John MacDonald,
Chair

Statement from the Chief Executive

I believe 2018-19 has been in most respects an excellent year at Sherwood Forest Hospitals NHS Foundation Trust (SFHFT). We are in a better position today than we were in 12 months ago and we recognise we can improve further. I am confident our next 12 months will be better still, in particular as we work even more closely with health and local authority partners across Mid Nottinghamshire and beyond.

I have listed below some of the achievements I feel proudest about and the detail within this annual report is further evidence of the many positive improvements we have delivered over the last year. None of this would be possible without the fantastic colleagues I am lucky to work with. I feel very fortunate to have so many remarkable colleagues at Newark Hospital, Mansfield Community Hospital and King's Mill Hospital and I firmly believe that everything that has been achieved is because of the team we have here. This is not just the paid colleagues at SFHFT but also the 650 volunteers, the governors and the colleagues who work in our many partner organisations from primary care to local authority.

Some of our achievements from the last 12 months I feel proudest about are:

Safety, quality and patient experience

- We delivered an overall reduction in harm events compared to the previous year
- The Care Quality Commission assessed us as Good Overall and Outstanding for Caring in our 2018 visit
- All ten services visited by the CQC were assessed as Good Overall
- Urgent and Emergency Care and Outpatients assessed as Outstanding for Well Led
- Maternity and Medicine (Mansfield Community Hospital) assessed as Outstanding for Caring.

Staff engagement

- We were the top acute Trust in the Midlands for overall engagement and the 11th best in England (out of 89 acute Trusts nationally)
- Top acute Trust in the Midlands and joint 8th best in England as a place to work and receive treatment
- Top acute Trust in the Midlands and joint 6th best in England for staff satisfied with their quality of work and care they provide
- Our response rate was 6th best acute Trust in England
- More substantive doctors and nurses working than ever before.

Access

- 94.2% patients on the emergency care pathway were treated within four hours
- Improvements in all cancer, elective and diagnostics standards compared to previous year
- No patients waiting 52 weeks for elective treatment on 31 March 2019.

Finance

- We delivered our year end control total for the third successive year
- We delivered all elements of the Provider Sustainability Funding (PSF) that were linked to our financial and emergency care performance.

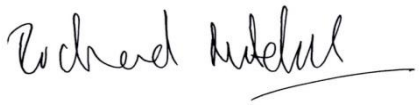
Other

- Our NHSI "Single Oversight Framework" segmentation improved from a three to a two indicating acknowledgement of overall improvement
- 2093 patients were recruited onto research trials - 22% more than the previous 12 months

- We strengthened our relationship with health and local authority partners within our Integrated Care Provider and Integrated Care System
- We are "buddying" with The Queen Elizabeth Hospital King's Lynn NHS FT to provide support
- We launched our new strategy "Healthier Communities, Outstanding Care".

Whilst this is all very positive I do recognise we are far from perfect. I continue to personally experience a range of emotions as the Chief Executive. I feel proud and honoured to be the Chief Executive and I am pleased we are beginning to make small improvements with our culture. Well supported staff deliver safe care. Like last year, as well as feeling lots of pride, I continue to worry. I worry and do not feel good about the pressure colleagues have been under and I do not feel good about the length of time some patients have waited for their treatment or admission. I am aware of the impact this has on their lives and whilst this winter has been better, I would like to take this opportunity to recognise we have more work to do, with colleagues, to improve our hospitals.

Thank you again to all colleagues be them paid or voluntary, and to all of our partner organisations who have made a contribution in the last 12 months. I look forward to continuing to work with you this year.



Richard Mitchell
Chief Executive

Overview of Performance

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

Our History and Structure

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

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

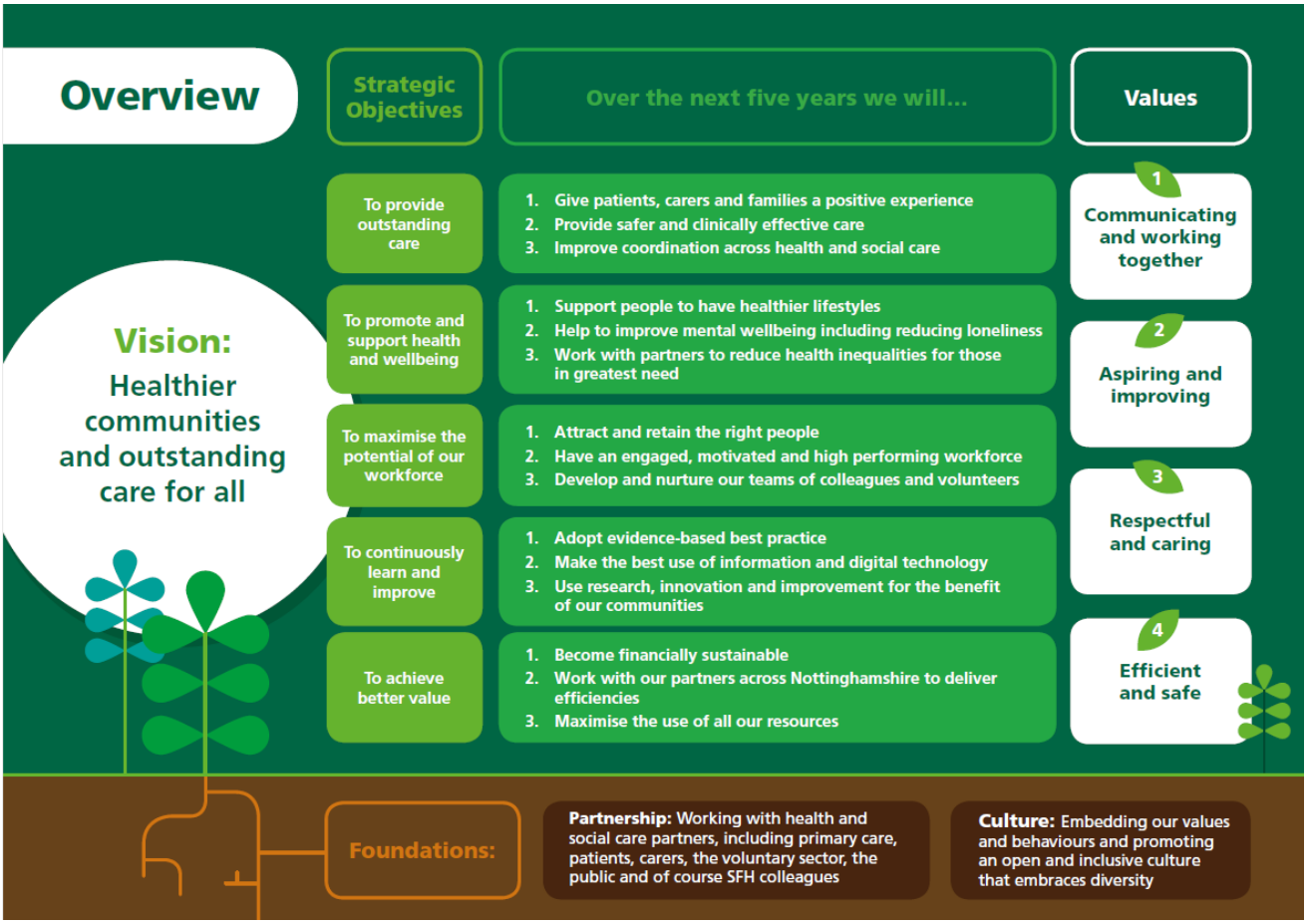
During the past year we have continued to make significant improvements in our journey towards becoming a provider of outstanding care. We are proud the CQC has rated us as 'Good' overall and 'Outstanding' for the care we provide and we are confident we can improve further. Our staff survey results demonstrate that we have one of the most engaged NHS teams in England, whilst our performance against NHS constitutional standards has been relatively strong.

Our purpose and activities

During the past year, we have carried out one of our largest ever engagement exercises, as we have revised our organisation's vision and strategy. In the past we have focussed on providing healthcare from hospitals, but we recognise we have an opportunity and a responsibility to support our local population to become healthier. This is why over the next five years we will play a key role in supporting healthier communities and outstanding care for all.

This is not something we can achieve on our own. It will be a partnership involving everyone in our community including those who work and volunteer in health and social care across the Nottinghamshire system, those who use our services and those who may need our services in the future. Together with partners we will focus on prevention and ensuring people receive the right support in their home, in the community and in hospital.

Our vision and strategy can be summarised as follows:



Our five year strategy is shaped in the context of the NHS's ten year plan[1]. The challenges and priorities set out in the national plan are relevant to us, and yet the setting that we work in is distinct. Nottinghamshire has been chosen as one of the first areas in the country to develop what is known as an Integrated Care System (ICS). An ICS is a way to bring our local NHS, councils and the voluntary sector together to combine healthcare and other services to look after people within their homes, communities and hospitals. As an ICS we have more freedom to manage local services including deciding how we spend money on health and care.

Within the Nottinghamshire ICS, there are multiple Integrated Care Providers (ICPs), one of which covers mid-Nottinghamshire. ICPs allow providers of care to come together to plan and deliver services for a defined population, based on local needs. Working in this way enables care to be designed and coordinated to meet patients' needs, ensuring that organisational priorities are not in conflict with one another.

The mid-Nottinghamshire ICP (which covers Mansfield, Ashfield, Newark and Sherwood) consists of six Primary Care Networks (PCNs). These networks allow GP practices to come together, working with community providers, mental health services, pharmacies, social care and voluntary services. This enables PCNs to have larger and broader teams of staff, stay open for longer, provide better access to specialist services and proactively care for the population they serve. We will work closely with the six PCNs in our area, to ensure we are collectively meeting the needs of our local communities, sharing information across primary and secondary care and providing the best possible care, in the home, community and hospital.

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 450,620 outpatient

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

appointments, more than 105,629 people attended our Emergency Department at King's Mill Hospital 25,434 patients were seen and treated at the Urgent Care Centre at Newark Hospital, and we delivered around 3,241 babies.

Risks to delivery of objectives

Our vision, values and strategic objectives express our ambition to see healthier communities and outstanding care for all. We are committed to the NHS Constitution and the nationally mandated standards described within. Nevertheless, as with other Trusts across the country, we have continued to experience increasing pressures over the last year and whilst our performance compares favourably with other Trusts, our ability to meet the constitutional standards has been compromised in some areas (see Performance Report for further information). We continue to endeavour to return to meeting the standards in the coming year, but the combination of demand and constrained resources present a risk to this objective.

Working in partnership as part of ICS, ICP and with PCNs is a fundamental mitigation to this risk, as is our continued focus on improving our internal working processes and practices to ensure patients receive high quality care in a timely manner.

Further detail with regard to our risk management approach is included in the Annual Governance Statement, later in this report.

How we are using our FT status to develop services and improve patient care

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

We develop our services and improve patient care based on evidence. We proactively seek and use feedback from patients and staff, as well analysing data that benchmarks the performance of our services against other Trusts'. It is vital that our culture engenders a desire to improve and innovate. That is why we will be continuing to train colleagues in the 'Sherwood Six Step' approach to improvement. This supports them to take a systematic approach to improvement, empowering colleagues to turn good ideas into sustainable reality.

End of Life:

In October 2018, a new End of Life service was launched collaboratively between local providers, underpinned by a 'shadow' capitated budget. The service provides a single pathway, supporting patients and carers both before and during times of crisis and enabling patients to leave hospital to their planned place of care. In addition to the patient benefits of this personalised care, the model supports the avoidance of unnecessary ED attendances and hospital admissions.

Home First Integrated Discharge:

This project is a priority for partners across mid-Nottinghamshire. It is underpinned by the principle that where possible, patients should be discharged home, with support from community and social care providers. This will ensure that only those patients requiring bedded rehabilitation are transferred to Mansfield Community and Newark Hospitals. The model aims to reduce length of stay for these patients and ensure that patients do not remain in hospital if they can be supported in their usual place of residence.

Going concern

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

In adopting the going concern basis for preparation of the financial statements, the Directors have considered the organisation's business activities as well as the principal risks and uncertainties. Although access to cash support has not yet been finalised, we have agreed to the deficit control total set by NHS Improvement. On this basis, the Board is satisfied that the organisation will be able to operate within the level of its facilities for the foreseeable future. Therefore after making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts, however a material uncertainty exists which may cast significant doubt about the Trust's ability to continue as a going concern. More detail has been provided within Note 1 of the accounts.

Performance Analysis

Throughout 2018/19 we have seen consistent performance against the majority of the operational access standards.

Referral to Treatment

The NHS Constitution sets out that (as a minimum) 92% of our patients should wait no longer than 18 weeks from GP referral to treatment (RTT). Our performance in 2018/19 has remained relatively stable; this has been delivered in part by better planning for elective activity over the winter period. In December 2018, we completed an exercise to understand the demand for a first outpatient appointment versus the capacity in place. Over the coming months we will build on this work in collaboration with commissioner and system partners to ensure that patients are appropriately referred into the right-setting first time and are optimised and receive treatment in a timely manner.

Referral to Treatment	2017/18	2018/19
Q1	92.84%	89.73%
Q2	92.20%	90.58%
Q3	91.25%	90.49%
Q4	89.71%	90.01%

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 of referral. We have performed well throughout 2018/19 balancing the demands of routine diagnostic referrals with urgent and cancer activity.

DM01	2017/18	2018/19
Q1	99.32%	98.94%
Q2	98.77%	99.24%
Q3	99.45%	99.23%
Q4	98.12%	98.99%

Cancer standards

Cancer Waiting Times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. There are seven operational standards; our performance against each target is shown in the table below. We know it is better for the vast majority of patients to be seen, diagnosed and treated for cancer as soon as possible. We remain focussed on actions to support earlier diagnosis and are working closely with tertiary providers and system partners to systematically deliver national optimal pathways and improve outcomes for our patients.

	Target	2017/18	2018/19
2 week wait all cancers	93%	96.10%	96.10%
2 week wait breast symptomatic	93%	97.20%	95.10%
31 day wait from diagnosis to 1st treatment	96%	98.60%	98.10%
31 day wait for subsequent treatment - surgery	94%	90.90%	93.30%
31 day wait for subsequent treatment - drugs	98%	100%	95.60%
62 day wait urgent referral to treatment	85%	84.10%	81.40%
62 day wait for first treatment from screening	90%	84.90%	92.50%

Stroke

The Sentinel Stroke National Audit Programme (SSNAP) is a tool used to capture and measure different parts of a patient's journey, from the moment they arrive in the Emergency Department and their admission to the stroke unit, through to rehabilitation and discharge. It consists of 10 domains, such as scanning and thrombolysis, and measures the time taken to undertake a scan and, if applicable, perform thrombolysis from the moment the patient arrives at hospital. It also considers the amount of input provided by a Multi-Disciplinary Team (MDT) which has 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 as well as the discharge and the service improvement processes. Each domain is closely monitored by our stroke team so that areas of the pathway needing further attention can be addressed, and to maintain areas of good practice. We consistently perform well in this audit programme and are now one of the best in the country and top in the East Midlands for recognising and treating patients who have had a stroke.

	Sentinel Stroke National Audit Programme
August – November 2016	A
December 2016 – March 2017	A
April – July 2017	A
August – November 2017	A
April 2018-June2018	A
July 2018 – Sep 2018	A
Oct 2018 – Dec 2018	A

Urgent and Emergency Care

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

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

We formally monitor performance in this area to evaluate it on a daily, weekly and monthly basis through robust and audited reporting mechanisms. This approach allows performance against all clinical indicators to be evaluated and assessed by our clinical and operational teams, as well as by various groups such as the Divisional Performance Reviews, through to the Executive team, to the Trust Board.

As well as the emergency departments being effective, the delivery of effective and timely emergency care involves the whole hospital from the wards, diagnostic services such as imaging and pathology, through to the community hospitals and the porters. Everyone plays a role and most critical all our staff work together to form one team supporting emergency care.

This is also the case with our partners, mainly Nottinghamshire Healthcare NHS Trust and Nottinghamshire Social Services, along with colleagues within the voluntary sector. Without working in partnership and their support we would not be able to provide effective emergency care. This is all held together by the Mid-Nottinghamshire A&E Delivery Board.

Emergency Department (ED) 4-hour performance

We achieved this standard in both the first and second quarters of 2018/19 and continue to perform well nationally. Great focus is placed on achieving this standard as timely emergency access is a positive marker of quality and patient experience.

ED 4-Hour Performance	2017/18	2018/19
Q1	96.04%	95.14%
Q2	94.19%	95.92%
Q3	90.70%	94.14%
Q4	88.28%	91.75%
Total for year	**92.33%**	**94.23%**

Accident and emergency attendances

2018/19 saw an increase in A&E attendances overall of 5.5%.

Number of Accident & Emergency Attendances (Primary Care 24, KMH Emergency Department and Urgent Care Centre, Newark Hospital)	2016/17	2018/19	Increase
Q1	38,234	39,417	3.1%
Q2	37,572	39,889	6.2%
Q3	38,131	39,472	3.5%
Q4	36,824	40,320	9.5%
Total for year	**150,761**	**159,098**	**5.5%**

Ambulance arrivals

The number of patients arriving via ambulance has increased by 4.3% on the previous year. We measure handover performance, which is the time taken from the moment the ambulance crew arrives, to the safe handing over of the patient to the team in the Emergency Department.

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

Number of ambulances bringing patients to hospital in an emergency	2017/18	2018/19	Increase /Decrease
Q1	8083	8,532	5.6%
Q2	8265	8,423	1.9%
Q3	8825	9,164	3.8%
Q4	8860	9,376	5.8%
Total for year	**34,033**	**35,495**	**4.3%**

Emergency admissions from the Emergency Department

Emergency admissions from ED have increased by 12.8% this year; this has mainly been for admission to medical specialties.
There has been a significant amount of work in the past year with both the medical teams in the ED and community partners to ensure there are alternatives to hospital care for patients and also that patient who are safe to do so receive their treatment same day in the Ambulatory Emergency Care Unit rather than needing to be admitted to a bed.

Emergency Admissions from the Emergency Department	2017/18	2018/19	Increase
Q1	7,350	8,035	9.3%
Q2	7,537	8,148	8.1%
Q3	7,727	8,869	14.8%
Q4	7,766	9,205	18.5%
Total for year	**30,380**	**34,257**	**12.8%**

Financial Analysis

We are reporting a deficit in the year of £12.7m our regulators, NHS Improvement, issued us with a control total for 2018/19 of a maximum deficit of (£46.4m) excluding Provider Sustainability Funding (PSF). After adjusting the deficit for a reversal of an impairment of £14.2m, which reflects the revaluation of our assets to the current market value and other items not included in the control total of £0.5m, our deficit on a control total basis excluding PSF is (£46.3m), £0.1m better than required.

During the year we received £11.3m of Provider Sustainability Funding, which was our allocation of national funds made available to support the delivery of financial plans and performance targets relating to emergency care. Available initially was a maximum of £12.4m, the balance of £1.1m which has not been achieved related to the Integrated Care System delivering its control total, which has not been achieved in quarters 2 to 4 of 2018/19. In addition to the £11.3m noted above a further £7.6m was awarded to us from the National Incentive funds 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 Financial Improvement Plans (FIPs) / Cost Improvement Programmes (CIPs) delivered £16.5m of savings in 2018/19. Among the key improvements realised include: clinical productivity gains, medical and nurse agency cost reductions, corporate services cost reductions, and PFI maintenance savings. 2019/20 plans are in place to continuously improve on our 2018/19 success and deliver further savings. Delivery will be underpinned by the same robust governance process seen in 2018/19.

NHS Improvement has set our 2019/20 control total to be a maximum deficit of £14.9m, including Provider Sustainability and Financial Recovery Fund allocations. We are confident that we can achieve this, building on the success of our savings programmes this year in conjunction with the improvements we have made to our financial governance and cost control. Key to success is increased system wide engagement with operating plans fully aligned between providers and commissioners.

Income and expenditure

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

Operating income

Total operating income for the year was £318.6m which represented a increase of 4.6% from the previous year (£304.7m). Income received from patient care activities was £262.4m (£249.7m in 2017/18). Non-clinical income received contributes directly to the provision of healthcare services as well as our operating costs.

Income Disclosures

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

Operating expenses

Our total operating expenses (excluding impairments) rose during the year to £328.4m from £313.4m in 2017/18, an increase of 4.7%. Employee costs rose by £10.4m driven by the recruitment to vacant posts and national pay awards, offset by a fall in agency spend. Notable increases in Drugs and Clinical Supplies resulted from the growing number of patients seen and treated.

More than half of our operating expenses - £206.0m (63%) - were spent on employee costs. A total of £50.8m (15%) of our expenditure (excluding impairments) paid for prescription drugs, clinical supplies and services. The majority of the remaining £71.4m (22%) was spent on items relating to the PFI and mandatory contributions to the Clinical Negligence Scheme for Trusts.

Fixed assets

During 2018/19 we invested £10.8m in our fixed asset infrastructure, which compares with £9.8m the previous year. This comprised £4.1m invested in buildings and the estate, £3.2m in equipment, and £3.5m in IT infrastructure. No borrowing was required in year to support the delivery of planned expenditure.

Charitable funds

We recognised £0.5m (£0.2m in 2017/18) 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 £0.2m (£0.4m in 2017/18) to enhance the welfare of patients and staff, and support our activities. Included in these figures are the generous donations received from the local community, voluntary services and local charity partners including; Leagues of Friends, for Mansfield and Sutton, and Newark.

Projects supported Include:

- Enhancements to Sconce ward include an end of life suite to offer support for patients and carers. The ward has been enriched to make the environment dementia friendly.
- Trauma and Orthopaedic ward development offering enhanced facilities for patients receiving care requiring.

PFI

As a result of the adoption of International Financial Reporting Standards (IFRS) in 2009/10, the PFI scheme is included within our Statement of Financial Performance (SOFP). This continues to have a significant adverse impact on the SOFP, because the associated value of the building is low in comparison to the remaining debt outstanding. Borrowings on the SOFP associated with PFI have reduced to £259.6m (£269.2m in 2017/18). Overall, the scale of the PFI liability, along with the increasing income and expenditure deficit reserve, is the reason that the total taxpayers' equity amounts to a negative £181.0m. Payments of £46.2m were made in year relating to the PFI, of which £35.3m (2017/18 £33.1m) was recognised in the Statement of Comprehensive Income (SOCI).

Cash, liquidity and financial support

Our planned deficit for the year meant that we required cash borrowings from the Department of Health to meet our planned expenses. To support the income and expenditure position a number of borrowings, supported by revenue term loans of £36.3m, were agreed and drawn. Interest payments of £2.9m were accounted for on this and previous borrowing. Repayments of £1.7m were made relating to existing capital borrowing, no capital borrowing was required in year.

Principal risks and uncertainties

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

Financial risks

We plan to achieve NHS Improvement's control total of £14.9m in 2019/20. However, we face a number of risks in doing so, as follows:

- Our CIP target is £12.8m, which represents a total of 3.9% 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.
- A key part of our Strategy is to build on the work during 2018/19 to make sure we are working with partners to make decisions across mid-Nottinghamshire (Ashfield, Mansfield, Newark and Sherwood) that are the best for our patients and community rather than what is best for individual organisations. In keeping with strategic objective five 'To achieve better value' we have pledged to maximise the use of resources. One of the key ways we will do this in 2019/20 is by having a shared NHS budget which means ourselves and our commissioners will agree contracts and changes together as far as we possibly can. For 2019/20 we have a jointly agreed contract with our commissioners that will help us redesign and improve our outpatients and be paid fairly for the amount of emergency work we do while working through the Transformation Board to jointly agree any further changes and mitigate demand.
- Our plan includes the receipt of £21.3m from the Provider Sustainability Fund and Financial Recovery Fund, which is dependent on delivery of the agreed year to date financial performance compared to plan.

Sustainability Report

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve.

'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. 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).

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

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 SFH colleagues and local people in this mission we have taken part in a number of awareness campaigns to promote the benefits of sustainability; for example, we worked with our PFI partners, Skanska, to undertake a sustainability day at a local school which focused on the importance of local wildlife.

The challenges of climate change

Climate change poses new challenges for our organisation, both with respect to our estate as well as to patient health. Examples in recent years include the impact resulting from heat waves, extreme temperatures and prolonged periods of cold, floods and drought, with the frequency of such events being expected to increase. Our lead for emergency planning and business continuity continues to amalgamate data in relation to this whilst still working 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.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT) tool.

Our organisation is starting to contribute to the following Sustainable Development Goals (SDGs).

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our colleagues.

Policies

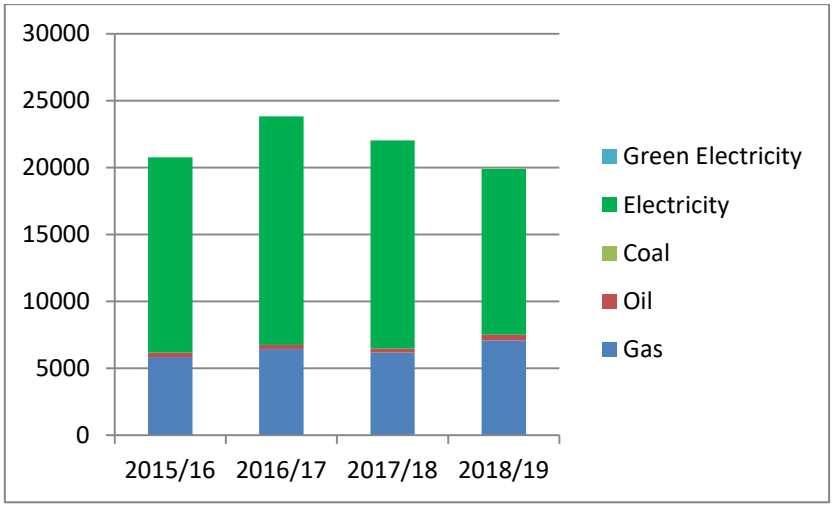
The following table shows the areas that are relevant to our work and confirms that sustainability is considered within each related policy:

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

Energy and carbon emissions

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

Since 2014 we have continued to reduce our overall energy emissions (expressed as tCO2e in the table below), which represents creditable progress towards the 2020 target. Our estimated total carbon footprint for 2018/19 is 16,963 tonnes of equivalent carbon emissions, which is 27% lower than the baseline year of 2013/14.



Our total spend on energy over the past year amounted to £4.2m, an 18% increase when compared with the previous year. This has been affected by market forces which generate an increase in commodity prices as well as direct cost increases.

Resource		2015/16	2016/17	2017/18	2018/19
Electricity	Use (kWh)	26,025,353	27,561,330	27,046,136	23,926,561
	tCO2e	14,572	17,070	15,549	12,365
Gas	Use (kWh)	36,734,891	34,388,341	40,858,141	35,272,798
	tCO2e	5842	6449	6169	7082
Oil	Use (kWh)	1,074,155	968,428	960,488	1,388,285
	tCO2e	343	307	314	442
Green Electricity	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Total Energy CO2e		20757	23826	22032	19889
Total Energy Spend		£3,789,474.00	£3,149,924.00	£3,597,936.00	£4,263,273.00

These calculations are derived from a sustainability reporting portal 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 https://www.sduhealth.org.uk/delivery/measure/reporting.aspx

To note, we do not currently report on green electricity: this is an avenue we are exploring for future innovations.
Although our carbon emissions are reducing our actual spend on energy is increasing due to a number of factors, including distribution and transmission costs from the utility providers and market fluctuations.
Usage whilst decreasing, has been impacted through additional outpatient activity resulting in clinics running outside of the original based energy consumption; showing an increase of 4.5% against the previous year's patient figures.

We are in the process of feasibility planning for a combined heat and power plant (CHP) as a source of energy on our King's Mill site. Combined heat and power (CHP) is a highly efficient process which captures and utilises the heat that is a by-product of the electricity generation process. By generating heat and power simultaneously, CHP can reduce carbon emissions by up to 30% compared to the separate means of conventional generation via a boiler and power station.

Improvements are also planned to the geothermal system within the King's Mill reservoir to increase its efficiency. This system offers an environmentally efficient means of providing heating and cooling to King's Mill Hospital. We continue to devise and implement initiatives targeted at reducing energy related emissions across our hospital estate.

Travel

We can improve local air quality and so improve the health and wellbeing of our local community by promoting 'active travel' to our SFH Colleagues 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.

We have been fortunate as an organisation to employ higher numbers of staff this financial year; however this has had a negative impact on the carbon footprint as the number of commutes increases, with 80% of staff using cars to travel to work.

Category	Mode	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Staff commute	miles	3,121,633	3,266,100	3,266,100	3,621,528	3,794,439	3,948,749
	tCO_2e	1,153.36	1,200.06	1,181.14	1,308.86	1,352.05	1,407.03

We have installed electric vehicle charging points at the King's Mill Hospital site to reduce our environmental impact even further. One is for use by our PFI service provider Skanska, who have invested in an electric van for use across our hospital sites, another is situated in the main visitor's car park and two have been fitted in a staff car park at rear of site. We are considering fitting additional charging points.
We are also considering an increase in bicycle storage and potential update to changing facilities to encourage colleagues to travel through other modes of transport as part of the active travel theme.

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. This year we have continued to review our waste streams with recycling amounts continuing to grow and reducing the amount of waste requiring high temperature disposal. We have implemented a proactive approach to auditing hazardous waste and have introduced an effective behavioural change programme, which includes training and raising awareness across the organisation to ensure colleagues and hospital users are disposing of waste in the most appropriate way.

We continue to review opportunities to dispose of waste effectively, with our significant programme of recycling seeing cardboard packaging separated at source and compacted on-site. The waste stream for metal has generated an income to us, whilst being reused and not sent to landfill. Other initiatives have been brought online, which has given benefit to two charities providing support to Syrian hospitals through unwanted items which would have seen disposal through our waste streams being redirected.

Waste recycled		**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recycling	(tonnes)	140.00	149.56	321.16	323.00	336.00	368.15
	tCO_2e	2.94	3.14	6.42	6.78	7.31	7.503

Our waste management programme has delivered a significant reduction in carbon emissions year on year since 2015. Further reviews are being undertaken in relation to recycling other items used, such as disposable curtains and theatre wrap, and additional education being provided specifically relating to confidential waste and recycling in liaison with our Information Governance Team.

The continual work on the back of this resulted in a joint entry with our estates partners winning the Sustainable Health and Care Awards, Waste and Resource Award, November 2018 for the work undertaken within that previous 12 month period.

Finite resource use – Water

Water		**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Mains	m^3	129,275	145,608	137,442	155,423	150,537	155,340
	tCO_2e	118	133	125	141	137	141
Water and Sewage Spend		£334,597	£290,419	£312,508	£333,805	£246,285	£246,835

Following water consumption rising significantly in 2016/17 we have noted consistent consumption since that point. Overall, we have seen an increase in emissions since the 2013/14 base year. The main likely cause of this is due to the legionella minimisation programme, which requires additional flushing to keep water flowing and temperatures maintained. Work is being undertaken to review the current estate in relation to this, particularly around areas of reduced use and their removal.

We will continue to work with Advanced Demand Side Management (ADSM) and our estates providers to review additional sub-metering across sites, which will allow for in depth analysis of water usage by area as a means of introducing further innovations for water use reduction.

Social, Community, Anti-Bribery and Human Rights

We are fully committed to the principle of equality, inclusivity and diversity for all colleagues, patients and carers. We oppose all forms of unlawful or unfair discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, political affiliation, trade union membership and social and employment status.

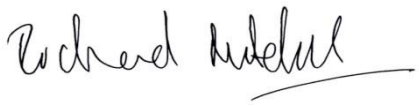
We accept that such an environment requires individual differences and cultural diversity to be recognised and valued. Promoting equality, embracing diversity and ensuring full inclusion for people who use our services or work at our sites is central to our vision and values. Our approach is to have an inclusive approach to supporting aspects of social, community, anti-bribery and human rights underpinned by our Equality approach. The effectiveness of policy documents are reviewed regularly ensuring feedback is obtained from users to inform future policy decisions.

Equality of opportunity, tackling discrimination and ensuring equality and diversity at the centre of our organisational culture is integral to delivery of our core values and corporate aims, and to ensuring the delivery of healthcare services which specifically meet the needs of our users. We will continue to develop and harness the skills of our diverse workforce to ensure that we are reflective of the communities we provide services for.

We have an Equality Strategy, which is our public commitment to equalities and human rights and provides a framework and objectives to demonstrate how we will meet the duties placed upon us by The Equality Act 2010 and how we can best ensure that we are meeting the needs of our community and staff at all levels.

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

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



Richard Mitchell
Chief Executive

Accountability Report

Directors' Report

Board of Directors

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

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

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

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

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

The Chair declared on appointment a significant commitment as Chair of University Hospitals North Midlands; this appointment ended in August 2017. The Chair was also the Independent Chair of the Better Together Board for Mid-Nottinghamshire until 30th April 2019. The Chair has no other significant commitments.

Attendance at Board meetings

	Public		Private	
Name	Actual	Possible	Actual	Possible
John MacDonald	11	12	12	13
Richard Mitchell	10	12	10	13
Suzanne Banks	11	12	12	13
Paul Robinson	10	12	11	13
Dr Andrew Haynes	10	12	11	13
Peter Wozencroft	12	12	11	13
Paul Moore	3	3	4	4
Simon Barton	9	12	9	13
Shirley A Higginbotham	10	12	10	13
Julie Bacon	12	12	13	12
Kerry Beadling-Barron	11	12	11	13
Tim Reddish	12	12	13	13
Neal Gossage	12	12	12	13
Claire Ward	10	12	11	13
Graham Ward	12	12	13	13
Barbara Brady	10	12	11	13
Manjeet Gill	4	5	4	5

Register of Interests

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

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

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

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2019.

Well-Led Framework

NHS Improvement's well –led framework was introduced in June 2017. In response in 2017/18 we undertook a self-assessment against each of the Key Lines of Enquiry (KLOE).

In December 2018, we commissioned KPMG to undertake an external Well-Led Review of the organisation
The organisation was assessed against each of the eight questions identified in NHSI Well-led framework. Each question was rated using the four point scoring methodology:

Well-Led Framework Scoring Methodology		
Rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber/Green	Partially meets expectations but confident in management's capacity to deliver green performance within a reasonable time frame.	Some elements of good practice, has no major omissions and robust action plans to address perceived short falls with proven track record of delivery.
Amber/Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable time frame.	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in an early stage of development with limited evidence of track record delivery.
Red	Does not meet expectations	Major omissions in quality governance identified. Significant volume of action plans required and concerns on management capacity to deliver

KPMG's assessment of performance against the eight key lines of enquiry is detailed in the table below:

NHSI Well-Led Framework		
	Question	KPMG Rating
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	Green
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	Amber/Green
3	Is there a culture of high quality sustainable care?	Amber /Green
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Amber/Green
5	Are there clear and effective processes for managing risks, issues and performance?	Green
6	Is appropriate and accurate information being effectively processed, challenged and acted on?	Amber/Green
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	Amber/Green
8	Are there robust systems and processes for learning continuous improvement and innovation?	Amber/Green

The Board has reviewed the report and developed actions with regard to the recommendations made.
Objectives have been defined and actions agreed, some of which have been implemented during the year, for example enhanced Speaking Up arrangements and the development and launch of our strategy.

The full report is available on our website, see link below

https://www.sfh-tr.nhs.uk/media/5207/sherwood-forest-hospitals-nhs-ft-final-report-141218.pdf

The Care Quality Commission inspected us during the year and assessed our overall Trust Well-Led score as Good, an increase from Requires Improvement in our previous inspection in 2016.

Patient Care

Our journey to outstanding is the driving force behind our approach to the culture of continuous improvement now well-embedded throughout the organisation. This is supported by our values of: *communicating and working together*; *aspiring and improving*; *respectful and caring* and *efficient and safe*.

We have robust systems and processes in place to enable colleagues to celebrate where we provide excellent, safe, high quality care but also quickly identify areas of focus for further improvement.

Building on the previous quality improvement programmes we agreed our Quality Strategy for 2018/21 as the vehicle for progressing improvement work, monitoring improvement initiatives and providing evidence of achievement to our patients and staff.

Quality Strategy 2018/21 Summary

Following the success of the Quality Improvement Plan (2015/16) and the Advancing Quality Programme (2016/18) the three-year Quality Strategy was approved by the Board of Directors in April 2018.

We believe that we can demonstrate outstanding care and be one of the best providers of healthcare in the country. Our Quality Strategy gives us the road map to get there. It reflects our quality priorities and takes account of national, local and independent reports and enquiries.

Improving the quality of care we deliver is about making our care safe, effective, patient-centred, timely, efficient and equitable. It is intended that we use the Quality Priorities to monitor service improvement, to demonstrate that high quality care and services are being provided and highlight areas where further improvements are required. Our Quality priorities are sub-divided into four improvement campaigns:

Campaign One: A positive patient experience: We aim to:

- Change behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide.

Campaign Two: Care is safer: We aim to:

- Focus on frailty and learning disability adapting to meet the healthcare needs of an increasingly elderly patient population and, by delivering 'better basics', reduce exposure to harm or complications of care.

Campaign three: Care is clinically effective: We aim to:

- Ensure patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Campaign Four: We stand out: We aim to:

- Be a leader in the delivery of high quality, safe healthcare, striving for excellence on our journey to outstanding.

Each year we review the quality priorities evaluating the implementation plan to ensure delivery of the Quality Strategy.

The progress made is monitored and reviewed each month by the Executive Medical Director and Chief Nurse. Progress is reported to the Quality Committee and Board routinely as part of the cycle of business for the Board of Directors. Each Campaign is comprised of a number of specific improvement workstreams, examples of which are illustrated in Diagram 1.

Diagram 1.

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

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

An example of the above is demonstrated in our Nottinghamshire-wide training approach to Quality Improvement (QI), which is delivered jointly between us, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare Trust. This uses the nationally accredited QI training approach, Quality, Service Innovation and Re-design (QSIR) as the platform to build capabilities, networks and a 'common QI language' across traditional organisational boundaries. This has been recognised as national best practice by the NHS Improvement's Act Academy.

We launched our QI approach in July 2018 - the 'Sherwood Six Step' – which is underpinned by the globally recognised Institute of Healthcare Improvement's 'Model for Improvement.'

Improvements in Quality Governance

We continue to build on the robust governance structures implemented in 2015, in particular the successful implementation of the Patient Safety Quality Group (PSQG), co-chaired by the Executive Medical Director and the Chief

Nurse. The reporting structure from 'ward to board' provides the required assurances that our patients receive the high quality, safe care they deserve. The reporting structure is illustrated in diagram 2:

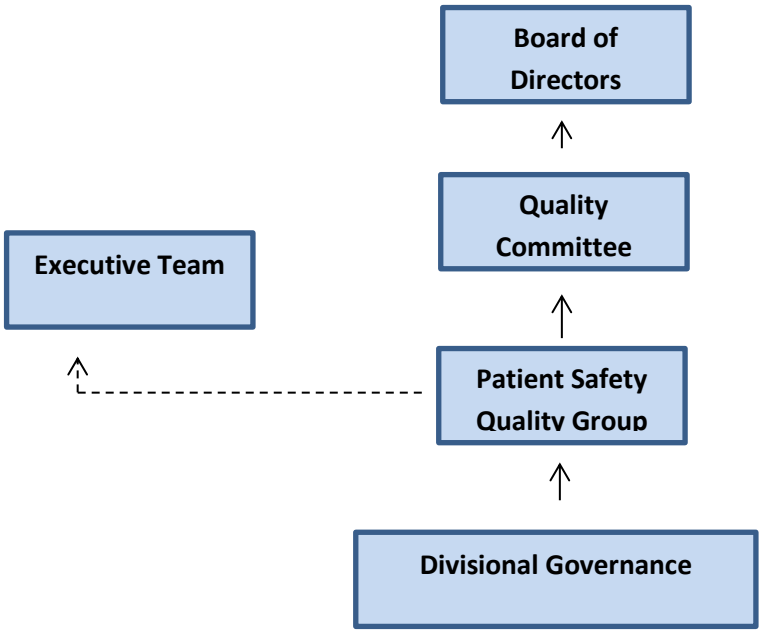


Diagram 2.

PSQG is overseen by the Executive Team, and meets monthly, providing a reporting and assurance role to the Trust Board's Quality (Assurance) Committee. PSQG drives the patient safety and quality agenda across the organisation, being the vehicle to monitor the effectiveness of governance in its widest sense and hold defined specialist areas and the clinical divisions to account.

The PSQG Annual Work Plan is aligned to that of the Quality Committee. A number of sub-groups ensure that timely and accurate accounts of quality standards are presented, good practice is recognised and rewarded, risks to the safety of patient care are identified and remedial action taken where required. Most importantly the sub-groups ensure that lessons are learned and shared across the organisation.

Local governance processes have strengthened with effective and constructive discussion at specialty and divisional level common place. Performance and quality metrics have been aligned to avoid duplication and to provide further assurance that the safety and quality of care is never compromised with the need to meet all necessary activity and financial standards.

Involvement of Governors

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

Patient Care: Improvements in patient/carer information

Patient and carer information is a fully functioning and successful service with 100% of leaflets reviewed and approved 28 days before their expiry date.

As membership of the NHS England Information Standard is to cease, we will continue to adhere to the standard's six principles until future plans are announced. With regards to a recognisable kite mark that acknowledges that our information is high-quality, as members of the Patient Information Forum (PIF) we have been authorised to use the 'Proud to be a PIF member' badge on our website/emails/presentations etc. This badge demonstrates our commitment to ensuring that the health information we deliver is of the highest possible standard, and is a sign of our expertise.

Our website, including the patient information library, has been refreshed. Accessibility tools and information on interpreting and translation are available to users.

The patient information leaflet section on our intranet site has also been refreshed. As well as the new policy and instructions on how to create a new leaflet, accessible information and health literacy (including a literacy checker) pages are now available to further educate colleagues.

During the past year we have explored the provision of providing health information in a video format, with the aim of benefitting a wide range of people who find it hard to use standard printed material. A video on bowel cancer screening has been produced and three more videos are currently in production.

Complaint Handling

We are committed to resolving any complaint or concern at the earliest opportunity. Preferably this is achieved through the patient, relative or carer discussing their concerns directly with the relevant clinical team or through the Patient Experience Team (PET). The Patient Experience Team provides confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/ward directly, or where they have done so but their concern remains unresolved.

The Patient Experience Team aim to resolve any concerns raised with them quickly and informally with the full cooperation of the department/ward involved in the care and treatment provided to the patient.

Should the patient or carer feel their concern should be formally investigated they are able to raise the issue through our formal complaint procedure. We operate a centralised complaint service, which supports a patient centred approach to the management of complaints.

All complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt. For complex complaints an alternative timescale can be agreed with the patient, relative or carer.

During 2018/19 we received 392 complaints. A total of 36 Local Resolutions Meetings took place with patients and families to listen and resolve complaints face to face. In the same reporting period we responded to 95% within the recommended 25 days. Some complaints are complex and as such a timeframe to respond will be agreed with the complainant on a case-by-case basis.

A total of 18 applications were received from the Parliamentary and Health Service Ombudsman (PHSO) during 2018/19, 13 proceeded for investigation. Of these 1 were upheld/partly upheld and 5 were not upheld. PHSO currently have 7 ongoing investigations at the time of writing this report

Stakeholder relations

Significant partnerships and alliances

We already work well with our partners in mid-Nottinghamshire and have an agreed set of principles for collaboration, which ensure that we are working towards a common goal. These include:

- Working together for the benefit of the system
- Aligned objectives and incentives to achieve system change
- A cost pressure causes a problem for the system, whilst a cost saving creates an opportunity for the system
- Openness and transparency i.e. an 'open book' approach
- Risks should be shared and collectively managed
- Contracts should reflect system objectives, incentivise delivery and enable transformation

Through working to these principles, we can collectively plan services within available resources, ensuring that a financial improvement for one organisation is a financial improvement for everyone. We have already done this in a range of areas, including through our collaborative MSK (musculoskeletal) service, which has yielded significant patient benefits and financial savings for our ICP.

Development of services involving other local services / agencies

We continue to build a strong and strategic partnership with Nottingham University Hospitals (NUH), seeking opportunities to work more closely together in areas that will benefit patients and staff. For example, the Neurology service that we previously provided is now one of a number of services run by NUH on our premises, overcoming the sustainability challenges we previously faced.

Consultation with local groups and organisations

A renewed focus on engagement and involvement with local communities has continued to build on progress in 2017/18. This focus encompasses the Engagement and Involvement strategy (2018 – 2021) which aims to build a culture that actively encourages public participation and a two-way dialogue. By doing this, we will improve patient experience and make services more open to patients. We are continuing to build better relationships between us and the communities we serve, which can be demonstrated by the below.

The Engagement and Involvement strategy is supported by the Patient and Carer Engagement Plan and the Public Engagement and Involvement Plan. A key part of our Quality Strategy is involving patients and the community.

In November 2017, we organised and held our first Forum for Public Involvement meeting. This meeting has become more established in the last 12 months and continues to be well received by the members of the group. The Forum has also gained recognition throughout SFH with the members becoming involved in various committee groups, reviewing patient and public materials and members providing feedback on issues they feel we should focus on. The Forum includes a total of 46 Trust members, members of the public and affiliates from local PPGs. The Forum's 'Terms of Reference' has been updated and will continue to do so annually. Meetings are held monthly at King's Mill Hospital with one in four held at Newark Hospital.

In October and November 2018, the Trust introduced phase one of the Sherwood Forest Hospital's strategy launch. This included initial engagement with members of staff and key stakeholders and provided an opportunity for the Trust to gain thoughts and feedback. To engage SFH colleagues on the strategy, all three hospital sites were visited throughout October and November 2018. To engage stakeholders and SFH members, the new strategy was discussed at the Forum

for Public Involvement meeting, via our Trust Matters monthly newsletter and with Healthwatch Nottingham and Nottinghamshire. We also visited local college, Vision West Nottinghamshire College in Mansfield where we had conversations and gained feedback from students in the local area.

In total we had over 750 conversations with SFH colleagues, key stakeholders and members of the public and over 300 responses to our Strategy survey. These conversations and survey responses have provided invaluable insight into how we shaped our Strategy ahead of the launch in April 2019.

In summer 2018 we launched a new stakeholder newsletter, timed to coincide with the announcement of our positive new CQC results. This was as a direct result of the feedback that we received from our first stakeholder audit in March 2018. The newsletter keeps stakeholders up to date on key SFH news and developments on a monthly basis and has a high open rate amongst recipients. We repeated this audit in February and March 2019 and the results and actions arising from it will be implemented in 2019/20.

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

Survey name	Date	Summary
Medical Services Feedback	April 2018	To ask members of the public for their views on medical services.
Looking ahead to 2024 – SFH Trust Strategy Survey	October 2018	To ask staff and members of the public their views and opinions on the Strategy.
Equality Delivery System 2 (EDS2): Help grade the Hospital Survey	October 2018	To ask members of the public to grade our Hospitals.
Maternity Services Feedback (Continuity of Carer Survey)	December 2018	To ask members of the public for their views on maternity services.
Antenatal and Postnatal Survey (Mansfield and Ashfield CCG)	January 2019	To ask members of the public where they would like to access maternity services.
Antenatal and Postnatal Survey (Newark and Sherwood CCG)	January 2019	To ask members of the public where they would like to access maternity services.

We have also established regular meetings with stakeholders including our local MPs and Healthwatch Nottingham and 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.

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code.

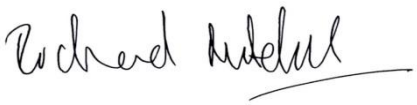
Our performance against this metric is shown as follows:

	2018/19		2017/18	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	76,475	199,558	81,585	191,970
Total non-NHS trade invoices paid within target	64,174	186,363	45,355	152,048
Percentage of non-NHS trade invoices paid within target	84%	93%	56%	79%
Total NHS trade invoices paid in the year	2,621	26,254	2,507	27,340
Total NHS trade invoices paid within target	2,050	23,799	1,430	23,675
Percentage of NHS trade invoices paid within target	78%	91%	57%	87%

Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust paid £1k in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2018/19 would be £ 81.5k. (2017/18 £160.7k) There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

All of this relates to non NHS invoices, and none relates to NHS healthcare contracts.



Richard Mitchell
Chief Executive Officer **23rd May 2019**

Remuneration Report

Scope of the report

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

Annual Statement on Remuneration from the Chair of the Remuneration Committee

The Remuneration Committee met three times during the year and key decisions made included the Disestablishment of the Director of Governance and Quality Improvement role and the disestablishment of the Head of Corporate Affairs and Company Secretary and the establishment of a Director of Corporate Affairs. The portfolio of the disestablished Director of Governance and Quality Improvement was distributed to the Director of Corporate Affairs, Chief Nurse and Executive Medical Director. The committee also approved the NHSI recommended salary increase for all eligible VSM staff. The committee also recommended an external independent review of executive director salaries.

Senior managers' remuneration policy

We must attract, develop and retain executive directors and senior managers of a high calibre in order to ensure that the organisation is well-led and able to deliver its strategy and vision.

Executive directors and senior managers receive an annual appraisal, in accordance with our performance management framework. This ensures the performance of the executive directors and senior managers is based on the delivery of objectives as defined within the annual plan. However, there are no contractual provisions for performance-related pay for executive directors and senior managers and, as such; no performance related payments were made relating to 2018/19.

Our approach to remuneration 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, the NHS Improvement's (NHSI) published pay ranges and the wider pay policies of the NHS.

Executive appointments to the Board of Directors continue under permanent contracts. During 2018/19 the non-executive directors dis-established the position of Director of Governance and Quality Improvement and divided its portfolio between the Executive Medical Director / Deputy Chief Executive, the Chief Nurse and the Head of Corporate Affairs and Company Secretary. The Head of Corporate Affairs and Company Secretary position was replaced with a Director of Corporate Affairs.

Governance for the approval of remuneration packages, in line with the policy, is in place through the Remuneration Committee, which considers pay on an individual basis attributed to scope and remit of role. Through the Remuneration

Committee, the Board assures itself that salaries are commensurate with other organisations of similar size and complexity. It also considers the nature of the patient, quality and safety challenges to provide assurance that any given salary reflects the degree of responsibility and accountability.

Senior manager remuneration table

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

Relocation expenses are paid in accordance with the Trust's general relocation policy, where an appointee is required to maintain two properties or move their primary residence to take up their position. No relocation expenses were paid during 2018/19.

	Basic pay	**Pension**	**Business expenses**	**Relocation Expenses**
	All senior managers receive a basic pay element to their remuneration, which is pro-rata for part time staff.	The Trust pays employer contributions for all senior managers who are enrolled in the NHS pension scheme. This is a % of pay set by NHS Pensions Authority.	Reimbursement 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
How the component support short and long term objectives of the trust	Set at point of recruitment, reviewed using pay benchmarking and other relevant information. Recruiting high calibre senior managers is crucial to the delivery of the Trust's objectives. Benchmarking takes into consideration other similar medium sized acute district general hospitals to ensure salary levels are competitive, but	Ensure the recruitment / retention of directors of sufficient calibre to deliver the trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the trust's objectives

	also represent value for money.			
How the component operates	Standard monthly pay	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme	Reimbursed as incurred, paid via monthly payroll	Reimbursed as incurred on appointment
Maximum payment	Basic pay	Contributions are made in accordance with the NHS Pension Scheme	Expenses incurred on official duties reimbursed	£6,000
Framework used to assess performance	Trust appraisal system	N/A	N/A	N/A
Performance measures	Individual objectives agreed as part of appraisal process	N/A	N/A	N/A
Performance Period	Annual Appraisal	N/A	N/A	N/A
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	N/A	N/A	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered	N/A	N/A	N/A

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.

The Trust does not have any executive directors or senior managers who are members of a different pension scheme who receive an employer contribution from the Trust as part of their remuneration.
With effect from 1 April 2018, the committee approved five executive directors / senior managers to receive a flat rate pay award of £2,075. In addition, it also approved two more executive directors / senior managers to receive this lump sum pro-rata to the number of months of eligibility. This was in accordance with the NHS Improvement (NHSI) letter to all NHS Trusts and NHS Foundation Trusts on 19th December 2018 , in which it recommended that a flat rate pay award of £2,075 be paid on a consolidated basis to Very Senior Managers (VSM) in all Trusts, where the individual is below the upper quartile pay threshold for their role.

Senior managers paid more than £150,000 per annum

Where a senior manager is paid more than £150,000 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 and the NHS Improvement's (NHSI) published pay ranges.

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

Since June 2015, any salary approved in excess of £150,000 is subject to a 10% earn-back in the event of under-performance of the post-holder.

Non-Executive Directors' remuneration table

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

The remuneration for Non-Executive Directors has been determined by 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 2018/19 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 2018/19.

None of the Non-Executive Directors are employees of SFH; 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.

We do 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.

The balance of the Board 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 our 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 SFH, 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 2018/19.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

We do not consult with employees when setting our senior manager remuneration policy. However, the pay and conditions of other SFH employees were taken into account. The flat rate uplift of £2,075 paid in 2018/19 was commensurate with the cash value of the 2018/19 award applied to agenda for change employees at the top of pay bands 8c, 8d and 9. This therefore mirrored the Agenda for Change: National NHS terms pay award that was received by other employees of SFH and the NHS in general with effect from 1 April 2018. All other national NHS terms are mirrored for SFH senior managers, including annual leave and sick pay.

Payments for loss of office

No payments for loss of office were made during 2018/19.

Payments to past senior managers

No payments to past senior managers were made during 2018/19, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Annual Report on Remuneration (not subject to audit)

Service Contracts

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

Name	Title	Start Date	Expiry	Notice Period
Ray Dawson	Non-Executive Director	01.06.2013	April 2018	1 month
Claire Ward	Non-Executive Director	01.05.2013	30.04.2019	1 month
Tim Reddish	Non-Executive Director	08.07.2013	31.10.2019	1 month
Neal Gossage	Non-Executive Director	01.05.2015	30.04.2020	1 month
Graham Ward	Non-Executive Director	01.12.2015	30.11.2020	1 month
John MacDonald	Non-Executive Director (Chair)	01.03.2017	28.02.2020	1 month
Barbara Brady	Non-Executive Director	01.10.2018	30.09.2021	1 month
Manjeet Gill	Non-Executive Director	01.11.2018	31.10.2021	1 month
Richard Mitchell	Chief Executive	01.07.2017		6 months
Dr Andrew Haynes	Medical Director/Deputy CEO	01.07.2014		6 months
Suzanne Banks	Chief Nurse	06.02.2017		3 months
Paul Robinson	Chief Finance Officer	23.03.2015		6 months
Simon Barton	Chief Operating Officer	01.01.2018		3 months
Julie Bacon	Executive Director HR & OD	01.12.2016		3 months
Peter Wozencroft	Director of Strategy and Commercial Development	02.12.2013		6 months
Paul Moore	Director of Governance and Quality Improvement	01.03.2017	08.07.2018	3 months
Shirley A Higginbotham	Director of Corporate Affairs	04.04.2013		3 months
Kerry Beadling-Barron	Head of Communications	03.07.2017		3 months

Major decisions on senior managers' remuneration

There were no major decisions on senior managers' remuneration during 2018/19.

Substantial changes to senior managers' remuneration during the year and the context for these

There were no substantial changes to senior managers' remuneration during 2018/19.

Remuneration and Nominations Committees

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

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

During the year, the following Non-Executive Directors have served on the committee, which has met three times during the year:

Name	Meetings attended out of possible total
John MacDonald (Chair)	3/3
Tim Reddish (Senior Independent Director)	3/3
Graham Ward	3/3
Neal Gossage	3/3
Claire Ward	2/3
Barbara Brady	2/2
Manjeet Gill	2/2

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

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

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

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

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

Through an open recruitment process the committee successfully recommended appointment of two new Non-Executive Directors, one with a clinical background and the second with experience of transformational change across the health economy system, to enhance the challenge and debate at Board and Council of Governors. The committee also successfully recommended the re-appointment of Non-Executive Directors who had reached the end of their tenure.

Disclosures required by Health and Social Care Act

Governor and Director Expenses

During the year the total number of Directors who served on our Board was, 18 and the total number of Governors serving on our Council of Governors totalled 29. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		Total paid 2018/19 £'00	Total paid 2017/18 £'00
John MacDonald	Chair	33.6	27.8
Ray Dawson	Non-executive director	1.2	9.4
Claire Ward	Non-executive director	1.9	7.6
Tim Reddish	Non-executive director	4.3	2.5
Neal Gossage	Non-executive director	10.7	8.2
Graham Ward	Non-executive director	1.8	No Claim
Sean King	Non-executive director	No Claim	No Claim
Barbara Brady	Non-executive director	10.7	No Claim
Manjeet Gill	Non –Executive director	No Claim	
Peter Herring	Chief Executive	No Claim	2.6
Richard Mitchell	Chief Executive	2.0	3.4
Suzanne Banks	Chief Nurse	3.7	4.9
Julie Bacon	Executive Director of HR & OD	2.6	5.6
Peter Wozencroft	Director of Strategic Planning and Commercial Development	15.1	11.1
Roz Howie	Chief Operating Officer	7.5	2.4
Denise Smith	Chief Operating Officer	No Claim	No Claim
Simon Barton	Chief Operating Officer	No Claim	No Claim
Dr Andrew Haynes	Executive Medical Director	No Claim	No Claim
Paul Robinson	Chief Financial Officer	8.3	4.8
Paul Moore	Director of Governance	No Claim	No Claim
Shirley Higginbotham	Director of Corporate Affairs	2.2	No Claim
Kerry Beadling-Barron	Head of Communications	2.7	No Claim
Marcus Duffield	Head of Communications	No Claim	No Claim
	TOTAL	**127.5**	**90.3**

Governors	Constituency	Area	Total 2018/19 £'00	Total 2017/18 £'00
Amanda Brown	Appointed Governor	Ashfield District Council	No claim	No claim
Amanda Sullivan	Appointed Governor	NHS Newark & Sherwood and Mansfield & Ashfield CCG	No claim	No claim
Andrew Berridge	Public Governor	Derbyshire	No claim	No claim
Angie Emmott	Staff Governor	Newark Hospital	0.3	0.7
Ann Mackie	Public Governor	Newark & Sherwood	4.1	5.9
David Payne	Appointed Governor	Newark & Sherwood District Council	No claim	No claim
Dilip Malkan	Staff Governor	King's Mill & Mansfield	No claim	No claim
Carol Atkinson	Co-opted Governor	Derbyshire	No claim	0.05
Morgan Thanigasalam	Staff Governor	King's Mill & Mansfield	0.1	No claim
Ian Holden	Public Governor	Newark & Sherwood	No claim	No claim
Jackie Hewlett-Davies	Public Governor	Ashfield	No claim	No claim
Jane Stubbings	Public Governor	Ashfield	1.2	0.2
Jayne Leverton	Public Governor	Ashfield	No claim	No claim
Jim Barrie	Public Governor	Newark & Sherwood	No claim	No claim
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	No claim
John Barsby	Public Governor	Mansfield	No claim	No claim
John Roughton	Public Governor	Mansfield	No claim	No claim
John Wood	Public Governor	Mansfield	No claim	No claim
Keith Wallace	Public Governor	Mansfield	No claim	0.3
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	2.3	1.4
Nick Walkland	Public Governor	Rest of East Midlands	1.6	5.4
Ron Tansley	Volunteer Governor	King's Mill & Mansfield	No claim	No claim
Roz Norman	Staff Governor	King's Mill & Mansfield	No claim	No claim
Samantha Annis	Staff Governor	Newark Hospital	No claim	No claim
Sharron Adey	Appointed Governor	Mansfield District Council	No claim	No claim
Susan Holmes	Public Governor	Ashfield	0.7	2.2
Valerie Bacon	Public Governor	Derbyshire	1.4	3.5
Yvonne Woodhead	Appointed Governor	Nottinghamshire County Council	No claim	No claim
TOTAL			**11.7**	**19.65**

Annual Report on Remuneration (subject to audit)

Senior managers' disclosure

	2018/19						2017/18					
Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefit (bands of £2,500)	Total
	£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors												
Mr R Mitchell (Chief Executive Officer) Appointed 1 July 2017	170 - 175	2,100	0	0	42.5 - 45	215 - 220	125 - 130	300	0	0	70 - 72.5	195 - 200
Mr P Robinson (Chief Financial Officer)	150 - 155	800	0	0	0	150 - 155	150 - 155	500	0	0	0	150 - 155
Ms S Banks (Chief Nurse)	125 - 130	400	0	0	0	125 - 130	125 - 130	500	0	0	75 - 77.5	200 - 205
Dr A Haynes (Executive Medical Director)	180 - 185	0	0	0	0	180 - 185	180 - 185	0	0	0	7.5 - 10	190 - 195
Ms S Higginbotham (Non-voting Director of Corporate Affairs)	100 - 105	200	0	0	40 - 42.5	145 - 150	90 - 95	0	0	0	30 - 32.5	125 - 130
Mr P Moore (Non-voting Director of Governance and Quality Improvement) Appointed 1 March 2017 - left 8 July 2018	25 - 30	0	0	0	62.5 - 65	90 - 95	100 - 105	0	0	0	35 - 37.5	135 - 140
Mr P Wozencroft (Non-voting Director of Strategic Planning and Commercial Development)	110 - 115	1,500	0	0	15 - 17.5	130 - 135	105 - 110	1100	0	0	67.5 - 70	175 - 180
Ms J Bacon (Executive Director of Human Resources and Organisational Development)	110 - 115	300	0	0	0	110 - 115	110 - 115	600	0	0	0	110 - 115
Mr S Barton (Chief Operating Officer) Appointed 1 January 2018 - Note 1	120 - 125	0	0	0	87.5 - 90	210 - 215	30 - 35	0	0	0	72.5 - 75	100 - 105
Ms Kerry Beadling-Barron (Non-voting Head of Communications) Appointed 3 July 2017 - Note 1	70 - 75	300	0	0	20 - 22.5	90 - 95	50 - 55	0	0	0	35 - 37.5	85 - 90
Ms B Brady (Non-voting Specialist Advisor to the Board of Directors) Appointed 26 March 2018 - left post 12 September 2018 - Note 2	5 - 10	400	0	0	0	5 - 10	0 - 5	0	0	0	0	0 - 5
Mr P Herring (Chief Executive Officer) Appointed 19 November 2015 (Managing Director 11 June to 31 October 2016) - left 30 June 2017	N/A	N/A	N/A	N/A	N/A	N/A	65 - 70	300	0	0	0	65 - 70
Ms R Howie (Chief Operating Officer) Appointed 1 October 2016 - left post 3 September 2017 Note 3 Trust termination date 2 September 2018	N/A	N/A	N/A	N/A	N/A	N/A	50 - 55	200	0	0	252.5 - 255	300 - 305
Mrs D Smith (Chief Operating Officer) Acting from 4 September - 31 December 2017	N/A	N/A	N/A	N/A	N/A	N/A	30 - 35	0	0	0	282.5 - 285	315 - 320
Mr M Duffield (Non-voting Head of Communications) Acting from 1 April - 30 June 2017	N/A	N/A	N/A	N/A	N/A	N/A	15 - 20	0	0	0	0	15 - 20
Non-Executive Directors												
Mr J MacDonald (Chair)	50 - 55	3,400	0	0	0	50 - 55	50 - 55	2800	0	0	0	50 - 55
-	0 - 5	100	0	0	0	0 - 5	15 - 20	900	0	0	0	15 - 20
Mr T Reddish	15 - 20	400	0	0	0	15 - 20	15 - 20	300	0	0	0	15 - 20
Ms C Ward	10 - 15	200	0	0	0	10 - 15	10 - 15	800	0	0	0	10 - 15
Mr G Ward	10 - 15	200	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mr N Gossage	15 - 20	1,100	0	0	0	15 - 20	15 - 20	800	0	0	0	15 - 20
Ms B Brady (Non-voting Specialist Advisor to the Board of Directors) Appointed 13 September 2018 - Note 2	5 - 10	700	0	0	0	5 - 10	N/A	N/A	N/A	N/A	N/A	N/A
Ms M Gill Appointed 1 November 2018	5 - 10	0	0	0	0	5 - 10	N/A	N/A	N/A	N/A	N/A	N/A
Ms R Beech Left 31 October 2017	N/A	N/A	N/A	N/A	N/A	N/A	5 - 10	0	0	0	0	5 - 10
Dr S King Appointed 24 July 2017 - left 31 December 2017	N/A	N/A	N/A	N/A	N/A	N/A	5 - 10	0	0	0	0	5 - 10

Notes

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

2 - Ms B Brady Became non-Executive Director on 13 September 2018

3 - Ms R Howie (Chief Operating Officer)
Appointed 1 October 2016 - left post 3 September 2017 - Seconded to Nottingham City CCG, terminated with SFH 2 September 2018

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

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

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

Fair Pay Multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.
The banded remuneration of the highest paid director in the Foundation Trust in the financial year 2018-19 was £180,000 - £185,000 (2017-18, £180,000 - £185,000). This was 7.43 times (2017-18, 7.94 times) the median remuneration of the workforce, which was £24,214 (2017-18, £22,683). In 2018-19, no employees (2017-18, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £7,234 to £180,000 (2017-18, £6,648 to £180,000).

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.

The change in year reflects an increase in the median salary due to the 2018/19 Agenda for Change pay award.

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

There were no agency Board members as at 31 March 2019.

Pension disclosure

2018/19

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr R Mitchell *	2.5 - 5	0 - 2.5	35 - 40	65 - 70	354	74	464	0
Ms S Banks	0 - 2.5	0 - 2.5	45 - 50	145 - 150	934	90	1071	0
Dr A Haynes	-2.5 - 0	-2.5 - 0	75 - 80	235 - 240	1750	131	1959	0
Ms S Higginbotham (nee Clarke) *	2.5 - 5	0	15 - 20	0	196	53	269	0
Mr P Moore *	0 - 2.5	0 - 2.5	35 - 40	95 - 100	547	29	686	0
Mr P Wozencroft *	0 - 2.5	-2.5 - 0	35 - 40	90 - 95	642	80	757	0
Mr S Barton *	2.5 - 5	7.5 - 10	25 - 30	60 - 65	327	107	462	0
Ms K Beadling-Barron *	0 - 2.5	0 - 2.5	10 - 15	20 - 25	126	31	169	0

2017/18

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

Notes

* These members' pension entitlements relate to the total values under two different NHS schemes
Please be aware that last year there was a calculation error such that the CETV factors used and provided to us by NHS pensions for some individuals with benefits in the 2015 Scheme were incorrect. New figures have been provided this year and used into the 2018/19 table only were applicable. Accrued pension and lump sum figures for Paul Moore have also changed since the prior year following notification from NHS Pensions.

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

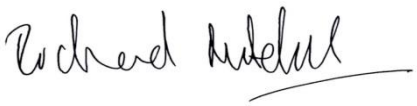
The defined benefit pension liability is uplifted in line with the Consumer Price Index (CPI) to calculate the minimum pension increases for index-linked pensions.

Related party transactions

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

Compliance statement

In compliance with the UK Directors Remuneration Report Regulations 2002, the auditable part of the remuneration report comprises executive Director's remuneration and Non-Executive Director's fees.



Richard Mitchell
Chief Executive

23 May 2019

Staff Report

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

Our average workforce numbers from 1 April 2018 to 31 March 2019 are:

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

		2018/19		2017/18
	Total	**Permanent**	**Other**	**Total**
Medical and dental	**548**	466	82	**530**
Administration and estates	**1,022**	1,016	6	**1,016**
Healthcare assistants and other support staff	**938**	938	0	**916**
Nursing, midwifery and health visiting staff	**1,236**	1,128	108	**1,260**
Nursing, midwifery and health visiting learners	**0**	0	0	**0**
Scientific, therapeutic and technical staff	**388**	367	21	**380**
Healthcare science staff	**113**	113	0	**110**
Other	**8**	8	0	**9**
Total average numbers	**4,253**	**4,036**	**217**	**4,221**
Of which:				
Number of employees (WTE) engaged on capital projects	**1**			**1**

While only 1 full time member of staff is employed to permanently manage capital, other staff costs have been incurred and capitalised relating to specific 2018/19 capital projects.

The permanent WTE's numbers disclosed are based on the average number of montly employees. This is different to the methodology set out in the FT ARM which is calculated based on weekly numbers.

Breakdown of staff (actual headcount as at 31 March 2019)

	Male	**Female**
Director	9	6
Other senior manager	65	125
Employee	840	3792
Total	**914**	**3923**

Staff Costs- Subject to audit

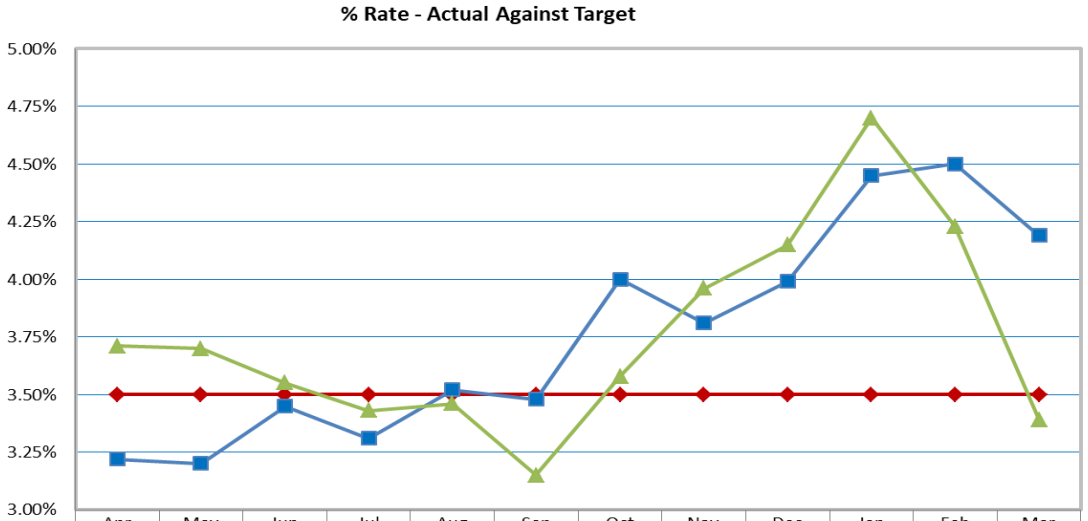
	Total	Permanent	Other	Total
	31 Mar 2019	31 Mar 2019	31 Mar 2019	31 Mar 2018
	2018/19	2018/19	2018/19	2017/18
Salaries and wages	156,410	156,410	0	147,458
Social security costs	16,497	16,497	0	13,693
Apprenticeship levy	809	809	0	713
Pension cost - employer contributions to NHS pension scheme	18,133	18,133	0	17,125
Pension cost - other*	0	0	0	0
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	99	99	0	0
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	14,272	0	14,272	16,775
TOTAL GROSS STAFF COSTS	**206,220**	**191,948**	**14,272**	**195,764**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	0
TOTAL STAFF COSTS	**206,220**	**191,948**	**14,272**	**195,764**
Included within:				
Costs capitalised as part of assets	317	317	0	299

Sickness absence

Our target sickness absence for 2018/19 remained at 3.50%.

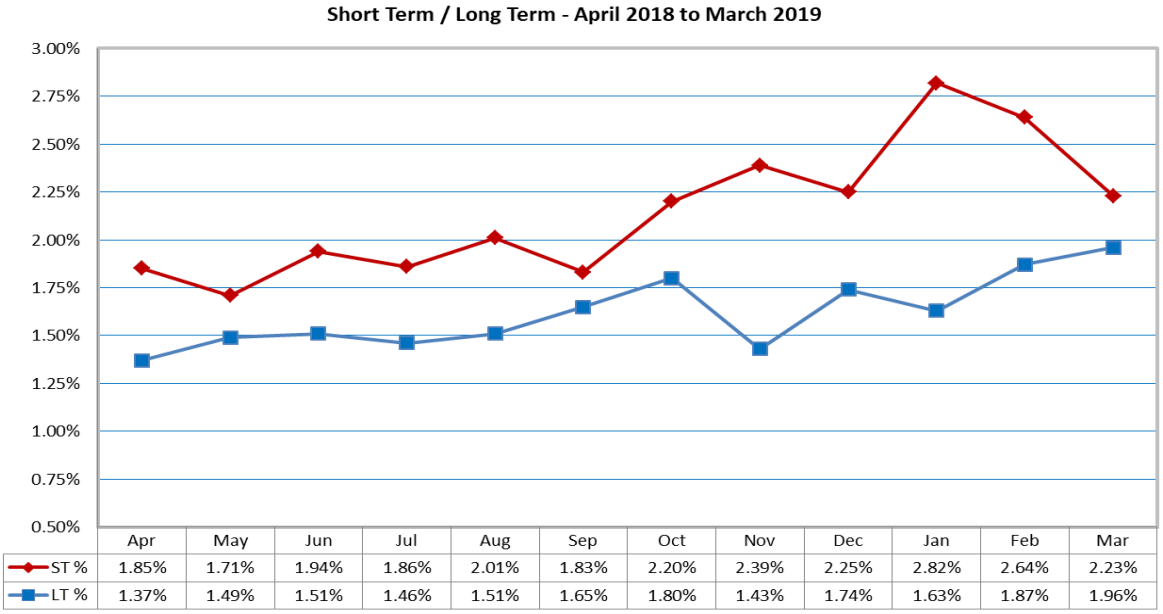
The total sickness absence rate for 2018/2019 was 3.76%, compared to 3.75% in 2017/18. The estimated cost of paying absent staff stood at £4.70m, compared to £4.62m in 2017/2018.

The chart below details our performance against target in month for 2018/2019 against 2017/2018:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%
2018/2019 %	3.22%	3.20%	3.45%	3.31%	3.52%	3.48%	4.00%	3.81%	3.99%	4.45%	4.50%	4.19%
2017/2018 %	3.71%	3.70%	3.55%	3.43%	3.46%	3.15%	3.58%	3.96%	4.15%	4.70%	4.23%	3.39%

The graph below shows a comparison of sickness absence rates in terms of short and long-term rates for 2018/2019:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ST %	1.85%	1.71%	1.94%	1.86%	2.01%	1.83%	2.20%	2.39%	2.25%	2.82%	2.64%	2.23%
LT %	1.37%	1.49%	1.51%	1.46%	1.51%	1.65%	1.80%	1.43%	1.74%	1.63%	1.87%	1.96%

We maintain our focus on managing short-term sickness absence, with Human Resources (HR) business partners supporting divisional managers to monitor trends and carry out absence reviews when required. In 2018 we continued our Happy Healthy Here campaign to highlight to all the ways we support employees in their health and wellbeing so that they feel fit and well enough to do their job and deliver outstanding patient care. We hold regular health & wellbeing drop in sessions providing access to a body mass analyser and advice on healthy living.

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

Further sickness absence information is outlined below:

	WTE days lost	**Previously reported**				
Staff sickness absence	**2018/19**	**2017/18**	**2016/17**	**2015/16**	**2014/15**	**2013/14**
Days lost (long-term)	23,635	24,188	24,387	28,292	24,754	36,945
Days lost (short-term)	31,337	29,723	30,154	27,666	29,761	22,604
Total days lost	54,972	53,911	54,541	55,958	54,515	59,549
Total Full Time Equivalent (FTE)	4103	3983	3875	3706	3677	3564
Average working days lost	13.40	13.54	14.07	15.09	14.83	16.71
Totals staff in period (headcount)	4837	4692	4558	4357	4301	4500
Total absence rate	**3.76%**	**3.75%**	**3.98%**	**4.17%**	**4.12%**	**4.63%**

Our sickness absence data is outlined below. Please note the figures given are in calendar years (January 2018 to December 2018).

	Figures converted by DH to Best Estimates of Required Data Items		Statistics Published by NHS Digital from ESR Data Warehouse		
	Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
Sherwood Forest Hospitals NHS Foundation Trust	4,171.48	36,036.43	8.64	1,522,589	58,459

Key priorities for 2019/20 in relation to managing sickness absence are:

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

Health and Safety at Work 2018/19

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

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

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

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

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

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

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

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.

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

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

We continue to be a signatory to the Charter for Employers who are *Positive about Mental Health*, reflecting the general philosophy of *Mindful Employer*. This Charter helps us to support staff who experience mental ill health. This has also been supported through the embracing the "Time to Change" agenda with focus of supporting employees with the opportunities to take about the mental heath agenda.

Information to be published under Regulation 8 revised Trade Union (Facility Time Publication Requirements) Regulations 2017

Table 1: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
42	35.74

Table 2: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	31
1-50%	8
51%-99%	2
100%	1

Table 3: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	£89,624.25
Provide the total pay bill	£205,174,527.17
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.043%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	4.4%

Expenditure on consultancy

Consultants have been used where specific expertise is required which is not available in- house or where the capacity to complete a time limited exercise does not exist. No consultancy has been used for Executive level appointments. We spent £0.43m on consultancy during the year, (2017/18 £0.09m).

Off-payroll engagements

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

Table 1

For all off-payroll engagements as of 31 March 2019, for more than *£245* per day and that last for longer than six months

Number of existing engagements as of 31 March 2019	Nil
Of which...	
the number that have existed for less than one year at time of reporting	Nil
the number that have existed for between one and two years at time of reporting	Nil
the number that have existed for between two and three years at time of reporting	Nil
the number that have existed for between three and four years at time of reporting; and	Nil
the number that have existed for four or more years at time of reporting.	Nil

Table 2

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than *£245* per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	Nil
Of which:	
Number assessed as within the scope of IR35	Nil
Number assessed as not within the scope of IR35	Nil
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	Nil
Number of engagements reassessed for consistency/assurance purposes during the year	Nil
Number of engagements that saw a change to IR35 status following the consistency review	Nil

Table 3

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	Nil
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.	Nil

Process for off-payroll arrangements

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

Exit packages (subject to audit)

We confirm that there have been no redundancy and termination payments made to serving senior officers within 2018/19. Three Contractual payments in lieu of notice were made totalling £14,700.92.

	2018/19			2017/18		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band
<£10,000	0	1	1	0	3	3
£10,001 - £25,0000	1	2	3	0	0	0
£25,001 - £50,000	0	1	1	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	1	4	5	0	3	3
Total resource used	24	79	103	0	0	22

	2018/19		2017/18	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs			0	0
Contractual payments in lieu of notice	3	38	3	22
Exit payments following Employment Tribunals or court orders			0	0
Non contractual payments requiring HMT approval	2	65	0	0
Total	5	103	3	22
Of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

2018 National NHS Staff Survey

Approach to staff engagement

This continued to be a high priority as it is recognised that an engaged and motivated workforce is vital for the delivery of safe, effective care and a positive patient experience.

Engagement and Organisational Development activities are set out in our Workforce Strategy, Maximising our Potential annual plan. This is supported by our Communications Strategy and department. The workforce strategy was developed by engaging with the Trust Board, Senior Leadership and SFH colleagues. Each annual implementation plan is also produced using an employee engagement approach.

Regular colleague briefing events took place throughout the year. There was emphasis on ensuring colleagues received regular and honest information about our performance, the CQC rating, quality and improvement activities and celebrating achievements.

Senior leaders continued their commitment to engagement. A blended approach to this was encouraged through CEO and executive open briefing and drop-in sessions held at each hospital site, executive attendance at board rounds on wards and Trust Board member workplace visits supplemented by formal “15 steps” visits from executives, senior clinical leaders and governors.

We email a weekly Bulletin and a weekly CEO Blog to colleagues. There is also a strong social media presence of the Executive Team and key teams and departments.

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

Our Organisational Development Team, supported by the Communications Team, HR Business Partners and Learning and Development staff, undertook a full culture and leadership diagnostic based on the NHSI/Kings Fund toolkit. This involved interviews of our Board members, a leadership survey and focus groups involving colleagues at all levels in order to identify the existing and desired culture and leadership style for SFH. Valuable feedback was obtain and synthesised into a report for the Board. Additional engagement sessions on the results and the desired culture were held with the Board and with the Senior Leadership Team.

Key themes for improvement obtained from this powerful staff feedback has been built into the Maximising our Potential implementation plan for 2019/20.

Regular quarterly employee friends and family surveys are sent out to all employees electronically and periodic ad hoc surveys are sent to staff on a range of topics.

Well-being and safety activities are set out in the Staff Health, Safety and Wellbeing Plan of Maximising our Potential and include the usual CQUIN Staff Health & Wellbeing work.

The ‘Happy, Healthy, Here’ initiative continues and includes an in-house fast-track colleague physiotherapy service and health and wellbeing drop-in sessions. A weight loss support programme has also been introduced in 2018/19.

The national ‘Time to Talk’ initiative introduced last year continues to support the mental health and wellbeing of colleagues, with events held to raise awareness and training provided for Time to Talk Champions.

Creating and maintaining a safe environment is important and therefore ensuring that all colleagues attend high quality mandatory training that reflects best practice is a priority. The compliance rates for attendance on this training continually exceed the 90% target, which was subsequently raised to 93% in autumn 2018 and the new target continues to be achieved.

All colleagues are encouraged to raise concerns through appropriate mechanisms and to have a culture where they are confident that they will be listened to and have their concern considered. This is achieved by adopting an open door policy with senior leaders being accessible to hear concerns and ideas.

We continue to actively promote Speaking Up and during 2018/19 reviewed our Speaking Up Guardian arrangements and policy. In order to provide dedicated time and resources to this important area, we have appointed a substantive Speaking Up Guardian who will be supported by a number of Champions. This will strengthen the original arrangements which relied on Guardians who did not have dedicated time allocated for this activity.

Where colleagues raised concerns we ensure these are addressed appropriately and feedback is provided to the person raising the concern. The concerns raised are monitored for themes and trends, periodically reported to the Executive Team and the Board and triangulated with KPIs, findings from pulse surveys and feedback from leavers.

Initiatives set out in the Recruitment, Reward and Retention Plan of Maximising our Potential and the Trust Communication Strategy continue to be applied. We refreshed our recruitment branding for medical consultant appointments and continue to use microsites and social media. Robust approaches to selection using assessment centres and values based recruitment have been extended. We engage with new starters prior to them commencing employment through our Welcome Assure Reassure Meet (WARM) principals. This means that new colleagues feel welcome and valued from the start of their employment at Sherwood.

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

The Leadership, Talent Management and Succession Plan and Training, Learning and Development Plan set out initiatives for improving the development of leaders and colleagues. A formal system of leadership talent mapping and succession is in place and our appraisal process was expanded to include talent conversations for staff at all levels.

In 2018/19 we introduced a new senior leadership development programme which is offered in partnership with NHS Elect. It is available to all middle and senior leaders, both clinical and non-clinical. The mixed cohort approach that is used is proving particularly beneficial. Commitment to this programme is high as evidenced by the attendance of the CEO and executive team on it.

The NHS Staff Survey

We participate in the national NHS Staff Survey on an annual basis. The survey is undertaken from the beginning of October until the end of November.

In 2018 we surveyed all staff and had 2,789 responses, giving a response rate of 62%. This was higher than in 2017 when it was 57% and in 2016, it was 41%. The average response rate in England for acute NHS Trusts, was 44%.

Overview

Below are the first five of the ten key indicator areas. This shows we scored above average in four of the five areas and scored at the average in the fifth.

(Score 1 - 10)	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
Average (Acute Trusts in England) 2018	9.1	5.9	6.7	6.1	5.4
Average (Acute Trusts in England) 2017	9.1	6.0	6.7		5.3
Average (Acute Trusts in England) 2016	9.2	6.1	6.7		5.3

(Score 1 - 10) Trust comparison	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
2018 score	9.2	5.9	7.0	6.4	5.6
2017 score	9.3	5.9	6.9		5.4
2016 score	9.2	6.0	6.6		5.2
Trust comparison statistically significant change 2018		Not significant		N/A	

Two areas; support from immediate managers and the quality of appraisals, were above average and had improved from 2017. This may reflect the relaunch and retraining offered on appraisals during 2018. In addition, we invested in a new senior leadership programme and toolbox talks.

The equality, diversity and inclusion score had fallen slightly compared to 2017. However, it still remained above average and was over 10% better than the worst performing acute Trust.

Below are the second five of the ten key indicator areas. Three scores are above average; one is at the average and one, safe environment – violence, is below average. The latter score has not changed since 2017.

(Score 1 - 10)	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
Average (Acute Trusts in England) 2018	7.4	7.9	9.4	6.6	7.0
Average (Acute Trusts in England) 2017	7.5	8.0	9.4	6.6	7.0
Average (Acute Trusts in England) 2016	7.6	8.0	9.4	6.6	7.0

(Score 1 - 10) Trust comparison	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
2018 score	7.8	7.9	9.3	6.8	7.3
2017 score	7.8	8.0	9.3	6.7	7.2

2016 score	7.8	7.8	9.2	6.5	7.1
Trust comparison statistically significant change	Not significant		Not significant		

Positively the staff engagement score has increased, together with the safety culture score. Both are appreciably better than average and significantly better than the worst score.

Recommendation of the Trust as a place to work and to receive care

One of the most important measures is whether or not our own staff would recommend us as a place to work or receive care. Positively, we have seen a year on year improvement in this.

I would recommend my organisation as a place to work

	2014	2015	2016	2017	2018
Best	77.1%	77.4%	76.1%	76.9%	81.0%
Your org	50.9%	46.6%	67.9%	69.5%	70.5%
Average	58.0%	60.3%	61.1%	60.7%	62.6%
Worst	31.9%	41.6%	41.5%	42.7%	39.2%

This indicated a very positive step change for us in 2016 and since then there has been incremental improvement. This score is well above average for an acute Trust in England and has positive implications for our recruitment and retention activities.

If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

	2014	2015	2016	2017	2018
Best	89.5%	86.1%	84.8%	85.3%	87.3%
Your org	61.6%	57.1%	73.2%	77.6%	79.4%
Average	65.4%	69.3%	69.1%	70.8%	71.3%
Worst	37.9%	45.8%	48.5%	46.4%	39.8%

This indicated a very positive step change for us in 2016 and since then there has been incremental improvement. This score is well above average for an acute Trust in England and is very significantly above the worst scoring acute trust.

Another metric in this suite relates to whether or not staff believes that the care of patients / service users is our top priority.

Care of patients / service users is my organisations top priority.

	2014	2015	2016	2017	2018
Best	87.6%	87.1%	87.8%	87.1%	88.3%
Your org	65.6%	70.0%	80.9%	80.5%	84.1%
Average	70.5%	75.0%	76.2%	75.5%	76.7%
Worst	42.6%	55.6%	57.1%	59.6%	60.2%

This question has seen a 20% improvement since 2014 and confirms we are trying hard to put the patient at the heart of all its decisions and actions. This is very close to the top scoring acute Trust and significantly above average. It is a good indicator of our perceived culture.

Performance in the five key areas

The score distribution across the five key areas of the survey is shown below.

	Your Job	Your Manager	Your Health, Wellbeing & Safety	Your Personal Development	Your Organisation
Above average	30	11	20	6	12
Average	0	0	2	0	0
Below average	0	0	15	2	0

All the scores relating to a colleagues own job, their manager and the organisation are above average for an acute Trust in England.

The scores relating to health, wellbeing and safety are much more variable, with almost half at average or below average. These questions reflect similar themes of concern to previous years around the colleagues experience of violence and aggression, stress, feeling under pressure to come to work, working long hours, bullying from colleagues, discrimination and being treated fairly.

The personal development scores largely reflect the position that colleagues have regular appraisals and that their work is valued, but that appraisals do not always help them to do their job or identify their training needs.

Where the Trust has performed significantly above average

The results have been analysed and we performed very close to the best performing acute Trust in a number of areas such as the two below:

I am enthusiastic about my job

	2014	2015	2016	2017	2018
Best	79.6%	85.0%	80.3%	79.2%	81.7%
Your org	72.0%	72.2%	78.4%	76.0%	78.9%
Average	69.4%	75.0%	75.2%	74.1%	74.8%
Worst	58.9%	67.0%	69.7%	67.9%	69.3%

We have performed well in this question since 2016.

I feel that my role makes a difference to patients / service users

	2015	2016	2017	2018
Best	95.0%	93.8%	92.8%	92.9%
Your org	90.8%	92.1%	91.1%	91.8%
Average	90.4%	90.4%	90.1%	89.5%
Worst	85.8%	87.9%	86.0%	84.1%

SFH is just over 1% less than the best score for this. The results for this question correlate with the high scores for staff recommending us as a place to receive care and colleagues report that they believe that the care of patients / service users is our top priority.

Where staff experience is significantly below average

The areas where we are significantly below average (more than 3% adverse to average) all appear to be clustered in the questions relating to health, safety and wellbeing. A couple of examples are shown below:

On average how many additional paid hours do you work per week for this organisation over and above your contracted hours?

	2014	2015	2016	2017	2018
Worst	45.5%	45.0%	48.4%	46.7%	46.0%
Your org	37.0%	36.0%	37.6%	37.3%	43.0%
Average	33.4%	35.1%	34.9%	35.7%	37.1%
Best	25.3%	20.3%	26.6%	26.5%	27.7%

This has increased by 6% over the last five years. It is potentially an indicator of the amount of overtime and bank shifts substantive employees are voluntarily undertaking to cover gaps in rotas. It is well below average and indicating that SFH employees are working more hours than the average acute Trust member of staff. However, it is positive that these are PAID hours. On the question concerning excessive UNPAID hours, we are reporting slightly better than average performance.

Have you felt pressure from your manager to come to work?

	2014	2015	2016	2017	2018
Worst	44.0%	41.1%	33.2%	35.1%	35.2%
Your org	39.6%	41.1%	33.2%	33.9%	35.2%
Average	33.3%	29.5%	27.1%	26.7%	25.9%
Best	20.8%	18.3%	18.2%	17.0%	19.1%

We are the worst performing acute Trust here. The theme of colleagues feeling pressurised to come to work when they feel unwell, is a prevalent theme, often linked to our sickness absence policy. However, when the trend analysis is scrutinised, it shows that there has actually been improvement in SFH when compared to 2014 and 2015.

In the last 12 months how many times have you experienced physical violence at work from patients / services users, their relatives or some other members of the public?

	2014	2015	2016	2017	2018
Worst	21.3%	22.1%	21.0%	22.2%	21.2%
Your org	21.3%	14.3%	19.1%	19.5%	20.0%
Average	14.9%	14.6%	15.7%	15.1%	14.3%
Best	8.4%	9.8%	8.2%	9.6%	10.1%

Whilst not the worst performing acute Trust, SFH is significantly below average here and SFH colleagues appear twice as likely to experience this as the best performing acute Trust. This appeared to improve significantly in 2014, but then rose again to previous levels. This is again a recurrent theme.

Actions and monitoring.

The results are to be communicated to colleagues in a number of ways including electronic and face to face briefings. Some of the positive results will also feature our recruitment campaigns.

The reports are analysed including scrutiny of the individual (anonymous) comments that were captured in the free text as these provide further important context. Analysis is also undertaken by staff group, Division and Department and site. Our new People, OD and Culture Committee will consider the themes and comments in detail.

Our Divisions are sent a copy of the SFH report, their Divisional results and the free text comments. They explore the themes further with their teams and develop action plans pertinent to their Division to address areas of concern. This also applies to corporate areas.

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce KPIs and Speaking Up concerns. This enables more targeted actions and interventions to be identified, supported by our OD Team and HR Business Partners

There will be Trust wide initiatives for incorporation into the Workforce Strategy 2019/20 Implementation Plans, particularly in relation to our culture and leadership work. These include a strong focus on employee health, safety and well-being and diversity and inclusivity aimed at addressing recurrent themes. Initiatives to address colleagues experiencing physical violence at work from patients / services users, their relatives or some other members of the public will be prioritised as will those aimed at reducing stress at work.

A Staff Survey Conference is scheduled to be held at both the King's Mill Hospital and Newark Hospital. This is aimed at engaging further with both staff and managers to identify how to address the key areas of concern.

The results will be discussed at the Staff Communication and Engagement Forum and with our staff side in order to obtain their views on priority actions.

The Diversity and Inclusivity results will be scrutinised by our Diversity and Inclusivity Group and appropriate actions incorporated into its work programme. The performance of the programme is reported through to the People Culture and OD Committee. Such performance and activity is reviewed in light of key priorities associated with the Trusts requirements under the Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS)

Equality Reporting

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

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

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

The Diversity and Inclusivity Group regularly review reports on equality data, including workforce information, recruitment data, the workforce race equality standard (WRES), the equality delivery system (EDS2), the gender pay gap and the staff survey. An equality dashboard is reviewed by the group on a six monthly basis, investigating equality patterns to improve the experience of staff and patients.

We publish relevant, proportionate information on our internet and intranet site, demonstrating our compliance with the Equality Duty. We have a three year Equality Strategy, which is available to the public, which includes specific measurable equality objectives we will be working towards.

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

Valuing our Members

		Total membership (March 2018)
Mansfield	includes the geographic boundaries of Mansfield District Council and the ward of Welbeck from Bassetlaw District Council	4782
Ashfield	includes the geographic boundaries of Ashfield District Council and the wards of Ravenshead and Newstead from Gedling District Council	4662
Newark and Sherwood	includes the geographic boundaries of Newark and Sherwood District Council plus wards from Bassetlaw, South Kesteven and Rushcliffe District Councils	3710
Derbyshire	includes wards from Bolsover and North East Derbyshire District Councils	1574
Rest of East Midlands	includes the remainder of the East Midlands region which is not covered in the other constituencies	805
Rest of England		146

Public membership breakdown at 31 March 2019

	Number of Members	Membership Profile	Population Profile	Trend
Age (years)				
0 – 16	0	0%	19.79%	↓
17 – 21	58	0.37%	6.17%	↓
22+	14, 437	92.27%	74.04%	↓
Not Stated	1,152	7.36%	0%	↓
Ethnicity				
White	13,978	89.33%	89.29%	↓

Mixed	30	0.19%	1.90%	→
Asian	84	0.54%	6.46%	↑
Black	32	0.20%	1.79%	→
Other	8	0.05%	0%	→
Not stated	1,515	9.68%	0%	↑
Gender				
Male	5,703	36.45%	49.45%	↑
Female	9,744	62.27%	50.55%	↓
Not stated	200	1.28%	0%	↑

Membership activity throughout the year

As part of our commitment to having an active membership, we have worked with the Governors' Membership and Engagement Committee during 2018/19 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 we are 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

In May 2018 we introduced a new way of showcasing the services we provide and reach out to more members by launching monthly digital events. The first digital event was sent out to our members via the monthly e-newsletter Trust Matters. Roger's Story, a video all about a prostate cancer patient and how a clinical trial has extended his life by over five years proved very positive. Further member events are held at locations across the area including King's Mill, Newark and Mansfield Community Hospitals.

Meet your Governor events

Once a month our Governors meet with patients, families, service users and SFH colleagues to discuss any concerns, compliments or ideas. These events are undertaken across all three hospital sites, enabling 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.

Community member engagement

We continue to work closely and engage with our members and community and attended the Newark Hospital open day and also West Nottinghamshire College open evening to promote membership to the younger generation.

Annual General Meeting/Annual Members' Meeting

Held on 24 September 2018 at King's Mill Hospital, this event was attended by members who visited the interactive display stands as well as attending the health check event and the Annual General Meeting itself.

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

Members can contact their Governors either through our website or by contacting the Director of Corporate Affairs, Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, HG17 4JL or emailing sfh-tr.governors@nhs.net.

Valuing our Governors

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

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

In addition, the Council of Governors, amongst other matters, is responsible for making decisions regarding the appointment or removal of the Chair, the Non-Executive Directors and our External Auditors.

Our 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.

The new process to enable a more robust approach for 'holding the Non-Executive directors to account', agreed in 2017/18 was embedded during the year, and a review of the process was discussed at the Council of Governors at its February 2019 meeting. All observer Governors reported positively on the process and their role on the committees and how this had improved relationships with the chairs of those committees and the wider Non-Executive Director team. The process will be enhanced going forward to ensure the observers of the committees play a role in the appraisal of the chair of that committee. The Membership and Engagement Group includes all Council members and this group oversees the engagement and feedback role of Governors. The Nominations and Remuneration committee remains and reports to the Council with recommendations regarding appointments, removal and any other requirements appropriate to their role.
During the year, the Council also recruited two new Non-Executive Directors with significant and wide ranging experience to enable a more in-depth debate in Board and at the Council.

Attendance at Council of Governor meetings

There have been four general Council meetings during the year. The following table details the Governors, the constituency they represent, their attendance and the date of their appointment.

NAME	AREA COVERED	CONSTITUENCY	TERMS OF OFFICE	DATE ELECTED	NUMBER OF MEETINGS ATTENDED
Amanda Sullivan	M&A and N&S CCG	Appointed	1	01.06.17	3/4
Angie Emmott	Newark Hospital	Staff	3	01.05.16	4/4
Ann Mackie	Newark & Sherwood	Public	3	01.05.16	4/4
Councillor David Payne	Newark & Sherwood District Council	Appointed	1	15.05.18	2/4
Councillor John Doddy	Nottinghamshire County Council	Appointed	4	25.07.17	2/4
Councillor Helen Hollis	Ashfield District Council	Appointed	1	14.05.18	2/3
Dilip Malkan	King's Mill Hospital	Staff	3	01.05.16	1/4
Ian Holden	Newark & Sherwood	Public	3	01.05.16	4/4
Jackie Hewlett-Davies	Ashfield	Public	3	01.05.16	4/4
Jane Stubbings	Ashfield	Public	3	01.11.17	4/4
Jayne Leverton	Ashfield	Public	3	01.05.16	4/4
Jim Barrie	Newark & Sherwood	Public	3	01.05.16	3/4
John Roughton	Mansfield	Public	3	01.10.17	1/2
John Wood	Mansfield	Public	3	01.05.16	3/4
Keith Wallace	Mansfield	Public	3	01.05.16	3/3
Louise Knott	Vision West Notts	Appointed	3	01.03.15	2/4
Martin Stott	Newark & Sherwood	Public	2	01.05.16	3/4
Morgan Thanigasalam	King’s Mill Hospital	Staff	3	01.10.17	4/4
Nick Walkland	Rest of East Midlands	Public	3	01.05.16	3/4
Ron Tansley	King's Mill Hospital	Volunteer	3	01.05.16	3/4
Roz Norman	King's Mill Hospital	Staff	2	01.05.16	4/4
Samantha Annis	Newark Hospital	Staff	3	01.05.16	0/4
Susan Holmes (lead)	Ashfield	Public	3	01.11.17	4/4
Valerie Bacon	Derbyshire	Public	3	01.08.16	3/4

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

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

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

Governors have undertaken their statutory duties with enthusiasm and we appreciate their commitment as we continue our improvement journey into 2019/20.

Governor elections 2019

There were significant Governor Elections during March and April 2019, with13 public governors across all public constituencies, two from the Ashfield Constituency, four from the Mansfield Constituency, four from the Newark Constituency, two from the Derbyshire Constituency and one from the Rest of the East Midlands Constituency. Staff Governors were also sought, two for Kings Mill and Mansfield Community Hospitals and two for Newark Hospital. Volunteer Governors were also due for election at this time.
The elections saw a turnout of 11.3%, with 17 Governors elected, there were no candidates nominated for the Volunteer Governors.

The following Governors were elected:

Public Governors

- **Mansfield Constituency**
  Tony Eggington, Belinda Salt, Gerald Smith and John Wood
- **Newark and Sherwood Constituency**
  Ian Holden, Ann Mackie, Richard Shillito and Martin Stott
- **Ashfield Constituency (unopposed)**
  Philip Marsh and Kevin Stewart
- **Derbyshire Constituency (unopposed)**
  Valerie Bacon and Brian Bacon
- **Rest of East Midlands Constituency (unopposed)**
  Lawrence Abrams

Staff Governors

- **Kings Mill Hospital and Mansfield Community Hospital**
  Roz Norman and Jayne Revill
- **Newark Hospital**
  Richard Boot and Jacqueline Lee

Annual Lead Governor report 2019

This has been an excellent year to be Lead Governor with the Trust being rated as Good overall by CQC, and the care we all receive as patients finally being recognised as Outstanding. However the journey is not finished yet with everyone striving to achieve an overall rating of outstanding the next time the CQC come.

Once again, I was involved in the judging of the Staff Excellence Awards with even more nominations – this year around 600. It was an extremely difficult task and heartening to know that so many staff had been nominated for an award by their colleagues. The awards evening is a very glamorous affair (paid for by sponsors), and felt like a fitting tribute to the winners.

I and other Governors were also delighted to be invited to the Long Service Award presentations for our volunteers who are 'the heart' of our hospitals. Where would we be without the way finders, buggy drivers, those who carry out the ward trolley rounds, the tea and toasted teacake volunteers in the café and so many others carrying out jobs? There are far too numerous to mention them all. This year they have been involved in raising a staggering amount towards the Gamma Scanner Appeal with it now hitting the £270,000 mark. Thank you to each and every one.

Exciting times lie ahead with changes to local health services and the way we work together, particularly being pro-active in improving the health of our local communities. I am excited to see how this fits into the new Trust strategy and how the Governors can support this.

Another new feature for Governors this year has been our involvement in the 15 steps programme where we join up with senior clinical and non-clinical managers to visit a patient area and see what the first 15 steps into that area feel like. We look for how clean is the area, what does the atmosphere feel like, are we challenged on hand hygiene etc. Governors are encouraged to do one a month and it has been enlightening to be part of this process and feedback to the Trust areas that we think are doing well and areas which could be improved.

This year we have elections for 19 Governors in public, staff and volunteer constituencies. The new Governors will be taking up their posts at the beginning of May 2019. We sometimes forget that Governors are volunteers too who unstintingly give of their time to ensure that you receive the best treatment possible, that your voice is heard and that our Non-Executive Directors are held to account. Some of our Governors will be retiring as they have completed the maximum three terms of three years each:

- Jim Barrie – Public Governor for Newark
- Angie Emmott – Staff Governor for Newark
- Ron Tansley- Volunteer Governor for Kings Mill and Mansfield Community Hospitals.

Thank you to them all.

Sue Holmes
Public Governor for Ashfield and Lead Governor

NHS Foundation Trust Code of Governance

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

Relating to	***Code of Governance* reference**	**Summary of requirement**	**Reference** **Page numbers**
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	25 67-69 81
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report.	25 41/42
Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	66/67 70
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	68
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	25

Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	(refer to website for profiles)
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	41
Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	42
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	42
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	25
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	67/68
Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by	N/A

		section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	36/37
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	27
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.93.	25 32/33 100
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	85 92 101
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	79

Audit Committee/ Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/A
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	78 79
Board/Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	66

Board/Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	65/66
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	67
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	65-67
Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.	25

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

Our Board of Directors brings a wide range of experience and expertise to its stewardship of the organisation and continues to demonstrate the vision, oversight and encouragement required to enable our organisation to thrive and improve on a continuous basis. During the past year we welcomed 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 our strategic direction and ensuring effective and efficient performance. The Chair conducts annual appraisals of the Non-Executive Directors as well as the Chief Executive.

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

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

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

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

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

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

Counter fraud

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

We continue to work to maintain an anti-fraud culture and we have in place a range of policies and procedures to minimise risk in this area. Colleagues have access to counter fraud awareness training which forms part of employee induction training on joining the organisation and a number of bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. In November 2018 we took part in Fraud Awareness Month and a number of alerts were issued to employee' e.g. online fraud, telephone scams and a counter fraud staff survey. We also disseminate the counter fraud newsletter 'Fraudulent Times' which helps raise awareness of fraud cases and how to identify where and how fraud can occur.

NHS Resolution

Our CNST premium has increased by £2.26m in 2018/19 (£10.58m to £12.84m). This represents a 21% increase.

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2018/19 these committees included:

- The Audit and Assurance Committee's the principal purpose of which is, to enhance confidence in the integrity of the Trust's processes and procedures relating to internal control and corporate reporting.
- The Quality Committee, which enables the Board to obtain assurance regarding standards of care and to ensure that adequate and appropriate clinical governance structures, processes and controls are in place.
- The Finance Committee, which oversees the development and implementation of our strategic financial plan and the management of the principal risks to achieving that plan

A review of our governance structure was undertaken in 2018/19 and it was agreed to establish a People, OD and Culture committee to enable the Board to obtain assurance regarding the challenges and mitigations with regard to the workforce and to understand and influence the culture of the organisation. This committee will commence in April 2019 and will be chaired by a Non-Executive Director

Audit and Assurance Committee

The Audit and Assurance Committee was chaired by Non-Executive Director Graham Ward , who is a fellow of the Chartered Institute of Management Accountants and has 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:

- Graham Ward 6/6
- Tim Reddish 5/6
- Claire Ward 4/5

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, PWC, 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 SFH colleagues to actively promote, 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 intranet. The Audit and Assurance Committee routinely receives financial information, including cash and liquidity and the going concern status of the organisation, as well as operational information.

Key agenda items of the committee during the year were:

- Operation of the Board Assurance Framework document,
- Report with regard to delivery and performance against the internal audit plan for 2018/19, of the 18 audit assignments included within the Plan, to date, eight reports have been issued with Significant Assurance, and were submitted to the relevant committee for discussion and monitoring, and two reports were issued with Limited Assurance; the lead executive presented these reports to the Audit & Assurance Committee and discussed the actions, providing assurance with regard to timelines and agreement to deliver the changes required. Two reports have been issued relating to advisory reviews and, therefore, did not have an opinion. Six reviews from the 2018/19 Plan have still to be concluded.

  Three reviews from the 2017/18 Plan were also concluded in year, 2 providing significant assurance and 1, relating to an advisory review, issued without an opinion
- Progress and achievement of actions against all internal audit reports are reported to committee.
- Counter Fraud progress reports are discussed at the committee and we were involved in the National Fraud Initiative.
- The SRT process summary was completed and the submission rated as green with an overall improvement on the previous year.
- Information Governance is discussed at each meeting and the committee were updated with progress against the IG Toolkit requirements, General Data Protection Regulation (GDPR) requirements.
- The committee received annual reports with regard to risk, procurement and counter fraud
- The Data Quality Group reported the planning requirements and progress during the year.
- The Committee requested a deep dive report into the clinical audit process and cyber security
- The Register of Interests is reported to each committee, significant improvement has been made this year with further initiatives to improve compliance being implemented
- The Clinical Audit planning process was presented and agreed by the committee.
- As part of the year-end process and approval of the accounts to the Board for ratification, in order to assure themselves of the effective financial propriety of the Trust, the committee reviews and takes into account:
    - The head of internal audit opinion on both financial and non-financial matters
    - The external audit opinion on the accounts, including the external value for money opinion
    - The letter of representation to external audit
    - Going concern/principal risks and uncertainties
    - Review of accounts and external audits ISA260

2017/18

- Financial Statements – one uncorrected mis-statement and one material adjustment relating to the PFI, additionally there was a prior period adjustment.
- Value for Money conclusion – modified VFM conclusion in respect of financial position and license condition,
- Quality Account – A clean limited assurance opinion on the content and consistency of the Quality Account. The auditors provided a qualified assurance opinion on the 2 mandated performance indicators. Action plans had been agreed with the divisions and progress reports were received during the year.

2018/19

External audit plan including significant risks

Standards of business conduct

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

Internal audit (360 Assurance)

The Audit Plan for 2018/19 was developed in line with the mandatory requirements of the NHS Internal Audit Standards. 360 Assurance, an external service, has worked with us to ensure the plan was aligned to the risk environment. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or underway. All audits with Limited Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate committee, either Finance or Quality. However our Audit and Assurance Committee receives a report stating which reports have been reported to other committees. Outstanding recommendations from internal audit are reported to our Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the organisation. Where owners of recommendations have not completed the actions by the implementation date they are invited to Audit & Assurance Committee to report on progress.

External audit service

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

We incurred £78,084 net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12 month period to 31 March 2019 (£76,553 net of VAT for the period to 31 March 2018). Non-audit services amounted to £8,636 net of VAT (£8,434 net of VAT for the period to 31 March 2018)in respect of the Quality Report.

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

Remuneration and Nomination Committee

As at 31 March 2019 and on-going, membership of the Remuneration and Nomination Committee comprises John MacDonald as Chair and all Non-Executive Directors. The attendance of Non-Executive Directors is detailed within the Remuneration Report.

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

Remuneration and Nomination Committee of the Council of Governors

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

Compliance with the Code of Governance

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

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2019, the Board considers that it was fully compliant with the NHS Foundation Trust Code of Governance with the following exceptions, where we have alternative arrangements in place.

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

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

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

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

We have a detailed scheme of delegation, which was reviewed and updated during 2018/19. This sets out, explicitly, those decisions reserved to the Board, those which may be determined by standing committees and those which are delegated to managers.

All members of our Board are invited to attend all public meetings of the Council of Governors. Governors and Non-Executive Directors take part in internal assurance visits to clinical areas across our sites and are involved in patient and staff engagement events.

Our Executive Team consulted with the Council of Governors during the year on matters such as the annual plan, Trust Strategy, quality account and quality indicator and other relevant strategies and reports.
In a NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Council of Governors. The appraisal of the Chair is therefore carried out for and on behalf of our Council of Governors by the senior independent director, supported by the lead Governor. Together they review the Chair's performance against agreed objectives and discuss any development needs before reporting the outcome of the appraisal to the Nomination and Remuneration Committee of the Council of Governors. This committee in turn reports to the Council of Governors.

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

NHS Improvement Single Oversight Framework

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

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

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

Segmentation

NHS Improvement, approved us moving from SOF categorisation segment 3 to segment 2 in January 2019. NHSI commented, '*We see this as a positive step forward for the Trust in terms of the progress that has been made and recognition of the hard work that has been done by you and all your teams:'*

We have scored positively with regard to the Income & Expenditure Margin as a result of achieving the control total and also positively for being under the agency ceiling.

This segmentation information is the Trust's position as at 31 March 2019. The latest segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

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

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

Area	Metric	2018/19 Scores				2017/18 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	3	3	4	4	4
Financial efficiency	I & E margin	4	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	1	4	2	1
	Agency spend	1	1	2	2	1	1	1	2
Overall Scoring		3	3	3	3	3	3	3	3

Foundation Trust License

Monitor applied a section 111 on us in April 2015 with regard to concerns in respect of leadership and governance. NHS Improvement removed this condition on our license in January 2019. NHSI confirmed 'The *concerns about the Trust's leadership, capability and governance, which triggered the imposition of the additional license condition, have been satisfactorily allayed*.'

There are now no additional conditions on our Foundation Trust License.

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.

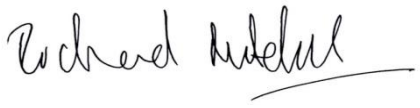
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Sherwood Forest Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts 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 and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- prepare the financial statements on a going concern basis.

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

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



Signed…….
Richard Mitchell **23 May 2018**

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Regulation

The Care Quality Commission (CQC) undertook a full announced inspection of our Core Services during April 2018, with a well- led review in May 2018. We improved our overall rating from Requires Improvement to Good.

We are fully compliant with the registration requirements of the Care Quality Commission.

The Trust has regular engagement meetings, involving the Medical Director and Chief Nurse with the Trust CQC Relationship Manager and the regional CQC Inspection Manager. The meetings are held every six to eight weeks and include a discussion on a wide range of issues ranging from examples of good practice in addition to areas of concern.

To demonstrate ongoing compliance the Trust undergoes inspections by the Care Quality Commission of all core service areas across the Trust providing further opportunity to ensure the Trust continues to meet the requirements of its registration.

Monitor applied a section 111 condition on our license in April 2015 with regard to concerns in respect of leadership and governance. NHS Improvement removed this condition on our license in January 2019. There are now no additional conditions on our Foundation Trust License.

Capacity to handle risk

Our Board of Directors provides leadership on the overall governance agenda. On the Board's behalf our Risk Committee has maintained and kept under review a policy for the management of risk. Our Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Audit & Assurance Committee, Finance Committee, and Quality Committee. Our Risk Committee is an executive committee focussing on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. Our Risk Committee is chaired by our Chief Executive (CEO) and comprises of selected members of

the Senior Leadership Team. Senior managers and specialist advisors routinely attend each meeting. We have kept under review and updated risk management policies during the course of the year. The output of the Risk Committee's work is reported to our Board and the CEO also ensure the Risk Committee works closely with front line divisional teams and all Committees of the Board in order to anticipate, triangulate and prioritise risk; working collectively to continuously balance and enhance risk treatment.

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

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

All significant risk exposures are reported to Board of Directors and Risk Committee at each formal meeting. All new significant risks are escalated to the Chief Executive and subject to validation by the Executive Team and Risk Committee. The residual risk score determines the escalation of risk and this is clearly established and embedded.

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

The risk and control framework

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

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

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

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

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

5. **Risk Reporting**

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

6. **Risk Review**

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

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

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

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

Table 1: Clinical, Operational and Financial Sustainability Risks

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

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

It is not envisaged these risks will change over the coming year. 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.

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

- Weekly PTL meetings for RTT and Cancer including;
    - A review of current position at reporting specialty level and action plans to address failing services
    - Patient level review of long waits
    - Monitoring of operational reports that impact on elective care data e.g. outpatient referral and waiting list management reports

    - Access to live self-service RTT PTL
- Elective Care Training programme for administrative staff involved in the management and validation of elective care pathways
- RTT and Data Quality educator with remit to improve data accuracy of reported information through various mediums
- Clear lines of responsibility for the management of patient pathways including the Central Booking Team, Operational Managers, waiting list staff, Cancer Tracking Team, Operational Outpatient Teams, Patient Pathway Coordinators, Data Quality Validation Staff
- A validation team who review and correct data on a daily basis to ensure accuracy
- Chief Operating Officer nominated and responsible for the sign-off of RTT and cancer returns.

In addition, we have a data quality strategy, which sets out our approach to improving our data quality, through responsiveness, proactivity and continuous improvement. This is supplemented by an annual work-plan, the delivery of which is overseen by our Data Quality Group. This includes plans for auditing, training and initiatives to address known areas of data quality deficiency. Our data quality dashboard includes KPIs that reflect known risks to the accuracy of our data, whilst further audit work by Internal Audit provides further assurance regarding data quality.

During the year we had an external Well-led review, the full details of which are available earlier in this report and on our website https://www.sfh-tr.nhs.uk/media/5207/sherwood-forest-hospitals-nhs-ft-final-report-141218.pdf

We share our Board Assurance Framework with the Council of Governors who are also involved in observing board committees where specific risks are discussed and mitigations agreed. The Governors also feedback from their engagement with members any risks identified. We also engage with our Clinical Commissioning Group (CCG), overview and scrutiny committee and healthwatch with regard to any risks inherent in service changes and developments.

Clinical Audit -National Audits

We actively participate in the National Clinical Audit Programme, and have done so for many years. This provides assurance to the Board of Directors and informs regulatory oversight. In 2018/19 the outcomes from national clinical audits can be summarised as follows:

- The Intensive Care National Audit & Research Centre (ICNARC) has shown that we have the lowest hospital mortality rate in the Trent network region along with a low re-admission rate of 0.8%.
- The Chronic Obstructive Pulmonary Disease (COPD) Audit results showed we achieved greater than the national average for administering Non Invasive Ventilation within the standard of three hours; national average is 30%, whilst SFH achieved 49% for the same period.
- The National Hip Fracture Database (NHFD) indicated that patients undergoing a Delirium assessment at pre-operative stage have increased significantly from 4.5% to 80.8%. In addition to this our post-operative length of stay has improved from an average of 13.2 days to 10.3 days.
- The Royal College of Emergency Medicines audit relating to Pain in Children shows that we are above the National Average for administering analgesia to patients with moderate pain within 20 minutes of arrival.
- The National Ophthalmology Database audit has indicated that cataract operations performed at the Trust have a complication rate of 0.24% compared to the benchmark national standard of around 1%.
- The National Cardiac Audit programme - Angioplasty Audit showed there has been a year-on-year increase in the use of radial artery access for angioplasty and the use of modern generation drug-eluting stents, both of which are associated with improved outcomes for patients.

- The National Emergency Laparotomy Audit (NELA) indicates that there is a Consultant Anaesthetist and Consultant Surgeon in Theatre where there a risk of death 5% or greater in 99% of cases. This compares very favourably against both regional (79%) and national (83%) averages.
- The National Neo-natal Audit programme shows we administered antenatal magnesium sulphate to 91.5% of women who are at risk of delivering preterm babies compared to the national average of 64%.
- The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE-UK) Perinatal Deaths for Births report has shown an improvement in the survival for twins with the stillbirth rate halved since 2014 and the neonatal death rate for twins reduced by a third for the same period.
- The National Cardiac Arrest Audit shows that our survival rate for patients in Shockable and Non-shockable rhythms is above the national average.

Workforce

Our workforce plan is linked to our workforce strategy, "Maximising our Potential", which seeks to attract, engage, develop, nurture and retain staff whilst supporting optimum performance. This strategy was approved by our Board in 2017 and contains annual implementation plans, with progress regularly reported to our Board and associated Committees.

Our workforce strategy and plan reflects our numerical and skill mix requirements and is aligned with the Integrated Care System People & Culture Strategy. It is consistent with our financial, quality and activity plans and also supports the Developing Workforce Safeguards recommendations as it is the result of a structured cross-trust approach.

In developing our workforce plans, divisional teams are supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver anticipated activity levels, in the short, medium and longer term. This bottom up approach to ensuring we have safe and adequate staffing levels is supported by our executive-led Workforce planning group. In addition, we have a Medical Taskforce led by the Executive Medical Director and a Nursing Taskforce led by the Chief Nurse.

Regular, nurse staffing establishment reviews are also undertaken and we have invested in e-Rostering, e-Job Planning and Clinical Activity Manager system. These all help better align our staffing to our activity and acuity levels.
Historically we have been disproportionately reliant on a temporary workforce due to recruitment challenges which arose for a number of reasons, including our geographic location, market factors affecting the domestic supply of available qualified employees and challenges with international recruitment. However, in the past 18 months we have made significant progress in increasing our substantive workforce, extending our pool of available bank workers and strengthening our temporary staffing governance processes. This has significantly reduced our dependency on higher cost agency staff and for 2017/18 and 2018/19, we have delivered our NHSI agency control total.

Part of our approach to workforce planning is to ensure that we optimally utilise the workforce that we already have. Electronic rostering and electronic job planning are key parts of our strategy and they are already well embedded in the organisation for both nursing and medical colleagues.

Key risks concerning workforce capacity and capability are contained in the Board Assurance Framework and were regularly reviewed by the Quality Committee during 2018/19.

New roles are being developed in order to support our medium and longer term workforce requirements. These include the use of nurse associates and nurse apprentices and the introduction of Advance Clinical Practitioner and Doctors

Administrator roles. During 2018/19, we made effective use of our Clinical Fellow Programme and CESR doctors, which is being extended into Geriatrics.

We will continue to work closely with Health Education East Midlands (HEEM), and be guided by the Local Workforce Action Board (LWAB) and national policy. We continued to work with partners such as East Midlands Leadership Academy (EMLA) and NHS Elect during 2018/19 in order to develop the existing workforce.

The combined impact of internal efficiency improvements and the ICS led transformation work resulted in some re-shaping of our services in 2018/19 and will continue over the medium and longer term. We will see growth in some areas through the introduction of new roles to meet planned activity changes, but a reduction in others due to meeting our financial control total and responding to ICS changes. We are also taking a lead role in the establishment of a Talent Academy for the system and we coordinate all work experience placements for Nottinghamshire.

The Apprenticeship Levy continues to be an effective tool in supporting workforce transformation across our organisation and the wider ICS. We intend to develop and grow year on year the number of apprenticeships we support. We are determined to achieve an appropriate balance of clinical and non-clinical apprenticeships. The levy is also being used to support leadership development with levy funded Masters Programmes.

International recruitment of both doctors and nurses is a key part of our workforce strategy. We have also assessed the risk associated with EU nationals in our workforce. We anticipate the impact of Brexit on our workforce supply to be minimal, due to our limited reliance on EU staff. However, we have taken steps to make funding available to cover the cost of our EU colleagues applying to the settlement scheme as a precautionary measure.

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

We are compliant with NHS Foundation Trust Condition 4. Our governance committee structure has provided our Board of Directors with assurance during the year with regard to quality, including compliance with the CQC standards and finance, particularly with regard to specific issues raised by NHS Improvement in terms of loans and working capital facility.
During the year, our Board has received assurance regarding the performance through the Single Oversight Framework Integrated Performance Report and supporting exception reports for indicators rated as red on the performance dashboard, bringing together performance metrics and information relating to workforce, quality priorities, staffing and finance.

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

We are registered to provide healthcare on the following hospital sites – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital and Ashfield Health Village. The registration requirements are reviewed on an annual basis with our CQC Local Team. The Chief Executive, Chief Nurse, and the Deputy Director of Governance and Quality Improvement facilitate a regular engagement meeting every six weeks with our CQC Relationship Manager and the Lead Inspector. This meeting provides an opportunity for us to demonstrate ongoing improvements in care but also an opportunity for CQC colleagues to gain assurance that timely and appropriate actions are in place to address issues raised through incident reporting, complaints and patient experience feedback. Since July 2017 CQC colleagues have visited a specialty area during the engagement meeting to enable them to meet SFH colleagues and further understand

about the care we provide to our patients. These visits have been received very positively by both parties and have provided additional assurance that we understand where we provide excellent care and where there is further work to do.

We are fully compliant with the registration requirements of the Care Quality Commission.

We have published an up-to-date register of interests for decision-making colleagues within the past twelve months, as required by the 'Managing conflicts of Interest in the NHS' guidance

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

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

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

We have undertaken numerous public stakeholder engagement events during the year providing a great deal of focus on the development of our new strategy, together with the development of our public engagement strategy. More detail is provided earlier in this report within the consultation of local groups and organisations section.

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

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

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

We continue to actively recruit to our employee establishment and have been successful in reducing our number of vacant posts, but recruitment difficulties continue in the nursing and medical workforce. Although the challenges in our nursing and medical workforce remain we have reduced our spending on agency and locum colleagues and continue to be within the ceiling set by NHS Improvement. Agency spending reduced in year to £14.3m against a target of £16.7m.

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

- **Executive-led Taskforces:** We have a Medical Taskforce and a Nursing Taskforce, both of which are core work streams within our Cost Improvement Programme (CIP). The Medical Taskforce is led by our Medical Director, and the nursing equivalent by our Chief Nurse. Fortnightly work stream meetings are chaired by the executive lead.
- **Cost Improvement Programme (CIP) Board:** Every month the CIP Board, chaired by the Chief Financial Officer, and featuring wider executive membership together with representatives from the programme management office and divisional management teams, seeks assurance of progress against the agreed savings trajectory for all workstreams including the executive led Taskforces.

- **Finance Committee:** The CIP Board presents an exception report to the Finance Committee detailing progress against savings trajectories, as well as core risks of non-delivery with respective mitigating solutions. The Finance Committee also receives detailed financial operating and outturn information, including pay spend and assurance about financial control.
- **Risk Committee:** This Committee receives assurance regarding the risks on the Board Assurance Framework, a number of which relate to workforce recruitment and retention, organisational sustainability and financial performance.
- **Trust Board**: The t Board receives assurance from its committees mentioned above. In particular, the Finance Committee provides assurance to the Board about performance of the Trust's CIP programme and overall financial position. A comprehensive dashboard and report on agency spend is presented monthly.

The formal strategic partnership with Nottingham University Hospitals NHS Trust remains in place, (following the decision in October 2016 not to pursue a formal merger) to share improvements in working practices and the avoidance of unnecessary costs across the Integrated Care System.

These arrangements have been with the full agreement and support of NHS Improvement, with formal governance arrangements in place throughout and related resourcing approved by NHS Improvement.

We have ended the year with a deficit of £17.1m. Adjusting for a reversal of previous asset impairments and other non-control total items gives a control total basis deficit before PSF of £46.3m, £0.1m better than agreed with NHS Improvement. Details relating to this position are included elsewhere in this report. Despite meeting our agreed financial control totals, we remain in a financially challenged position with a significant underlying deficit. We work closely with our commissioners and NHS Improvement to manage contractual risks and our liquidity position. We are working with partners to identify and implement health economy improvements to deliver financial savings across the regional footprint, whilst also delivering improvements in service provision and patient experience. Our partnership work in the Nottinghamshire-wide Integrated Care system is pivotal to achieving this.
Liquidity support has been agreed with NHS Improvement/the Department of Health and Social Care in the form of loans. A total of £36.3m of revenue support term loans have been drawn down during 2018/19. 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 2019/20 and we are planning to deliver the deficit control of £14.9m set by NHS Improvement. It is therefore our intention to prepare our accounts on a going concern basis. A detailed going concern paper was reviewed and approved by the Audit and Assurance Committee in support of this assessment, and is subject to an external audit review as part of the annual accounts process.

Our programme management office supported us in achieving cost improvement programme savings of £16.5m in 2018/19. The improvements realised include: clinical productivity gains, medical and nurse agency cost reductions, corporate services cost reductions and PFI maintenance savings. 2019/20 plans are in place to continuously improve on our 2018/19 success and deliver further savings. Delivery will be underpinned by the same robust governance process seen in 2018/19.

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

As a result of challenges with regard to recruitment of colleagues, we have a reliance on agency staff, however the shift to improving and utilising bank staff has continued in year. This together with successful negotiation with regard to rates paid to agencies means we have reduced agency expenditure by £2.5 million from 2017/18, ensuring an underspend against the agency ceiling set by NHSI.

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs who is also our Caldicott Guardian and the Chief Finance Officer, who is our Senior Information Risk Owner (SIRO). The SIRO is supported by a network of information asset owners, who ensure the integrity of, and monitor access to, the systems for which they are responsible. The Director of Corporate Affairs as Caldicott Guardian and the SIRO share the chair of the IG Committee. A working group also operates as part of the IG structure. The reporting and management of risks relating to data and security are safeguarded by ensuring all of our employees are reminded of their data security responsibilities through education, at induction and through mandatory training requirements. More than 4,000 colleagues received mandatory IG training in 2018/19, and regular reminders are shared via internal communications. Near misses and lessons learned are used to inform the training programme, ensuring that the programme remains dynamic and reflects current and meaningful issues to facilitate greater employee engagement and ownership of IG processes.

Work continues to raise the profile of IG across a variety of mediums to ensure that incidents and lessons learned are raised to the attention of all employees.

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

Risk Management and Assurance

As part of ensuring continued compliance with the IG agenda, we review the Terms of Reference for the IG Committee on an annual basis. The group has a strategic focus to ensure effective policies, processes and management arrangements are in place covering all aspects of information governance, including:

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

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

The IG Committee monitors the completion of the Data Protection Security Toolkit (DSPT) submission, data flow mapping, and information asset registers. We have implemented the DSPT requirements achieving 100/100 standards met, with two areas having supporting action plans to achieve full compliance by end of June 2019.

NHS Digital released an end of year proposal for those who are approaching a level of standards met in all but a few areas, will be required to provide an improvement plan of how they are going to bridge the gap between their current position and meeting the DSPT standards. The SIRO approved the improvement plan prior to submission.

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2018/2019 in order to ensure refresh of skills and awareness of legislative changes.

Data Flow Mapping

Data from and to SFH is mapped and reviewed on an annual basis. The data flow mapping template has been updated in line with GDPR legal basis Article 6 and Article 9, which now includes categories of data subject/personal data, categories of recipients, information transferred overseas, whether data is retained or disposed of in line with polices, if not why not, national opt out relevant and whether there is a data sharing agreement in place.

The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. During 2018/19 we have undertaken an annual review of information flow mapping to ensure we are assured information flows into and out of the organisation are identified, risk assessed and addressed. This is then expanded to ensure we have assurance all information is stored securely and appropriately and any partners in delivery of either shared care or information storage achieve the same high levels of information governance assurance. Information flows that have been provided have been reviewed and approved by the SIRO.

Serious Incidents Requiring Investigation (SIRI)

As part of the Annual Governance Statement, we are required to report on any Serious Incidents (SIRIs) or Cyber Incidents which are notified on the DSPT reported through to either the ICO or NHS Digital.
To date there have been five, level 2, incidents reported to the Information Commissioners Office (ICO). We have had no further action from the regulators after investigation. The incidents ranged from information being disclosed inappropriately, inappropriate access to medical records, an email being sent to an intended recipient that did not have adequate security. Of the incidents reported only one now remains open and is currently being investigated by the ICO, this relates to high cost drugs being incorrectly addressed by a third party supplier.

Information Sharing

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

Freedom of Information (FOI)

During 2018/19 to date we have processed a total of 530 FOI requests. This function is managed by the IG Team and the activity is demonstrated in the table below.

Total	Breached timeframe of 20 days	Escalated to ICO
530	**180**	**0**

Any breaches in the 20 day response timeframe are due to complex requests that require input from multiple teams or due to an issue with a gap in the process, which has now been addressed and will ensure where possible full compliance.

Of the 530 requests, 524 are currently completed, 2 on hold waiting further information and 4 in progress.

Of the 530 requests completed 422 have been completed within 20 days which show a compliance rate of 80%.

The main themes and trends for FOIs during 2018/19 have been requests regarding temporary staffing and costs, assaults on colleagues and knife injuries.

Subject Access Requests

In 2018/19 we received 3028 requests for access to patient records. The majorities of cases are processed in line with national guidance which is exemplary given some of these cases represent hundreds of pages of information and require methodical attention to detail to ensure information is released appropriately. There have been no complaints to the Information Commissioners Office – any requests for review of content of records by patients have been handled locally and achieved satisfactory resolution for patients. The access to records team have seen a 21 % increase in requests from January 2017 to January 2019 and we are currently monitoring whether this is due to the changes in the DPA 2018 or attributable to other care providers as we work to a more integrated service.

April 2018 to March 2019 Total	**Completed < 21 days**	**Completed 21-30 days**	**Completed > 30 days**
3028	Kings Mill 2369 Newark 381 Information Governance 4	Kings Mill 199 Newark 44 Information Governance 0	Kings Mill 0 Newark 29 Information Governance 2

General Data Protection Regulation (GDPR)

The Data Protection Act 2018 came into force on 23rd May 2018 and enshrined the General Data Protection Regulation into UK legislation.

A summary of the key requirements is detailed below:

1) Lawful, fair and transparent processing – lawful means of processing for a legitimate purpose
2) Limitation of purpose, data and storage – limiting processing and collecting only data that is necessary
3) Data Subject rights - data subjects have a right to ask what we do with their information, ask for corrections, object to processing, lodge a complaint, ask for deletion or transfer of data
4) Consent – if data is to be processed further than legitimate reasons explicit consent must be asked
5) Personal data breaches – data breaches should be informed within 72 hours of identifying the breach
6) Privacy by Design – should incorporate organisational and technical mechanisms to protect personal data in the design of new systems and processes, that is, privacy and protection aspects should be ensured by default.
7) Data Protection Impact Assessment should be conducted when initiating a new project, change or product.
8) Data transfers – data controller has the accountability to ensure that data is protected and GDPR requirements respected, even if data is processed by a 3rd party.
9) Data Protection Officer - Assign a DPO, who has responsibility of advising the company about EU GDPR requirements
10) Awareness and training – Create awareness amongst employees about key GDPR requirements

We developed and implemented a robust action plan to ensure achievement of the regulation by the May 2018 deadline.

Horizon Scanning 2019/20

Community Care Portal

We participate in the use of the Nottinghamshire Health and Care Portal. The community portal enables Nottingham University Hospitals (NUH), Nottinghamshire Healthcare and SFH to share electronically health and social care information, such as hospital and GP attendances, test results, medication and care plans. At present we share pharmacy information and it is envisaged that during this year we will roll out the use in other specialties, moving towards a more integrated care system.

Phasing out Faxing

It was announced in December 2018 by the Department of Health and Social Care, that NHS Trusts will be required to invest in new technology to replace outdated systems. The requirement to phase out faxing is by 31st March 2020. NHS organisations will be monitored on a quarterly basis until they declare themselves fax free. The IG Team will be working with departments across SFH to provide alternative ways of transferring information. This will be predominately NHS mail. The Government will look to end contracts with providers who do not implement alternative methods of transferring data. A survey will be conducted during Quarter 1 of 2019/20 to find the number of faxes still in use and work towards phasing these out.

Records Management

At present there are two inquiries being undertaken by the Government: the Goddard Inquiry which relates to historical child sexual abuse and the Infected Blood Inquiry. The infected blood inquiry will examine why men, women and children in the UK were given infected blood or infected blood products. Both of the inquiries require us to preserve records until the inquiry has concluded. As a result increased pressures are being encountered with current storage issues. The IG team is working with departments to predict the meterage of space needed to accommodate records over the next three years and will source suitable suppliers for offsite storage. A business case is currently being conducted to recruit an interim records manager, who will work with departments on storage issues and road map our current paper records.

Medefer

The introduction of Medefer aims to provide clinical triage for referrals from primary care to secondary care. This will be achieved by consultant-led triaging, investigating and where appropriate virtually managing patients referred into the service. This will be piloted in Cardiology, Dermatology and Gastroenterology. It is hoped that the implementation of Medefer will reduce the number of 'clinically avoidable referrals into secondary care triaging and reduce the times that patients wait for an outpatient appointment. The IG team has been involved to ensure confidentiality of information.

Cyber Security

The Cyber Assurance Delivery Group was established to deliver the Cyber Strategy's 94 Cyber commitments. At present 73% of the commitments have been delivered, this is in line with our plan.

We are working on phase 1 of the removable media programme, which entails the blocking of unencrypted mass storage devices; this will be completed by 31st March 2019. This piece of work has taken a considerable amount of time to complete, due to resources within the department. Phase 2 will entail limiting removable devices e.g. optical drives, modems etc. and is in the early stages of discussion.

Cyber security remains high on the IG agenda and other areas we anticipate to strengthen during 2019/20 are access controls within systems and unsupported devices on the network.

Electronic Prescribing and Medicines Administration (EPMA)

Project work is being undertaken to source and implement an electronic system for e-prescribing. Some benefits include reduction in prescription errors, reduction in patient harm, financial and staff savings.

Patient Level Information Costing System (PLICS) Pilot for Nottinghamshire Integrated Care System

Many providers are implementing PLICS. SFH and NUH were early implementers of the National PLICS portal. PLICS helps us to understand the activity and cost of different groups of patients and is crucial to managing the health needs of the population.

Working with NUH and Nottinghamshire Healthcare, the PLICS system for Nottinghamshire is a project that is in the early stages of development. This will enable the organisations to better understand the variation of cost in the delivery of their services in Nottinghamshire. Population based healthcare and integrated care systems require us to understand how we use our resources and understand patient pathways to deliver a better standard of care to our patients. As a result of understanding these pathways new models of care can be developed.

Spine Compliance & Medway

NHS Digital hosts the most up to date patient demographics service the national Spine. During the year 2019/20 we will move towards implementing connecting the Spine and Medway and interfacing between the SystmOne GP units. This will reduce the number of incidents which have occurred whereby the details on the Medway system has sent a message to the GP unit and changed patient demographic details. Some impacts on this have been patients unable collect prescriptions, delay in fertility treatment and merging of adopted records.

Clinical Information Systems Working Group (CISWG)

The CISWG was formed as a result of a number of incidents and gaps in control identified in the implementation of new systems and issues arising post implementation. The group has held its first meeting and will report directly to the Risk Committee and ultimately the Board of Directors on the robustness of current processes involved in the implementation and utilisation of IT systems with regard to the integrity and availability of information. The group will also make recommendations to mitigate the risks; address gaps in control and resolve specific issues.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports, which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Report presents a balanced picture of our performance over the period covered from April 2018 to 31 March 2019 and indicates that there are appropriate controls in place. These controls include:

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

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

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

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

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

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

- Monthly divisional performance management meetings

- Patient Safety and Quality Group
- Quality Committee

For 2019/20 the Council of Governors have agreed the following quality priorities:

1. SHMI (mandated indicator)
2. 85% of End of Life patients will die in the preferred place;
3. 10% reduction in unsatisfactory discharges;
4. 10% improvement in the utilisation of Learning Disabilities pathways.

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

In 2018/19 we have improved the quality and accuracy of our elective care data in the main by strengthening the governance arrangements for the management of the Trust waiting lists underpinned by an effective suite of reports and ongoing training for staff. More detail is provided earlier in the risk management and assurance section of this Annual Governance Statement

Review of effectiveness

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

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through their internal audit work. The Head of Internal Audit has provided me with a significant opinion for 2018/19. This reflects the improvements made by the organisation in both embedding risk management and implementing and sustaining a robust Board Assurance Framework assurance process through the Board Risk Committee, which is chaired by me as the Chief Executive. Internal Audit have issued two Limited Assurance reports: Data Security and Protection Standards, and Compliance with legislation (Mental Health Act) the actions identified are monitored via the Audit and Assurance Committee, to ensure timely completion.

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

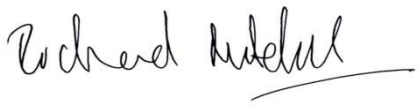
controls designed to give assurance that assets are safeguarded, waste and inefficiency are avoided, reliable information is produced and that value for money is sought continuously.

My review for 2018/19 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
- Clinical Audit

Conclusion

I have identified above all those issues which may be deemed significant there are no further significant control issues I wish to report. I am satisfied the organisation has a sound system of internal control supported by a robust governance structure. All internal control issues raised during the year have been, or are being addressed through appropriate action plans and escalation processes.



Richard Mitchell

Chief Executive

23 May 2018

Quality Account and Reports 2018/19

Introduction to the Quality Account

This report is designed to assure patients, the public and commissioners about the quality of care at Sherwood Forest Hospitals NHS Foundation Trust. The report provides a review of the Trusts quality improvement activities, and achievements during 2018/19, including where the Trust could improve.

The report also identifies and explains the Trusts quality priorities for 2019/20. The 2018/19 sections of the report refer to quality improvement activities completed during the 2018/19 financial year. These sections include the mandatory reporting requirements set out by NHS Improvement as referenced in the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2018/19
- Data Dictionary

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

The last 12 months at Sherwood Forest Hospitals NHS Foundation Trust has been another year of positive progress. I believe the two most important things for any hospital to focus on are high quality of care to all and treating patients and colleagues in the same way as you would like to be treated. We have made progress on both of these aims.

My role as Chief Executive at Sherwood involves working with colleagues to improve quality, improve staff engagement, improve access standards (which are an important indicator of quality), delivering our financial agreements and working closely with partners. Regarding quality, whilst it already feels a long time ago, in August 2018 we received positive feedback from the Care Quality Commission who reported on their inspection, which took place in April 2018. Our overall rating was Good, we were rated Outstanding for Caring and all ten services visited were rated Good for Safe. It was also pleasing to see that our maternity services, our urgent and emergency care services, outpatients service and medicine at Mansfield Community Hospital were viewed as Outstanding.

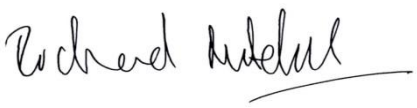
Our staff engagement results in 2018 were the best they have ever been although I think we still have much more to do here. Too many colleagues do not feel supported at work and feel their jobs are unmanageable and I will continue to commit personally to focus on this. Quite simply, happy staff provide safe care and we want to improve the safety of our services.

Our access standards (waits for emergency, elective, cancer and diagnostic care) have improved over the last 12 months and we are proud that we continue to provide some of the best access standards in the NHS. We believe timeliness of care is an important indicator of overall quality. We have delivered on our agreed financial position this year and we are working even more closely with partners in health and social care through the Mid Nottinghamshire Integrated Care Partnership and the Nottingham and Nottinghamshire Integrated Care System. Sherwood is not an island and we recognise we have a big responsibility to work with partners to transform the services for our patients and public. We are fortunate to work in buildings, which are very clean and, in general, across our three hospital sites are modern and spacious, but we are also committed to developing these services.

I remain worried about the pressure colleagues feel and I do not feel good about the length of time some patients have waited for their treatment or admission. I am aware of the impact this has on patient and colleagues lives and we will make further improvements at Sherwood over the next year.

I believe our services today are better than they were 12 months ago, and will be better again in another year's time. Thank you to the staff and volunteers who individually and collectively played a key role in providing safe patient care over the last year.

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



Date: 23/05/19

Richard Mitchell,
Chief Executive

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

2.1 Priorities for Improvement

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is committed to providing safe, high quality care to all patients and service users. The Trusts focus on continuous improvement is driven by the Quality Priorities identified within the Quality Strategy 2018-2021. The programme is led by the Executive Medical Director, who, in conjunction with the Chief Nurse receives regular progress reports with formal reporting through the Trust Quality Committee and Board of Directors as part of the routine cycle of business. The Advancing Quality Programme is monitored, updated and amended throughout the year.

2.1.1 Providing High Quality Safe Care

Quality improvement activities are progressed through a number of internal and external sources. The following are examples that have been used to support the development of the Quality Strategy 2018/21.

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

The Trust continues to build on the governance and performance framework that is now well established throughout the organisation. This framework is regularly evaluated and reviewed where necessary ensuring risks to the safety and quality of patient care are identified and managed resulting in clinically sustainable and financially viable services.

The achievement of each quality priority is measured through a range of metrics articulated in each campaign. Progress is underpinned by the Trust assurance processes with the formal monitoring and measurement reported through a range of committees and groups with final approval by the Board of Directors. An update on progress is presented to the Council of Governors annually.

2.1.2 Approach to Quality Improvement

The Trust's approach to quality improvement is based on well-defined tools for accelerating improvement that have been widely adopted across the NHS. The questions below guide the improvement of care at the Trust:

- What problem are we attempting to solve - what exactly are we trying to achieve?
- What change can we make to bring about improvement?

- How will we know that making a change delivers an improvement?

These questions ensure that there are clear aims, measures, specific interventions, and how changes will be tested in the clinical setting. All improvement requires change, but not all changes result in improvement. Changes that do not result in improvement are helpful as they can help the Trust to learn and adapt. By implementing changes, succeeding and failing as the Trust moves forward, sustainable cha In addition to using internal intelligence sources to identify and drive improvement, the Trust works with surrounding health and social care partners to support wider improvement programmes. The Trust also takes account of external sources such as GIRFT (Getting It Right First Time) with the clinical divisions providing exception reports to the Patient Safety Quality Group on their GIRFT performance. This is demonstrated in the Trusts approach to quality improvement training, which is delivered in partnership with other providers. The training uses a standardised strategy recognised by NHS Improvement to implement and measure service improvement and is designed to develop a common language across traditional organisational boundaries.

The Trust launched its quality improvement approach in July 2018 - the 'Sherwood Six Step' – which is underpinned by the globally recognised Institute of Healthcare Improvement's 'Model for Improvement'. With the appointment of a new role – Associate Director of Service Improvement – the key focus areas are shown in diagram 3 below.

Diagram 3

In three months, over 60 staff received training to support the QI approach, and by June 2019, an additional 34 staff will be accredited at QSIR Practitioner level. The training plan over 2019/20 is expected to reach 150 staff, with 60 QSIR Practitioners.

The third focus for QI is to progress the Safety Culture Programme, which has received regional interest, and which has been presented at an East Midlands Patient Safety Collaborative QI event in November 2018, and at regional clinical networking events. The Safety Culture Programme was undertaken within ED, Maternity and Theatres over 2018/19; this work will continue into 2019/20, with a re-survey of 29 ward areas. This Programme directly supports understanding cultural enablers and barriers to delivering outstanding patient care, and empowers staff to lead improvement in their area.

Over 2019/20, the Trust will build on its networks of QI champions – a hugely important asset - to share and manage knowledge and information to support QI both internally, and to meet the challenges of a wider health and social care system.

Quality Priorities 2018-2021

By 2021 the Trust aspires to be rated as outstanding by the Care Quality Commission; we understand this represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks.

The Quality Strategy led by the Executive Medical Director, reflects the Trust's ambition for sustainable, high value, high quality services delivered in partnership with other health and social care providers across the Nottinghamshire footprint. As we move forward we will witness a much closer alignment between quality, activity and financial planning to boost our combined efforts to deliver safe, effective and financially sustainable services in the longer term.

The challenges that lie ahead are significant and will require creative adaptation within the Trust and across the wider health care system in order to meet them. By investing in service improvement expertise to deliver improvements and developing our teams to lead, learn, and continuously improve we are positioning the Trust to act as the system leader for quality.

The Trust believes it can demonstrate outstanding care and be one of the best providers of healthcare in the country. The Quality Strategy provides the road map to get there. The Strategy reflects the quality priorities and takes account of national, local and independent reports and enquiries. The quality priorities support the Trust Strategy, which has been developed in wide consultation with staff and external stakeholders. Future plans and progress against the quality priorities are regular agenda items at the Trust Quality Committee, which has patient and public representation and attendance.

The Trust aims to change behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services. Three improvement priorities for specific focus in 2019/20, as agreed by the Council of Governors, are indicated below:

Specific Indicator	Quality Priority	Success Measure
Clinical Care	Reduce harm for those using our services who have a learning disability	10% increase in the use of Learning Disability Pathways
Patient Experience	Ensure we adhere to patient choice for their preferred venue at the end of life	Maintain at least 85% or more alignment with patient's preferred discharge venue at the end of their life
Patient Safety	Improve effectiveness of discharge planning and resilience of discharge venue	Reduce by 10% the number of incidents or complaints (based on 2018/19 figures) concerning unsatisfactory/unsafe discharge

Improving the quality of care we deliver is about making care safe, effective, patient-centred, timely, efficient and equitable. It is intended that the Trust uses the Quality Priorities to monitor service improvement, to demonstrate that high quality care and services are being provided and highlight areas where further improvements are required.

Each year, the Trust will review and identify the quality priorities establishing an implementation plan to drive forward the Quality Strategy. This annual plan is known as the Advancing Quality Programme (AQP). Progress against the quality priorities is monitored monthly by the Executive Medical Director and Chief Nurse through the Advancing Quality Oversight Group. A Report is presented to each Quality Committee as part of the regular agenda.

The progress made towards implementation of the Quality Strategy is monitored and reviewed each month by the Executive Medical Director and Chief Nurse. Progress is reported to the Quality Committee and Board routinely as part of a cycle of business for the Board of Directors.

2.1.4 Review of Quality Priorities during 2018/19

The following section provides an overview of the Trust's quality priority performance during 2018/19. Three key priorities were selected from each of the four quality campaigns of the 2018/21 Quality Strategy. The table below describes the Trusts' 2018/19 Quality Priorities and progress to date.

Quality Priority 1: Positive Patient Experience	**Outcomes:** 1. Focus on explaining care in an understandable way 2. Engage and involve people in planning and delivering their care 3. To enable service users to be active participants in the Trust Governance groups
Progress: In 2018/19 progress has been made as follows: • The National Inpatient Survey confirms that 73% patients receive information in an understandable way across the relevant areas of the Trust. • A Patient and Public Representative has been a full member of the Patient Safety and Quality Group since October 2018. An initial six-month review has been undertaken with positive feedback received from the individual and wider group membership. • The Trust is using the '#Hellomynameis' campaign as the 'Always Event'. This is also linked to positive patient identification • A pilot has commenced in the Intensive Critical Care Unit to determine 'what is important to me' from the patient, carer and staff perspective. The outcome of the pilot identified that relatives and carers felt an expansion in the times they were allowed to visit needed to be more flexible enabling them to make better use of the time, balance home and visiting needs and provide an opportunity to be actively involved in the care of their loved one. Visiting times have now been expanded to cover 14.00-21.00 seven days per week. • In addition relatives highlighted that it was often difficult to make out the name of clinical staff caring for the patient from the standard Trust Staff Identification Badge. This quite often caused confusion and anxiety as to who to ask for support and guidance. A new style name badge stating only the first name of the staff member of a yellow background has been agreed following consultation.	

Quality Priority 2: Care is Safer	**Outcome:** 1. Achieve high reliability of risk assessment and effective care planning for patients at risk of falls 2. Achieve high reliability of risk assessment and effective care planning for patients at risk of hospital acquired pressure ulcers 3. Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken
Progress: In 2018/19 progress has been made as follows:	

- The Trust takes a proactive approach to reducing the likelihood of patient falls whilst inpatients in any of our hospitals. A falls group reports regularly to the Nursing, Midwifery and AHP Board, chaired by the Chief Nurse. The Trust achieved the target of 92% or more compliance with implementation of falls care plans for at risk patients through 2018/19 with falls performance being an integral metric of Perfect Ward performance indicators.
- The Trust consistently met the 92% or more compliance with the implementation of pressure sore prevention plans for at risk patients. The Tissue Viability team has made significant improvements in the prevention of hospital acquired pressure ulcers providing advice, guidance and support to staff across all three-hospital sites.
- All theatre activity is recorded on the Operating Theatre IT System – Blue Spier. 100% compliance with the WHO Safety Checklist for each operating list has been consistently achieved throughout 2018/19. This work has been further enhanced by the development of 'safety checklists – LocSSIPs and NatSSIPs for those areas who undertake invasive procedures outside the main theatre areas. The Trust Consent Group has the overall accountability for ensuring adherence to safety checklists receiving regular audit updates from specialties.

Quality Priority 3: Care is Clinically Effective	**Outcome:** 1. Reduce harm for those using our services who have a learning disability 2. Focus on preferred venue at the end of life 3. Ensure all patients have a timely review from a Senior Clinician following admission

Progress: In 2018/19 progress has been made as follows:

- We were able to establish an accurate baseline (compared to 2017/18) of harm for those patients using our services with a known learning disability. We had previously not collected this information. This has enabled us to identify specific themes to inform further improvement work. Pressure Ulcers upon admission remain as one of the top areas of reporting. To address this, the effective use of the Learning Disability Care Plan will reduce incidents and staff are being encouraged to complete this. The Trust is reviewing all learning disability documentation to help streamline this. It is envisaged that parts of the Learning Disability Care Plan will form part of this generic documentation and will support the uptake of its completion. Consultant review within 14 hours of emergency admission.
- The Trust End of Life Team has been working very closely with the wider Better Together Alliance to ensure patients who are at the end of life have the best possible experience for both themselves and their families. We continue to work towards our standard of 90% of patients reaching their preferred venue of discharge prior to their death. There has been significant investment for the team from external stakeholders such as Macmillan to strengthen our ability to deliver the care patients and their loved ones deserve. In addition, we have trained clinical staff across the organisation on the national ReSPECT Tool and plan to go live on 1 April 2019.
- The new format audit was conducted in February 2019 with 94% compliance demonstrating amongst the highest performing Trusts in the East Midland's region. The effectiveness of ensuring all patients are seen by the most appropriate senior doctor as early on as possible following admission has a tangible benefit on reducing the time spent in hospital and improving their outcomes.

Quality Priority 4: We Stand Out	Outcome: 1. Focus on the specific staff satisfaction questions from the Annual National Staff Satisfaction Survey 2. Promote an open and learning culture 3. Get to the learning faster; response to serious incidents

Progress: In 2018/19 progress has been made as follows:

The Trust uses two of the questions from the National Staff Satisfaction Survey as the staff Family and Friends Test (FFT):

1. Would Staff recommendation of the organisation as a place to work?
2. Staff recommendation of the organisation as a place to receive care or treatment?

These questions are circulated to all members of staff each quarter with a response of >80% to both questions for 2018/19. This is an excellent result and demonstrates the confidence and pride staff have in the safety and quality of care they deliver to patients.

There is a robust governance framework in place, specifically in relation to the recognitions and reporting of potential incidents. A twice weekly 'Serious Incident Scoping meeting' is held where services present their initial findings when something has gone wrong. We consistently exceeded the required >75% of incidents presented to the Scoping meeting within 72 hours of the incident occurring ensuring immediate actions are taken and an appropriate investigation is commenced. We have maintained 100% compliance with the statutory Duty of Candour requirement demonstrating that we are a transparent, open and learning organisation, including our patients and their families in the investigation process wherever possible.

Additional Quality Priorities 2018/19

Progress against each of the additional quality priorities can be found in section three.

1. **Improving the safety of patients**

- Improve the safety of patients
- Reduce harm from falls
- Reduce the number of infections

2. **Improving effectiveness of clinical care**

- Improve the effectiveness of clinical care
- Improve care and learning from mortality reviews
- Improve the experience of patients coming to the end of their lives

3. **Improving Patient Experience**

- Improve the experience of care for dementia patients and their carers
- Use feedback from patients and their carers to define improvement priorities
- Safeguard vulnerable people

The Trust recognises there is further work to be undertaken to engage and involve a wider stakeholder group, including patients, families and carers in the future development of quality improvement priorities.

2.2 Statements of Assurance from the Board

1. General Statement

During 2018/19 Sherwood Forest Hospitals NHS Foundation Trust provided 59 relevant health services.

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

The income generated by the relevant health services reviewed in 2018/19 represents 82.37 % of the total income generated from the provision of relevant health services by Sherwood Forest Hospitals NHS Foundation Trust for 2018/19. Each year we look after over 55,538 inpatients, 450,620 outpatients, and 131,063 attendances to our emergency department and 3,241 women choose to give birth at King's Mill Hospital. We employ 4,831 staff, including 173 consultants, working in hospital facilities that are some of the best in the country.

2. Participation in Clinical Audit

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

During 2018/19, 57 national clinical audits and 4 national confidential enquiries covered relevant health services that Sherwood Forest Hospitals NHS Foundation Trust provides.

During that period the Sherwood Forest Hospitals NHS Foundation Trust participated in 52 of 57 (91%) 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 NHS Foundation Trust was eligible to participate in and participated in during 2018/19 are as follows:

Project name (A-Z by project name)
Adult Community Acquired Pneumonia
BAUS Urology Audits - Female Stress Urinary Incontinence Audit
BAUS Urology Audits - Nephrectomy audit
Case Mix Programme (CMP)
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database
Feverish Children (care in emergency departments)
[1] Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.
Learning Disabilities Mortality Review Programme (LeDeR)
[3] Major Trauma Audit
Mandatory Surveillance of bloodstream infections and clostridium difficile infection

Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance (reports annually)
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries (reports alternate years)
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries (reports annually)
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries (reports annually)
National Adult Non-Invasive Ventilation (NIV) Audit
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Cardiac Rehabilitation
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia (care in general hospitals) - Dementia care in general hospitals
National Audit of Intermediate Care (NAIC)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
National Cardiac Arrest Audit (NCAA)
National Audit of Cardiac Rhythm Management (CRM)
Myocardial Ischaemia National Audit Project (MINAP)
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
National Heart Failure Audit
[5] National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children
National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage
National Diabetes Audit - Adults - National Diabetes Foot Care Audit
National Diabetes Audit - Adults - NaDIA-Harms - reporting on diabetic inpatient harms in England
National Diabetes Audit - Adults - National Core Diabetes Audit
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)
National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)
National Joint Registry (NJR)
[4] National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Mortality Case Record Review Programme
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
[2] National Ophthalmology Audit (NOD) - Adult Cataract surgery
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship
Sentinel Stroke National Audit programme (SSNAP)

Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Seven Day Hospital Services Self-Assessment Survey
Surgical Site Infection Surveillance Service
UK Cystic Fibrosis Registry
Vital Signs in Adults (care in emergency departments)
VTE risk in lower limb immobilisation (care in emergency departments)

The national clinical audits and national confidential enquires that Sherwood Forest Hospitals participated in, and for which data collection was completed during 2018/19, 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.

Project Name (A-Z by project name)	**Included in NHSE Quality Accounts List**	**Commissioned by HQIP - part of NCAPOP**	**%**
Adult Community Acquired Pneumonia	Y	N	100%
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Y	N	100%
BAUS Urology Audits - Nephrectomy audit	Y	N	100%
Case Mix Programme (CMP)	Y	N	100%
Elective Surgery (National PROMs Programme)	Y	N	100%
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls	Y	Y	100%
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Y	Y	100%
Feverish Children (care in emergency departments)	Y	N	100%
[1] Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	Y	N	50%*
Learning Disabilities Mortality Review Programme (LeDeR)	Y	Y	100%
[3] Major Trauma Audit	Y	N	82%*
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Y	N	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance (reports annually)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries (reports alternate years)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	Y	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries (reports annually)	Y	Y	100%
National Adult Non-Invasive Ventilation (NIV) Audit	Y	N	100%
National Asthma and Chronic Obstructive Pulmonary Disease	Y	Y	100%

(COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care			
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Y	Y	100%
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	100%
National Audit of Cardiac Rehabilitation	Y	N	100%
National Audit of Care at the End of Life (NACEL)	Y	Y	100%
National Audit of Dementia (care in general hospitals) - Dementia care in general hospitals	Y	Y	100%
National Audit of Intermediate Care (NAIC)	Y	N	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Y	100%
National Cardiac Arrest Audit (NCAA)	Y	N	100%
National Audit of Cardiac Rhythm Management (CRM)	Y	Y	100%
Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	100%
National Heart Failure Audit	Y	Y	100%
[5] National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Y	Y	0%*
National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage	Y	N	100%
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Y	Y	100%
National Diabetes Audit - Adults - NaDIA-Harms - reporting on diabetic inpatient harms in England	Y	Y	100%
National Diabetes Audit - Adults - National Core Diabetes Audit	Y	Y	100%
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Y	Y	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	100%
National Emergency Laparotomy Audit (NELA)	Y	Y	100%
National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	Y	Y	100%
National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)	Y	Y	100%
National Joint Registry (NJR)	Y	N	100%
[4] National Lung Cancer Audit (NLCA)	Y	Y	50%*
National Maternity and Perinatal Audit (NMPA)	Y	Y	100%
National Mortality Case Record Review Programme	Y	N	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Y	Y	100%
[2] National Ophthalmology Audit (NOD) - Adult Cataract surgery	Y	Y	70%*
National Paediatric Diabetes Audit (NPDA)	Y	Y	100%
National Prostate Cancer Audit	Y	Y	100%

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	Y	N	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	Y	N	100%
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	Y	N	100%
Seven Day Hospital Services Self-Assessment Survey	Y	N	100%
Surgical Site Infection Surveillance Service	Y	N	100%
UK Cystic Fibrosis Registry	Y	N	100%
Vital Signs in Adults (care in emergency departments)	Y	N	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Y	N	100%

Study Title	Participation	Project Status	%
Acute Bowel Study	Yes	No patients meet criteria. We will however submit an organisational questionnaire.	0%
Long-Term Ventilation	Yes	No patients meet criteria. We will however submit an organisational questionnaire.	0%
Peri-Operative Diabetes	Yes	Patients Submitted to study	100%
Pulmonary Embolism	Yes	Patients Submitted to study	100%

Non-Participation

1. **Inflammatory Bowel Disease (IBD) programme**
   Historically data has been collected and submitted manually for this audit. Whilst a new data platform has recently been secured and installed, it use requires Trust sign-off to adhere to Information governance standards. The Trust has however continued to input minimal data manually but has not been able to input a complete data set. Approximately 50% of the data has been inputted for 2018/19 to date.

2. **National Ophthalmology Audit**
   Only 75% of the required data has been submitted for 2018/19, as the Trust has not had the capacity to collect and submit pre-operative data until February 2019. This has now been addressed and a full dataset will be submitted going forwards.

3. **Major Trauma Audit**
   82% of the data has been inputted but the Trust has been unable to input a complete data set within the 40-day lock down target. Action has been taken to increase the frequency that patient data is supplied to the TARN administrator meaning there will be a quicker turnaround in case notes being reviewed and data submitted in future.

4. **National Lung Cancer Audit**
   Due to deficiencies in the Site specific data collected relating to cancer patients, a decision was taken by the Executive Medical Director to suspend data entry for this audit. In the meantime, the Trust has continued to submit core data items for the lung Cancer audit.

5. **National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children**
   The Trust has obtained an exclusion statement from the National Comparative Audit of Blood Transfusion, as it does not see enough patients to meaningfully participate in this audit. This means no data has been submitted for this audit..

The number of clinical audits both national and local, which formed part of the 2018/19 Audit Plan are as follows:

Total Number of Audits of the 2018/19 Plan: 302
Number of Local / Other Audits: 241
Number of National Audits, Inc. NCEPOD: 61

The provider reviewed the report of 61 National Clinical Audits in 2018/19 and Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

1. **National Audits and NCEPOD**

Various committees, clinical governance forums and specialties at Sherwood Forest Hospitals Foundation Trust in 2018/19 reviewed the reports of national clinical audits and NCEPOD studies. The Trust intends to take action to improve the quality of healthcare provided by having completed some key actions. Below are examples of some of the agreed actions.

2. **Inflammatory Bowel Disease Registry**

- Inflammatory Bowel Disease nurses to begin clinics at the Newark Hospital site.
- Set up of patient education groups across both Newark and King's Mill Hospital sites
- To be part of the re-audit every 6 months using the RCP audit tool and ward/department assessment tool.

3. **Mothers and Babies; reducing risk through audits and confidential enquiries - MBRACE-UK- UK Perinatal Deaths for Births**

- The unit will continue to with work in line with Saving Babies Lives and Smoking Cessation.
- Doctors will undertake Trust wide training package/competency in order to perform counselling.
- Increase the number of staff available to report instances of still birth; in order that the cases can be reported as soon as possible.
- A full training package completed for all maternity staff around retention of placentas for histology.

4. **Non-Invasive Ventilation (NIV) case note review following National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report**

- Quarterly audit of NIV service and review of morbidity and mortality cases.
- Feedback to Junior Doctors regarding performance utilising ongoing audit of patient treatment quality markers.
- Implementation of NIV consultant ward round pro-forma and ongoing audit of patient treatment quality markers on online dashboard.
- Daily audit of NIV service performance utilising online dashboard.
- Implementation of an NIV discharge bundle prescription chart.

5. **Chronic Obstructive Pulmonary Disease (COPD) Audit**

- COPD Team to have access System1 for improved communication.
- COPD team beginning to work each Saturday.

6. **NCEPOD Study – Chronic Neurodisability**

- Ratified Cerebral Palsy Integrated Pathways – Scotland (CPIPS) within paediatrics.
- Established a named Neurodisability lead within the Trust.
- Established consultants with defined Neurodisability competencies and roles with their job plans and appraisals.
- Establish a plan to code ongoing outpatient Neurodisability diagnoses in the community and acute paediatrics.

7. **Procedural Sedation in Emergency Departments**

- Introduce a sedation pro-forma to be completed by clinicians.
- Use Capnography during monitoring.
- Document consent when sedation is offered to patient.

8. **Case Mix Programme – Intensive Care National Audit and Research Centre (ICNARC)**

- A business case has been submitted to increase staffing and bed space to accommodate an increase in demand for intensive care services.

9. **National Audit Reports Published 2018-2019**

During 2018-2019 a number of National Audits and NCEPOD studies have published reports which have shown improvements in the care being provided to patients at Sherwood Forest Hospitals Trust. Below are examples of some of these:

1. **Non-Invasive Ventilation case note review following NCEPOD report**

- The time from admission to Non-Invasive Ventilation (NIV) has fallen. The new NIV prescription chart therefore reduced delays in NIV, showing compliance to the targets advised by the British Thoracic Society and NCEPOD.
- There was a significant reduction of the time from blood gas indicating Acute Hypercapnic Respiratory failure (AHRF) to starting NIV.
- Improvements in appropriateness of NIV noted from 93.3% to 100%.
- Improvements were made in the documentation of a ceiling of care; 73.3% to 76.9%.

2. **National Emergency Laparotomy Audit (NELA)**

- 94% of patients have their risk of death documented before surgery. This is compared to the national mean of 74% and a regional mean of 79%.
- The postoperative assessment by a care of the elderly specialist is at 56%. This is 35% above the national average and 30% above the regional mean.
- The post-operative length has stay has again improved reducing from 10 days on average to 9 days. This is 2 days below the national mean.

3. **Chronic Obstructive Pulmonary Disease (COPD) Audit**

- Respiratory Specialists seeing patients within the first 24 hours of admission; national average is 55%, whilst SFH achieved 61% for the same period.
- The Trust has made good progress with regard to completing discharge bundles with patients before discharge; 43% in April 2017, 71% in April 2018.
- The Trust has made progress with Smoking Cessation; patients accepting Nicotine Replacement Therapy, with stats improving from 0% in April 2017 to 38% in April 2018.
- The Trust achieved greater than national average for administering NIV within three hours; national average is 30%, whilst SFH achieved 49% for the same period.

4. **The National Hip Fracture Database**

The Trust improved performance significantly compared to results in 2016:

- Delirium assessment 80% (4.5% in 2016)
- Treating Sub-Trochanteric Fractures with nails 100% (76% in 2016)
- Acute Length of Stay has reduced to average 10.3 days (13.2 days in 2016)

We are also in the top quartile of acute trusts for the following:

- Mini Mental Test on admission (100%)
- Best Practice Tariff (BPT) met (73.6%)
- Supplementary nerve blocks
- Length of Stay (acute)

5. **National Neonatal Audit Programme (NNAP)**

- Mothers who deliver babies between 24 and 34 weeks gestation and were given any dose of antenatal steroids is at 90.5%, this is higher than both the expected standard of 85% and the national average.
- Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission is at 96.2%, which is higher than the national average of 94%.
- Babies of very low birth weight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity is at 93.9%. This is an improvement on the previous year's audit of 85%.

6. **The National Ophthalmology Audit**

- The complication rate was 0.24% for all cataract procedures, which is good compared to the benchmark national standard of 1%.
- Clinical and operative data entry completed by doctors under supervision of consultants. The Trust have entered 850 cataract operations to the database from September 2016 to February 2018.

Local Audits

The provider reviewed the reports of 105 local clinical audits in 2018/19 and Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

1. **18-19-3237 - Gynaecology Clerking Booklet Audit**

This local audit was undertaken as a re-audit of the gynaecology admission clerking. The results showed the following improvements in:

- Analgesia is being prescribed 100% of the time when required, this is an improvement on the first year.
- Past medical history documentation has improved with the implementation of the tick urine Beta Human Chorionic Gonadotropin (BHCG) is not always being documented in the booklets and there has been 13% drop in doing this.
- Swabs in miscarriage or Pelvic Inflammatory Disease (PID) are being done 93% of the time, which is an improvement on last year.

2. **18-19-3222 - Co-morbidity Checklists Re-audit**

This is the third audit in the cycle and aims to check performance against the specified standard, which states that all patients should have a co-morbidity checklist completed on admission to hospital.

- 99 % of the co-morbidity checklist completed.
- There has been a continuous improvement in completion rates at each audit rising from 50% at baseline to 99%.

3. **18-19-4103 - Use of AMTS Assessments in Patients over 65 in General Surgery – Re-audit**

This was a re-audit of work carried out in 2017-2018, which reviewed compliance of the Abbreviated Mental Test Score (AMTS) and was carried out across a number of departments.

- Improved compliance within surgery from 24% to 73% with introduction of new Abbreviated Mental Test Score format.

4. **18-19-2056 - An Audit of Use of Alert codes in Outsourced Reports**

An audit was undertaken in order to measure the compliance with the standard operating practice for acting on urgent results received from teleradiology.

- 100% compliance from the typists in alerting the reporting radiographers to urgent reports and phoning through urgent reports to referrers.
- Improvements have been made since the last audit in documenting the injection site.
- Consistent findings between last audit and re-audit on annular gauge and for patient follow up.
- 100% compliance from two teleradiology companies in emailing SFH with urgent reports, with 92% compliance from the remaining company.
- A reporting radiographer reviewed all reports and this was recorded on CRIS.
- All reports were phoned through to the requester and documented on the CRIS system as per the department policy.

Looking Back at 2018/19

As a consequence of additional resources allocated to support clinical audit oversight during the last 12 months, the Trust has improved its' clinical audit activity and has achieved the following:

- All Divisions receive a comprehensive report detailing their position on all of their activity including local audits, trust-wide audits, NCEPOD and national audits.
- The Trust Clinical Audit Lead has taken on the role of regional representative (East Midlands Region) on the National Quality Improvement and Clinical Audit Network (NQICAN).
- A trust-wide clinical audit dashboard has been developed which is produced on a monthly basis.
- Significant development has taken place on the clinical audit intranet site and the information and resources have been reviewed and improved upon.
- Work was undertaken to audit NPSA and CAS Alert compliance.
- A review of the Trust's 2018 CQC report was undertaken to ascertain where 'audit' was mentioned. The clinical audit team have contacted specific areas and Divisions to offer support in putting in place actions to improve upon the CQC findings.
- A clinical audit showcase event was held in May 2018 to promote awareness and engage staff in clinical audit. The event included clinical audit presentations, a clinical audit competition and external presentations.
- A communication plan in respect of clinical audit has been developed and sets out the activity for a 6-month period. This involves; pop-ups, communication bulletins, videos, twitter accounts and other aspects to promote the work being undertaken and the results that are being achieved.
- Clinical Audit Awareness Week was celebrated at the Trust. In 2018 (19th November 2018). There were a number of events, including hosting a stall in the KTC, drop-in sessions at Newark and Mansfield Community Hospital, targeted junior doctor training, nominating Audit Hero's and launching a Clinical Audit Survey to gather feedback from the wider Trust

Looking Forward to 2019/20

The future direction of the Clinical Audit team over the next 12 months include:

1. The Clinical Audit Team will attend each specialty governance meetings. The aim is to provide more insight into clinical audit and achieve more engagement amongst clinicians.
2. The Clinical Audit and Effectiveness Group plan to review the format of the meeting to offer Divisions the opportunity to interrogate their own clinical audit data.
3. The Specialty Clinical Audit Lead Job Description has been reviewed and this will be circulated to all clinicians holding the responsibility of Specialty Clinical Audit Lead. Each lead will be offered support to enable them to fully understand and have oversight of the specialty clinical audits.
4. National Quality Improvement and Clinical Audit Network are leading a piece of work to develop more structured audits against NICE Guidance. There is further exploration of whether Sherwood Forest Hospitals could participate in this work. Based on this work it is hoped that an electronic tool will be developed for all Trusts to enable them to easily audit against NICE Guidance without having to construct their own audits.
5. The Management of Diagnostic Results Audit commenced in 2018. The audit is split into 2 sections; the first is owned by the Specialty and the second owned by the area processing the diagnostic testing. It is expected that there will be an update of this review following publication of the results.
6. The forthcoming months will see focused work with clinicians to encourage them to undertake local clinical audits as a result of the findings of national clinical audits. This will involve undertaking a comprehensive gap

analysis of the national audit findings and identify areas for improvement and what action is required to enable this.

3 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 2018/19 recruited during the period to participate in research approved by the Research Ethics Committee was 2255. This figure includes patient's data and tissue samples.

The Trust is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I team is responsible for developing and supporting a varied research portfolio that will create greater opportunities for patients' and staff to participate in research activity, whilst informing the provision of high quality, evidence based health care. Patient participation in research is mainly through studies adopted by the National Institute for Health Research (NIHR). The Trust is involved in a small number of non-adopted studies which are typically undertaken for educational purposes.

Research activity in the organisation is increasing year on year with a total of 2097 participants recruited in to NIHR studies. This demonstrates a 27% increase on 2017/18 recruitment figures with a 119% increase over the last 3 financial years (see charts as 1 and 2). All data is based on local recruitment figures from the research management database EDGE.

Chart 1

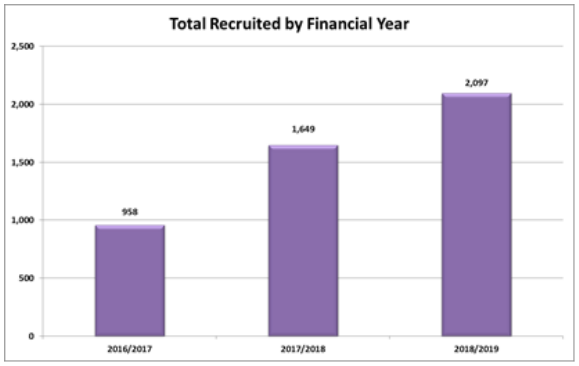
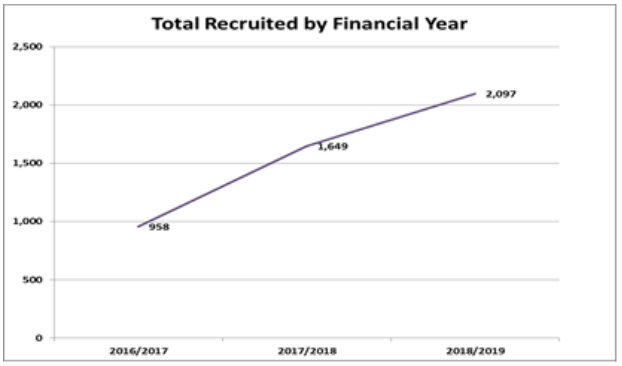


Chart 2



In 2019/20 the Trust aims to increase the number of patients who have access to research studies as part of their care pathway; with a target of 1800 patients. There will also be an additional focus on the NIHR Activity Based Funding weighting for studies. This relates to how complex the activity in a trial is with interventional studies receiving more funding and offering more choice of novel treatments for patients.

A key objective for 18/19 was to regain traction on increasing commercial research activity. East Midlands Clinical Research Network selected SFH as a key growth area in their Annual Delivery Plan 2018-19. SFH has exceeded expectation against the target set with 9 commercial trials opened and recruiting this year; 75% of those were interventional studies and all recruited to time and target. In 19/20 we intend to build on this activity, strengthening our reputation for delivery, with the aim of attracting more commercial companies to bring clinical trials to SFH.

It is important for patients taking part in clinical trials to have a positive experience, feel fully informed and receive the same high standard of care as they would when receiving their usual care. This year in September 2018, R&I re-launched the patient experience survey for research participants. At Q4 the average patient satisfaction score of the 121 patients surveyed was 96.82%.

The Trust is committed to expanding research activities and facilities and has developed strong associations with other Universities, NHS Trusts and stakeholders. To expand the types of research studies available to the local population the Trust has developed collaborative relationships with Nottingham University Hospitals NHS Trust and Nottingham Biomedical Research Centre. R&I are working closely with Chesterfield Royal Hospital NHS Foundation Trust by creating joint research posts with staff working across both organisations enabling the same studies to be opened at both sites resulting in more patients being able to take part in studies. At the centre of this growth remains the aspiration to develop a dedicated Clinical Research Facility. This would expand access to clinical trials for patients in the region and enable the uptake of more complex trials; particularly early phase and trials on new pharmaceuticals.

SFH is working closely with the East Midlands Academic Health Science Network (EMAHSN) and the life sciences industry expertise at BioCity Nottingham to deliver a unique, fully funded programme for staff with novel ideas that could benefit patients and the NHS. The programme will help to support staff and the organisation to progress a great idea to become a great innovation which could be commercially developed.

At a local level, the Trusts R&I team are working closely with Nursing and Allied Health Professional teams to begin to embed clinical research into frontline care. A joint initiative has commenced to support research secondments and dedicated research time within new posts, as part of the SFH Research Academy.

Research and Innovation have a presence at Trust board and a performance update is provided quarterly to the Trusts Patient Safety and Quality Group. In addition, the Research Governance committee meets quarterly to oversee and monitor activity. The Trust has an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This is a national KPI for NHS Trusts; “Performance in Initiation and Delivery of Clinical Research” in which SFH continue to retain its sustained performance improvement.

4 Commissioning for Quality and Innovations (CQUIN) Indicators

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

A proportion of Sherwood Forest Hospitals NHS Foundation Trust income in 2018/19 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 2018/19 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-2018

During 2018/19 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 2018/19 CQUIN predicted year end position.
A – Achieved
PA – Partially Achieved

Summary of Acute Schemes for 2018/19

CQUIN scheme	Indicator name	Description	Q1	Q2	Q3	Q4
National	Improvement of health and wellbeing of NHS staff	Achieving a 5% point improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress. The 2 questions did not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question.	A	A	A	A
National	Healthy food for NHS staff, visitors and patients	Providers were expected to build on the 2016/17 CQUIN by: • Firstly, maintaining the 4 changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 • Secondly, introducing the following 3 new changes to food & drink provision: <u>Year 2 (2018/19)</u> a.) The Trust must be signed up to the national SSB voluntary reduction scheme and the total litres sold of SSBs are 10% or less of all litres of drinks sold. b.) 80% of confectionery & sweets do not exceed 250 kcal. c.) At least 75% of pre-packed sandwiches & other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving & do not exceed 5g saturated fat per 100g.	A	A	A	A
National	Improving the uptake of flu vaccinations for front line staff within providers	Achieving an uptake of flu vaccinations by frontline clinical staff (permanent staff & those on fixed contracts) of 75% by 28.02.19.	A	A	A	A
National	Timely identification of sepsis in emergency departments and acute inpatients settings	The % of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to adults & child patients arriving in hospital as emergency admissions & to all patients on acute inpatient wards.	A	A	A	A
National	Timely	The % of patients who were found to have sepsis in	A	A	A	A

Summary of Acute Schemes for 2018/19

	treatment for sepsis in emergency departments and acute inpatients settings	sample 2a (above) & received IV antibiotics within 1 hour. The indicator applies to adults & child patients arriving in hospital as emergency admissions & to all patients on acute inpatient wards.				
National	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	The % of clinical antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours.	A	A	A	A
National	Reduction in antibiotic consumption per 1,000 admissions	There are 3 parts to this indicator. 1. Total antibiotic usage (for both inpatients and outpatients) per 1,000 admissions (33%) 2. Total usage (for both inpatients and outpatients) of carbapenem per 1,000 admissions (33%) 3. Increase the proportion of antibiotic usage (for both inpatients and outpatients) within the Access group of the AWaRe* category.	A	A	A	PA
National	Improving services for people with mental health needs who present to A&E	Successful achievement necessitates partnership working & joint governance between CCGs, acute providers, mental health providers & other key local partners. In Year 2, the Trust is required to maintain the 20% reduction in A&E attendances for the 2017/18 selected cohort of frequent attenders and identify a new cohort of frequent attenders who would benefit from psychosocial interventions and work to reduce the new cohort attendance by 20%.	PA	A	A	A
National	Offering advice and Guidance	The scheme requires providers to set up & operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local	A	A	A	A

Summary of Acute Schemes for 2018/19

		solutions where systems agree this offers a better alternative.				
National	Tobacco Screening	The % of unique adult patients who are screened for their smoking status and whose results are recorded in their notes	A	A	A	A
National	Tobacco Brief Advice	The % of unique adult patients who smoke and are given very brief advice	A	A	A	A
National	Tobacco referral and medication advice	The % of unique adult patients who are smokers and are referred to stop smoking services and offered stop smoking medication	A	A	A	A
National	Alcohol Screening	The % of unique adult patients who are screened for their drinking risk levels and whose results are recorded in local data systems	A	A	A	A
National	Alcohol Brief advice or referral	The % of unique adult patients who drink alcohol above the low-risk levels and are given brief advice or offered a specialist referral if the patient is potentially alcohol dependent,	A	A	A	A

During 2018/19 the Trust received payment of circa £5,464,028 from its commissioners for the CQUIN goals agreed during that reporting period. This is an increase in comparison to the £5,080,998 received in 2017/18.

5 Registration with the Care Quality Commission (CQC)

Sherwood Forest Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration is "registered". Sherwood Forest Hospitals NHS Foundation Trust currently has no restrictions on registration. The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2018/19.

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

The Trust has four locations registered:

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

CQC carried out an inspection between April and May 2018 and visited the following core services:

King's Mill Hospital

- Urgent and Emergency Care services
- Medical Care (including care of the older person)

- Maternity
- End of Life Care
- Outpatients
- Diagnostic Imaging

Newark Hospital

- Urgent and Emergency Care services (Urgent Care Centre)
- Medical Care (including care of the older person)
- Outpatients

Mansfield Community Hospital

- Community Inpatient care

Ashfield Community Health Village

- Outpatients#

In addition to the core service inspection CQC undertook a well-led inspection of the Trust between the 15th and 17th May 2018. It is expected that CQC will inspect the outstanding core services at a point in 2019/20.

The Trust received the final Report in August 2018 indicating the improvements made had resulted in a re-rating giving an overall rating for the organisation as ***Good*** with a rating of ***Outstanding*** for the caring domain.

6 Information on Secondary Uses Service for inclusion in Hospital Episode Statistics

Sherwood Forest Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
Which included the patient's valid NHS number was:

- 99.8% for admitted patient care
- 100% for outpatient care
- 98.5% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 98.8% for accident and emergency care.

7. Information Governance

The Sherwood Forest Hospitals NHS Foundation Trust Information Governance Data Security and Protection Toolkit for 2018/19 included 100 items out of 100 mandatory evidence items; two areas required an improvement plan to meet the standards.

Information Governance Aims for 2018/19

With the redesign of the Data Security and Protection Toolkit to encompass the National Data Guardian Review, the Trust aimed to focus on meeting the 100 Mandatory evidence items in order to achieve full compliance.

How Was This Achieved

The Trust participated in an internal audit (performed by 360 Assurance, Internal Auditors). This enabled the Trust to identify any weaknesses, strengths and gaps in our controls.

Monitoring and Reporting for Sustained Improvement

All actions taken from internal audits are monitored by the Information Governance Committee and the Audit and Assurance Committee.

Serious Incidents Requiring Investigation

In 2018/19, the Trust reported 5 information governance level 2 serious incidents that were reported on the Toolkit. The incidents ranged from information being disclosed inappropriately, whereby an address of a child who was in foster care was inadvertently disclosed to the biological father. The Trust reported an incident of inappropriate access to medical records by a staff member who accessed a patient's record on several occasions; the employee was subsequently disciplined by the Trust. Information regarding a patient was divulged to the media; on investigation this information was already publically available. One incident reported was an email being sent to an intended recipient that did not have adequate security. Of the incidents reported only one now remains open and is currently being investigated by the ICO, this relates to high cost drugs being incorrectly addressed by a third party supplier.

The Trust to date has received no regulatory action as a result of the incidents reported. Lessons have been learned and recommendations implemented to mitigate further reoccurrence.

8. Clinical Coding Audit

Sherwood Forest Hospitals NHS Foundation Trust was not subject to the Payment by Results Clinical Coding audit during 2018/19 by the Audit Commission.

The Trust has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 95,000 inpatient activities for 2018/19. Coded activity data is submitted to Secondary User Services (SUS) which is used to support commissioning, healthcare development and improving NHS resourcing efficiency.

Clinical Coding Aims for 2018/19

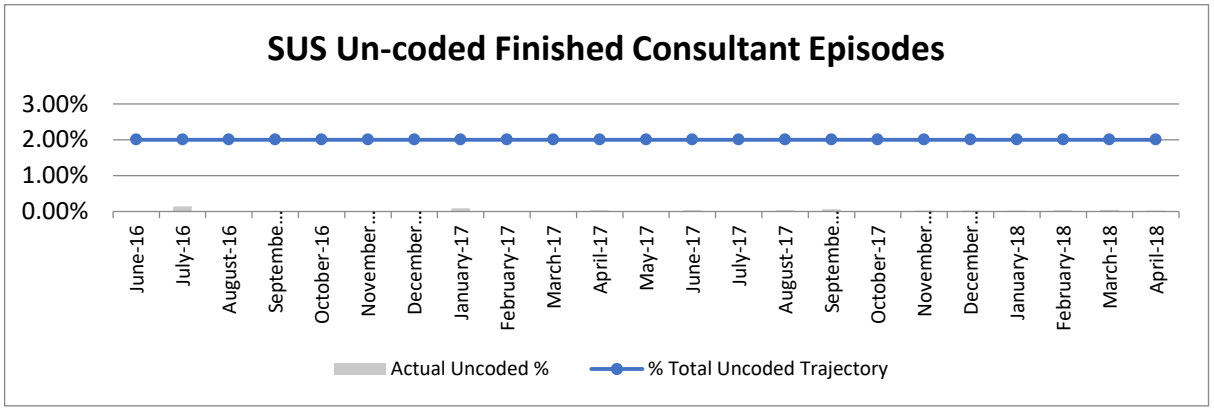
- Deadline and Targets: Achieve 100% coding target by the 5th working day after the month end.
- Audits: Improving coding accuracy by conducting monthly audits of coded data before the final submission.
- Recruitment and Training: Recruit and train trainee clinical coders in coding awareness and clinical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

Performance against this Target

The Trust has consistently achieved 100% coding targets by the 5th working day after the month end. The average percentage of finished consultant episodes coded at first submission has increased from 97.2% in 2016/2017 to 100% in 2018/2019.

		Spell Discharges				
FCE Month	**1st SUS Submission date**	**Total Number of Episodes**	**Volume Un-coded as SUS first Submission Date Actual & Trajectory**	**Actual Un-coded %**	**% Total Un-coded Trajectory**	**% Coded at 1st Submission**
April-13	17/05/2013	7167	2066	28.80%	28.8%	71.2%
May-13	19/06/2013	7473	1404	18.80%	18.8%	81.2%
June-13	22/07/2013	6937	1379	19.90%	19.9%	80.1%
July-13	19/08/2013	7356	1631	22.22%	22.2%	77.8%
August-13	19/09/2013	8129	1645	20.24%	21.0%	79.8%
September-13	21/10/2013	8326	1709	20.53%	20.0%	79.5%
October-13	19/11/2013	9012	2173	24.11%	18.0%	75.9%
November-13	20/12/2013	8826	1733	19.64%	14.0%	80.4%
December-13	20/01/2014	8294	2159	26.03%	11.0%	74.0%
January-14	19/02/2014	8780	712	8.11%	9.0%	91.9%
February-14	13/03/2014	8251	998	12.10%	6.0%	87.9%
March-14	24/04/2014	7538	498	6.61%	2.0%	93.4%
April-14	22/05/2014	7256	924	12.73%	2.0%	87.3%
May-14	20/06/2014	7407	1015	13.70%	2.0%	86.3%
June-14	22/07/2014	7300	1018	13.95%	2.0%	86.1%
July-14	21/08/2014	8234	283	3.44%	2.0%	96.6%
August-14	22/09/2014	6961	209	3.00%	2.0%	97.0%
September-14	21/10/2014	7819	163	2.08%	2.0%	97.9%
October-14	21/11/2014	7743	220	2.84%	2.0%	97.2%
November-14	17/12/2014	8114	393	4.84%	2.0%	95.2%
December-14	23/01/2015	8248	484	5.87%	2.0%	94.1%
January-15	20/02/2015	8666	940	10.85%	2.0%	89.2%
February-15	20/03/2015	8066	621	7.70%	2.0%	92.3%
March-15	23/04/2015	8809	496	5.63%	2.0%	94.4%
April-15	22/05/2015	8729	433	4.96%	2.0%	95.0%
May-15	18/06/2015	8044	565	7.02%	2.0%	93.0%
June-15	20/07/2015	8743	972	11.12%	2.0%	88.9%
July-15	20/08/2015	8985	917	10.21%	2.0%	89.8%
August-15	18/09/2015	7857	1101	14.01%	2.0%	86.0%
September-15	20/10/2015	8457	617	7.30%	2.0%	92.7%
October-15	19/11/2015	8732	431	4.94%	2.0%	95.1%
November-15	16/12/2015	9166	999	10.90%	2.0%	89.1%
December-15	21/01/2016	8655	1902	21.98%	2.0%	78.0%
January-16	18/02/2016	8680	1950	22.47%	2.0%	77.5%
February-16	18/03/2016	8996	2312	25.70%	2.0%	74.3%
March-16	21/04/2016	9376	2104	22.44%	2.0%	77.6%
April-16	20/05/2016	8866	702	7.92%	2.0%	92.1%
May-16	20/06/2016	8789	747	8.50%	2.0%	91.5%
June-16	20/07/2016	8960	733	8.18%	2.0%	91.8%
July-16	18/08/2016	9012	344	3.82%	2.0%	96.2%
August-16	20/09/2016	8897	85	0.96%	2.0%	99.0%
September-16	20/10/2016	9063	180	1.99%	2.0%	98.0%
October-16	18/11/2016	9404	42	0.45%	2.0%	99.6%
November-16	16/12/2016	9882	90	0.91%	2.0%	99.1%
December-16	20/01/2017	8972	35	0.39%	2.0%	99.6%

January-17	20/02/2017	9559	29	0.30%	2.0%		99.7%
February-17	20/03/2017	8721	36	0.41%	2.0%		99.6%
March-17	24/04/2017	10049	0	0.00%	2.0%		100.0%
April-17	19/05/2017	8644	12	0.14%	2.0%		99.9%
May-17	19/06/2017	9307	0	0.00%	2.0%		100.0%
June-17	19/07/2017	8898	1	0.01%	2.0%		100.0%
July-17	17/08/2017	9024	1	0.01%	2.0%		100.0%
August-17	19/09/2017	9082	0	0.00%	2.0%		100.0%
September-17	18/10/2017	8859	0	0.00%	2.0%		100.0%
October-17	17/11/2017	9297	8	0.09%	2.0%		99.9%
November-17	15/12/2017	9315	1	0.01%	2.0%		100.0%
December-17	17/01/2018	8447	1	0.01%	2.0%		100.0%
January-18	19/02/2018	9003	3	0.03%	2.0%		100.0%
February-18	16/03/2018	7899	0	0.00%	2.0%		100.0%
March-18	19/04/2018	8840	3	0.03%	2.0%		100.0%
April-18	21/05/2018	8196	0	0.00%	2.0%		100.0%
May-18	18/06/2018	8907	3	0.03%	2.0%		100.0%
June-18	18/07/2018	8558	5	0.06%	2.0%		99.9%
July-18	16/08/2018	8741	0	0.00%	2.0%		100.0%
August-18	18/09/2018	8783	2	0.02%	2.0%		100.0%
September-18	17/10/2018	8504	2	0.02%	2.0%		100.0%
October-18	16/11/2018	9411	2	0.02%	2.0%		100.0%
November-18	17/12/2018	9117	3	0.03%	2.0%		100.0%
December-18	17/01/2019	8614	4	0.05%	2.0%		100.0%
January-19	15/02/2019	9559	2	0.02%	2.0%		100.0%
Total		600311	42252		7.0%		93.0%
Avg No of Episodes over last 4mths		9175.25					

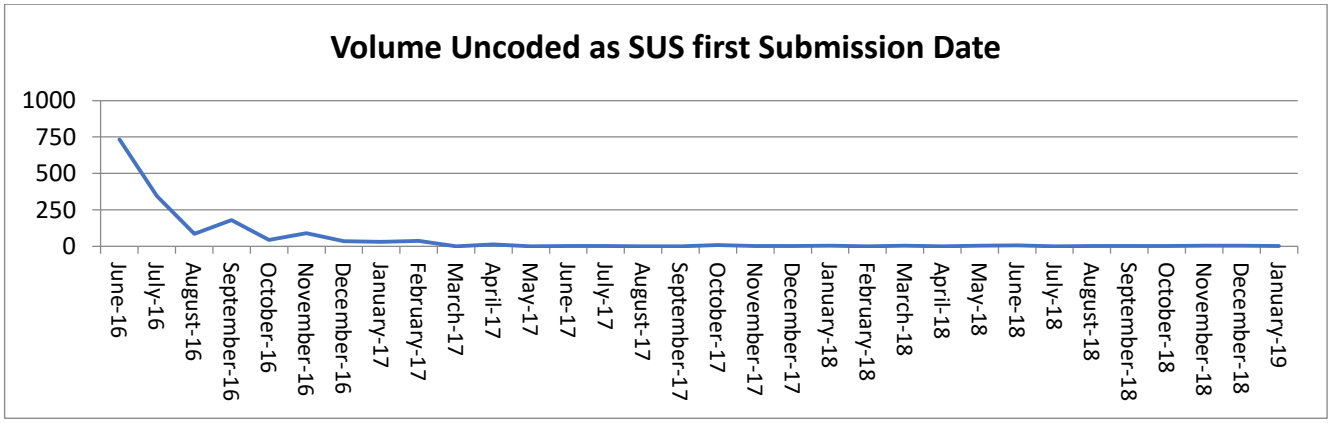


Notes:

The table above provides an indication of the volume of un-coded episodes for discharged hospital spells within each month

The 1st Submission date and % un-coded will aid users on what period to select for Mortality reports to ensure a more robust picture

All discharges are coded for the Post PbR Reconciliation deadlines and a refreshed SUS submission sent



Audits

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

2018 / 2019 Gross Savings or Income (£'000)													
Area:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Clinical Coding Audit	£73,415	£69,789	£79,605	£100,648	£72,756	£75,380	£98,567	£78,129	£0	£0	£0	£0	£648,289
Clinician & Coding Audit	£24,101	£23,161	£49,293	£31,287	£56,296	£55,452	£60,902	£48,653	£0	£0	£0	£0	£349,145
Total	**£97,516**	**£92,950**	**£128,898**	**£131,935**	**£129,052**	**£130,832**	**£159,468**	**£126,782**	**£0**	**£0**	**£0**	**£0**	**£997,434**
Investments (invoice dated)													
Area:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Data	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Auditors	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Net Savings													
Total	**£97,516**	**£92,950**	**£128,898**	**£131,935**	**£129,052**	**£130,832**	**£159,468**	**£126,782**	**£0**	**£0**	**£0**	**£0**	**£997,434**

Data Security Standard 1 Data Quality:

As part of Data Security and Protection Toolkit, the Trust has undertaken an audit of 200 finished consultant episodes (August - December 2018) to assess the accuracy of clinical coding. The Trust's coding accuracy meet the required percentage across all four areas.

The table below illustrates the clinical coding audit results compared to Terminology and Classifications Delivery Service recommended percentage of accuracy scores.

	Primary diagnosis correct	**Secondary diagnosis correct**	**Primary procedure correct**	**Secondary procedure correct**
Advisory	>=95%	>=90%	>=95%	>=90%
Mandatory	>=90%	>=80%	>=90%	>=80%
SFH Trust	93.5%	95.18%	97.71%	97.07%

Recruitment and Training

The Trust has appointed a dedicated Clinical coding trainer, Clinical Coding Auditor, and also successfully recruited three trainee clinical coders in March 2018.

Clinical Coding Awareness

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

Clinical Engagement

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

How Was This Achieved

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

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

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

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

Monitoring and reporting for sustained improvement

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

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

- Ensure that both operational 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 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 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.

9 Data Quality 2018/19

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.

Effective decision making by clinical, operational and managerial staff is dependent on the timely availability of accurate and high quality information. As such, patient care can be affected positively and negatively by the quality of data.

Data Quality Strategy for 2019-2020

The Data Quality Strategy describes the Trust's approach to optimising data quality, to enhance and improve decision-making and services to patients.

Patient data is collected and processed 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. It is essential that staff understand the value of capturing high quality data in real-time to improve patient care.

The Trust invested in ensuring that the recommended six data quality dimensions as indicated below are adhered to, thus providing assurance that all information reported is as robust as possible.

Six Dimensions of Good Quality Data

- Accuracy
- Relevance
- Reliability
- Timeliness
- Completeness
- Validity

Trust Data Quality Oversight Group (DQOG)

The Data Quality Oversight Group acts as a point of escalation for emerging data quality concerns and oversees the management and resolution of existing data quality issues. The group prioritises issue investigation and resolution based on risk and available resources, mobilising relevant teams as required. The group ensures that issues are dealt with in a timely manner, ensuring that the appropriate manager or team takes ownership of issues and their resolutions. The overarching aim is to improve the quality, accuracy and timeliness of data capture, reporting and use within the Trust.

The Trust has:

- Reviewed and updated the Governance and reporting hierarchy for data quality
- Reviewed the three key behaviours in our approach to providing data quality. These are:
    - **i.** Responsiveness
    - **ii.** Proactivity
    - **iii.** Continuous Improvement

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

- Provide consistent feedback to the Board to highlight issues identified through the Data Quality Oversight Group
- Review current data quality risks, outcomes and lessons learnt.
- Where instances of poor-quality data are identified, the Data Quality Team will endeavour to break the cycle of reporting poor quality data by following a Data Quality Improvement Process

Data Quality Improvement Process

Data Quality Training

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

Medway is the Patient Administration System (PAS) used by the Trust. Training is delivered by the NHIS IT trainers and is a prerequisite to obtaining access to the Trust's PAS. The Trust continues to deliver a comprehensive training plan for both Data Quality and Elective Care. The Trust has:

- Established ongoing review of Standard Operating Procedures, Medway process guides and role based user guides (acknowledging that this is a continuous process in the light of system upgrades);
- Undertaken a training needs analysis for elective care education;
- Developed an Elective Care Training Strategy;
- Developed online training packages and resources.

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

- Roll out of Elective Care Training Plan for both existing and newly appointed staff.
- Revisit training and user competency on an annual basis via mandatory training and/or appraisal process.

- Create a working group to address issues with Non-elective patient care data (in line with Elective Care training Strategy)
- To continue to keep the Trust informed of emerging data quality issues through our regular communication channels;
- To maintain the process of continuous evaluation of documentation designed to support system users to maintain data quality standards e.g. Standard Operating Procedures;
- Where system upgrades take place documentation is amended in response and appropriate user awareness sessions are delivered.
- Establish a process for assuring and signing off all data reported externally. To ensure processes are in place to provide the Trust with assurance that internally and externally reported data has received the required validation and sign off.
- To examine individual data items within the DQMI to identify areas that require improvement;
- To aim to increase total DQMI score to > 99% by reporting period Jul – Sept 2019.
- To investigate areas where performance is less than 100% to ascertain contributory factors and address any issues where this can be improved.

Data Quality Improvement KPI's

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

- Outpatient Referral Management
- Outpatient Activity
- Inpatient Activity
- Elective Waiting List Management
- Referral to Treatment (RTT)
- Maternity
- Medway PAS Maintenance Generic Data Quality

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

Data Quality Internal Audit Programme

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

Data Quality Communication Channels

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

The Data Quality Team coordinates communication through the following channels:

- Trust articles and bulletins;
- Dedicated Data Quality web page (on the Medway front screen e.g. contains Standard Operating Procedures [SOPs]; Q&A section; policies and procedures etc.
- All training sessions (e.g. System specific training [coordinated by NHIS]; Data Quality Team; and Information Governance Team);
- E-learning tools;
- Awareness sessions;
- Progress reports to the Board and Audit Committee;
- Dedicated Data Quality and Clinical Coding support provided to all Divisions (and Service Lines as appropriate).

Data Quality Position April 2018

The Data Quality Maturity Index (DQMI) is a quarterly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality. When compared to peer-group organisations based on similar size and population, only three NHS Trusts have a higher DQMI score.

The Trust has:

- Explored and improved accurate and real-time data capture in ED;
- Explored and improved accurate and real-time data capture within admitted patient care (APC);
- Completed internal project to address issues with historic referral management, validated and cleansed the data to establish true position of open patient episodes within the Trust PAS;
- Introduced a suite of Operational DQ reports with the aim of addressing process issues, resulting in potential failures to manage patients' care pathway following outpatient attendance and compounding referral management issues (Fig 3).

10. Learning from Deaths

During 2018/19 1446 of Sherwood Forest Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 362 deaths in the first quarter;
- 302 deaths in the second quarter;
- 367 deaths in the third quarter;
- 415 deaths in the fourth quarter.

By 31 March 2019, 1201 case record reviews and 51 investigations have been carried out in relation to the 1446 deaths included above. In 11 cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried was:

- 13 cases in the first quarter
- 16 cases in the second quarter
- 8 cases in the third quarter
- 14 cases in the fourth quarter

11 cases, representing 83.06% of the 1446 deaths are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 3 deaths representing 0.8% for the first quarter
- 2 deaths representing 0.6% for the second quarter

- 0 deaths were identified in the third quarter
- 3 representing 0.8 % for the fourth quarter

These numbers have been estimated using the Royal College of Physicians Structured Judgement Review (SJR) methodology.

There have been a number of components to the success of the Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) Mortality story. The Trust had been working closely with Dr Foster for a number of years; however the real progress became evident in 2014/15 when this collaborative relationship began to fully understand our mortality position by getting underneath the data and responding to what it was telling us.

The Trust learned the first step was to recognise the improvements required to not only improve our Hospital Standardised Mortality Ratio (HSMR) but also the changes needed to ensure the same level of care, access to diagnostics and senior input available regardless of the day of the week.

The Trust have continued to build on that relationship with a much more engaged and proactive approach to the monthly report to the Trust Mortality Surveillance Group. As a consequence the Trust has consistently performed within the expected HSMR range since April 2016, despite continuing increased crude mortality through the winter period.

The Royal College of Physicians Structured Judgement Review Methodology (SJR) is now well established across the organisation. The adoption of this review methodology has built firmly on the electronic Mortality Review Tool (MRT) introduced in 2015 providing a comprehensive, standardised review methodology that is well understood by clinical teams and facilitates the multidisciplinary and where required multispecialty review of care delivery and improvement opportunities.

In line with the national guidance the Trust has agreed those cases where, regardless of cause of death or care delivered, a Structured Judgement Review of the case must be completed. It is recognised that due to the demographics of our population we refer a higher than average number of cases to the coroner. For those cases accepted by the coroner for further investigation the Trust has received positive feedback on the usefulness of the SJR findings in supporting the coronial process.

Following the murders of over 200 patients by Dr Harold Shipman provision has been made in the Coroners and Justice Act (2009) for all deaths in England and Wales not investigated by a coroner to be scrutinised by an independent 'Medical Examiner'.

Medical Examiners will be senior doctors, specifically trained for this role, who will question the cause of death proposed by the treating doctor on the basis of proportional scrutiny of the medical records, an interview with the next of kin and where required an external examination of the deceased. The agreement of the Medical examiner will be necessary before the death can be registered, unless the case has been accepted by the Coroner.

Although the numbers are small the Trust has also focused on those deaths of patients with a diagnosed learning disability. The NHS Improvement (NHSI) *'National Guidance on Learning from Deaths' (2017)* and the review by the Care Quality Commission (CQC) *'Learning, candour and accountability' (2016)* both acknowledged that a person with a known learning disability has a shorter life expectancy and a such have introduced a standalone process for externally reviewing all deaths for this vulnerable group of patients.

The 'Learning Disabilities Mortality Review' (LeDer), commissioned by the Healthcare Quality Improvement Partnership (HQUIP) receives notification of all deaths of people with a learning disability. The process supports the independent review of each death for persons aged 4-74 years.

The robust review of deaths has identified common themes. Most commonly indicated is the confidence, ability and timeliness of clinical staff to have a documented discussion with a patient, their families and carers around care planning, in particular when patients are nearing the end of their life.

A significant proportion of SJR/Avoidability assessments presented to the Trust Mortality Surveillance Group identify a failure to apply appropriate, well-documented, well-explained and timely ceilings of care. This often leads to distress and confusion for the patient and relatives and on occasions inappropriate treatment or intervention.

As the mortality review system has matured across specialties, teams are becoming more competent at identifying those cases where a more in-depth review is required. This has led to some complex, but extremely productive multidisciplinary and multispecialty interactions and enhanced the opportunities for teams to learn together.

The Trust has committed to developing the Medical Examiner role and approved a business case setting out the service requirements. A pilot service was conducted through quarter two of 2018/19 with positive evaluation, particularly from bereaved families who were pleased to have their opinions requested and to be offered an authoritative and independent explanation of the cause of death. In addition, independent scrutiny of medical records, supplemented by discussions with the bereaved, has proved to be a consistent source of high-quality information about the quality of care, irrespective of the nature of the problem. Junior medical staff have also been appreciative of the support, advice and guidance they have received when completing the certificate of Cause of Death increasing their confidence and knowledge.

Through 2018 the Trust carried out a mortality review using the SJR Methodology for 14 learning disability cases and concluded that the Trust mechanism was robust and infact elicited more detail and learning opportunities with regard to care delivered when compared to the LeDer. We will continue to optimise our internal review method and continue to support the requirement for the external independent review.

The Trust is working collaboratively with external partner organisations to implement the ReSPECT Tool. The ReSPECT process creates individualised recommendations for a person's clinical are in emergency situations. The process involves a conversation, which:

- Develops a shared understanding of a person's condition, circumstances and future outlook
- Explores the person's preferences for their care and realistic treatment in the event of a future emergency
- Makes and records agreed clinical recommendations for their care and treatment in a future emergency in which they cannot make or express decisions at the time

The plan is to implement the tool from 1 April 2019.

The Trust recognises that learning from the care given to patients in their final days is about understanding how that care met their needs and those of their relatives and carers. It is about understanding the right decisions were made in conjunction with them and that they were fully informed at all times.

We have made good progress throughout the year and have a firm basis on which to improve even further. The learning themes from our mortality reviews have helped shape some of the Quality Strategy and improvement requirements for the coming year and it is hoped we will continue to optimise our learning opportunities, sharing good practice across the organisation and wider health system.

Zero case record reviews and zero investigations have been completed after 1 April 2018, which related to deaths, which took place before the start of the reporting period.

Zero cases representing 0% of the 1446 deaths are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using Royal College of Physicians structured judgement review methodology.

2.3 Reporting Against Core Indicators

1 Summary Hospital Level Mortality Indicator (SHMI) Banding

1.1 The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services by working with our partner organisations to ensure that our SHMI banding remains within the expected (2 “level of mortality”).

The table below illustrates the Trusts SHMI banding as being consistently recorded as a two, which indicates ‘as expected’ level of mortality.

Year	SFH SHMI Value	SFH SHMI Banding	National Average	Highest Performer	Lowest Performer	SHMI banding - Worst	SHMI banding - Best
Oct 16 – Sep 17	101.62	2	100.5	72.7	124.73	1	3
Jul 17 – Jun 18	97.72	2	100.35	68.92	125.72	1	3
Oct 17 – Sep 18	96.72	2	100.3	69.17	126.81	1	3

Percentage of Patient Deaths Coded as Palliative Care

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between Trusts in the way that palliative care codes are used. Using the same spell level data as the SHMI, this indicator presents crude percentage rates of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level. The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI). The table below provides the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

Year	% of deaths with palliative care coding	National Average	Highest Performer	Lowest Performer
Jul 17 – Jun 18	15.00%	32.90%	58.70%	13.40%
Oct 17 – Sep 18	15.20%	33.40%	59.50%	14.20%

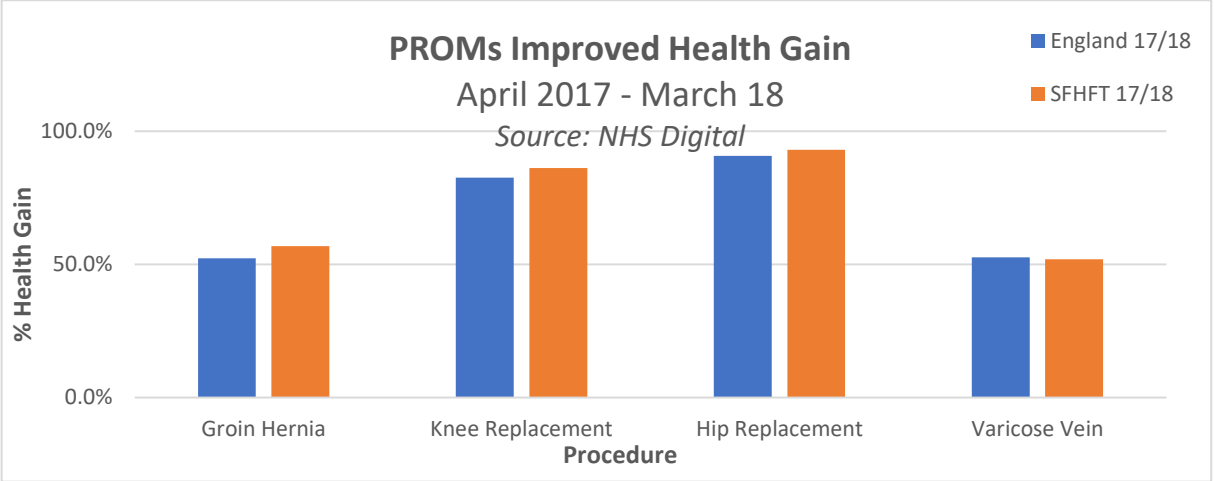
2 Patient Reported Outcome Measures (PROM's)

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; that it is made available to the Trust through NHS Digital.

PROMs measures health gain in patients undergoing groin hernia surgery, varicose vein surgery, hip and knee replacement surgery in England, based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009.

PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.

The graph below shows the how the Trust compares to the England average for measuring generic health status. This is one of the most commonly used generic health status measurement and has high levels of validity and reliability reported in various health conditions.



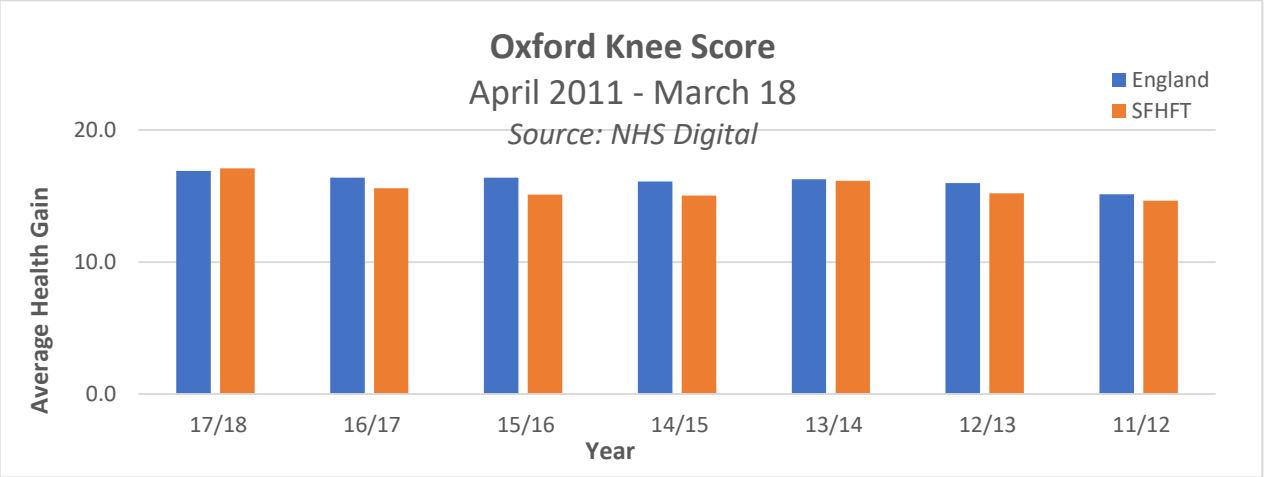
Improved Health Gains – April 2017 – March 2018

Note: Hernia & Varicose Vein covers Apr - Sep 17 collection ceased Oct 17 this is finalised. PROMs April 2017 to March 2018 Provisional data (Published 09/08/18).

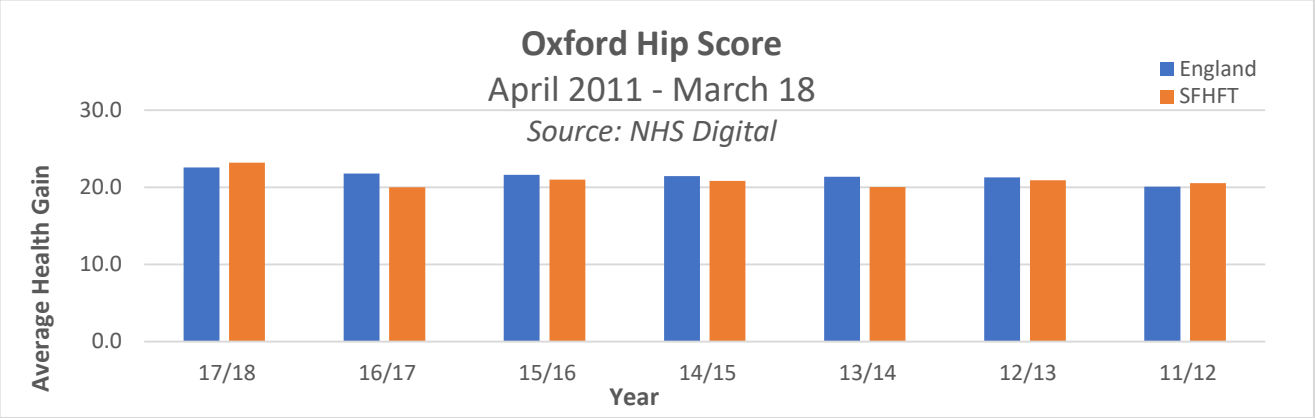
In response to the 2016/17 results the Trust has undertaken an audit and review of cases to ascertain how to improve the scores to above the national average. A key action was to implement a telephone clinic to enable a specialist nurse to support the patient in completing their post-operative questionnaire and compare their pre-operative questionnaire scores as patients do not have their pre-operative questionnaire scores in order to compare and support their completion.

The graphs below show the Oxford Scores for Hip and Knee replacements. The Oxford score is a patient-reported outcome instrument, which contains questions on activities of daily living that assess function and residual pain in patients specifically for undergoing Total Hip or Total Knee replacements.

Oxford Knee Score – April 2011 – March 2018



Oxford Hip score April 2011 – March 2018



Sherwood Forest Hospitals NHS Foundation Trust has seen a significant improvement in these scores in 2018/19. Total Hip Replacements has seen a 16.0% improvement in health gains whilst Knee Replacements have seen a 9.6% improvement with both procedures now better than the England National Average for the first time.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by working with our Clinical Commissioning Group to enhance and further develop our MSK pathways. In addition, the Trusts pre-operative assessment department are working with local councils to develop strategies to ensure patients are optimised and in the best health prior to surgery.

3 Percentage of patients readmitted to hospital within 28 Days

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

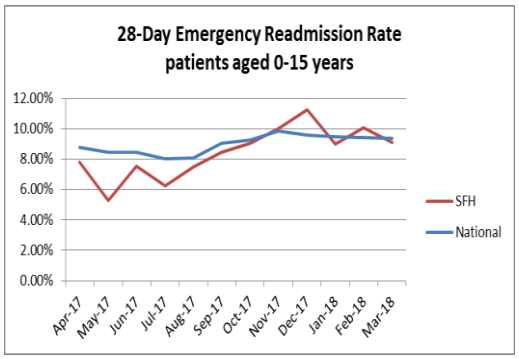
In 2018/19:

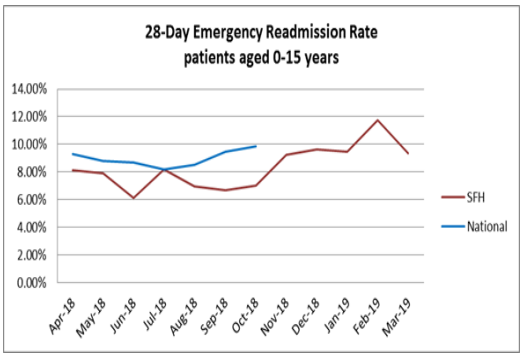
- 7.73% of patients aged 0 to 15 were readmitted to a hospital within 28 days of being discharged during the reporting period.

- 8.46% of patients aged 16 or over were readmitted to a hospital within 28 days of being discharged during the reporting period.

Emergency Readmission Rate % (28 Days) by Month of Discharge (0-15 years)

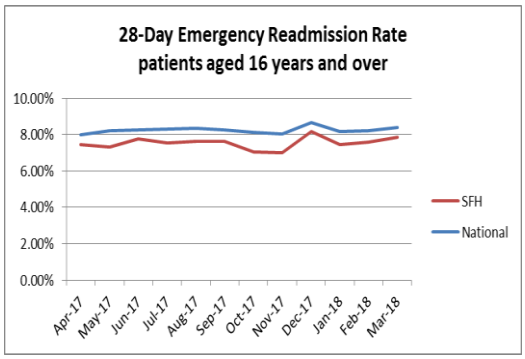
Data Source: Dr Foster

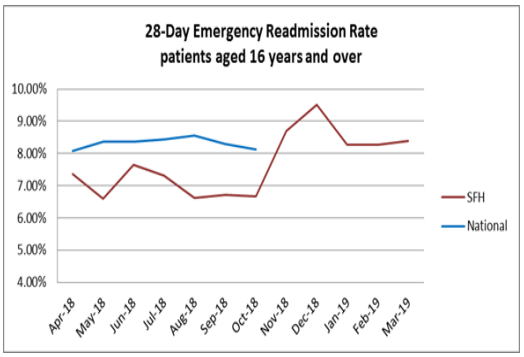




Emergency Readmission Rate % (28 Days) by Month of Discharge (16 years and over)

Data Source: Dr Foster





The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by:

- Safe, timely discharge planning ensuring patients are discharged to the appropriate place of residence. The Trust continues to build effective relationships with Community and external partners to ensure patients are supported safely through their discharge.

The 28 day readmission rate for patients across the Trust continues to be monitored monthly through the Executive-led Divisional Performance meetings and reported to the Board of Directors on an exception basis.

4 Trust Responsiveness to the Personal Needs of Patients

The Trust is committed to resolving any complaints or concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the Patient Experience Team (PET). PET provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/ward directly, or where they have done so but their concern remains unresolved. The PET aim to resolve any concerns that are raised with them quickly and informally with the cooperation of the department/ward involved in the care and treatment provided to the patient. Should the patient or carer feel that their concern should be formally investigated they are able to make a formal complaint. The Trust operates a centralised complaints service, which ensures that a patient centred approach is taken to the management of complaints and that

all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt, or where necessary an agreed timescale dependent upon the complexity of the complaint.

During 2018/19 the Trust received 392 complaints. In the same reporting period we responded to 95% within the recommended 25 days or agreed timescales when complaints are complex. A total of 36 Local Resolutions Meetings took place with patients and families to listen and resolve complaints face to face.

Responsiveness to personal needs of patients is reported through the National Inpatient Survey data reported annually and the Friends and Family Data collected daily and reported weekly to the relevant teams and departments.

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason: the survey was undertaken by Quality Health for Sherwood Forest Hospitals NHS Foundation Trust using the methodology determined by the survey co-ordinating centre for the overall national inpatient survey programme. At the time of writing this report the 2018 patient survey information is embargoed and will not be available until mid to the end of June 2019.

The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by triangulating the feedback with incidents, claims and coroner's inquest outcomes. Governance continues to be reported and monitored at the monthly Patient Safety and Quality Group, chaired by members of the Trust Executive Team. Friends and Family Data is monitored as a reported KPI to Trust Board monthly and as part of the monthly Nursing Ward Assurance programme.

Following the publication of the National Inpatient Survey in 2017/18, a number of recommendations highlighted key themes relating to:

- Patient Information – procedures, medication and raising concerns/complaints
- Waiting times for admission
- Communication – transfers, medications, decisions about care and discharge arrangements
- Carers information
- Catering, quality and care at mealtimes

Whilst some of the themes are national issues the Trust has identified a number of themes as priorities within the Advancing Quality Programme (AQP) 2018/21. The themes included are as follows:

- Patient Information – the Trust has a dedicated Patient Information Officer, and a policy is in place to ensure all patient information is reviewed and revised in accordance with this policy. An amnesty of all patient information was undertaken in 2017/18 to ensure all Patient Information leaflets were accurate and relevant with gaps in information identified. All patient information is held electronically and centrally, which staff can access via the Trust Intranet.

- Waiting times for admission - divisions continue to work with internal and external partners to reduce waiting times as far as possible. Whilst shortage of beds is a national issue, the Trust will continue to monitor wait times and prioritise patients who are most at risk through regular performance meetings.

- Communication - all patient feedback relating to communication is discussed as part of the outcome of the complaint investigation process. All complaints received regarding doctors are addressed as part of their annual appraisal process. The Trust is currently reviewing the communication skills and competencies relating to nursing and doctors' training, considering opportunities to enhance the current training packages at Trust Induction.

- Carers Information - the Trust introduced the Carers Charter in 2017 for all patient carers. This includes a 'Carers Passport; which is provided by the ward or the Patient Experience Team. This allows carers to visit their relatives outside the set ward visiting times to provide additional support for the patient. An example of this would be to invite relatives and carers to stay at meal times to help with feeding in addition to identifying current and ongoing emotional and practical needs.

- Patient Experience Surveys - During 2018/19 the National Survey Programme for 2018/19 has commenced, and currently the Trust has concluded two of the five surveys - Cancer Survey and Maternity Survey. The final reports have been received. The Maternity Survey Report and the Cancer Survey has confirmed improved results. Following the introduction of tumour specific cancer surveys to understand the experience and impact for patients are disease level. These surveys are sent quarterly to current patients in order to help provide real-time feedback for services to ensure improvements are made quickly and effectively. The Inpatient, Urgent and Emergency Care and Children's and Young Peoples' Surveys are currently ongoing at this time.

Additional Patient Experience Initiatives

The Trust continues to develop service-specific patient surveys and expand on the Friends and Family Test (FFT) to understand how effective the improvement work streams have been. Themes that have been identified within this work include the quality and presentation of patient meals, the quality and provision of patient information, the environment in the Radiology Department and the experience of patients within the recovery area of Theatres. Feedback from surveys, specifically the FFT is reported monthly to specialties and reviewed as part of the service line meetings. Currently there are no specific themes from the FFT and survey results to indicate ongoing concerns; therefore, we are hopeful the work streams are improving the overall patient experience.

5 Staff Friends and Family Responses and Recommendation Rates

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust continues to perform positively as being a place our staff would recommend as a provider of care.

- This is underpinned by the Trust's Care Values, which puts the patient and staff, at the heart of everything we do.

- The Trust's good CQC ratings triangulate this.

Areas identified for action following the 2018 NHS Staff Survey

The 2018 NHS Staff survey shows continued and steady improvement in almost all areas. This had been influenced by some of the initiatives that the Trust undertook in response to the 2017 NHS staff survey findings. These actions focused on the following areas:

Staff engagement

- This continued to be a high priority with activities set out in the Organisational Development and Engagement Plan element of the Workforce Strategy, supported by the Trust's Communications Strategy.
- Regular staff briefing events took place throughout the year. There was emphasis on ensuring staff received regular and honest information about the Trust's performance, the CQC rating, quality and improvement activities, sharing learning and celebrating achievements.
- Senior leaders continued their commitment to engagement. A blended approach to this was encouraged through CEO and executive open briefing and drop-in sessions held at each hospital site, executive attendance at board rounds on wards and Trust Board member workplace visits designed to increase visibility.

- The CEO's weekly email message and updates from Executive Directors help to keep staff updated and well informed.

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

Staff well-being and safety activities

- These are set out in the Staff Health, Safety and Wellbeing Plan of Maximising our Potential and include embedding as business as usual the CQUIN Staff Health & Wellbeing work undertaken already undertaken together with initiatives such as Time to Change. The link between engaged, well-motivated, happy and healthy staff and the delivery of high quality patient care is well documented and pivotal to our engagement philosophy in the Trust.

- Creating and maintaining a safe environment is important in the Trust and therefore ensuring that all staff attend high quality mandatory training that reflects best practice is a priority. For all of 2018/19, the compliance rates for attendance on this training continually exceeded the target (90% at the start of 2018/2019 increasing to 93% in October 2018).

- All staff are encouraged to raise concerns through appropriate mechanisms and to have a culture where they are confident that they will be listened to and have their concern considered. This is achieved by adopting an open door policy with senior leaders being accessible to hear concerns and ideas and promoting a no blame culture. The Trust's Freedom to Speak Up Guardian's role and contact details continue to be widely publicised through Staff Brief, Orientation Day, Staff Bulletins, posters and pop up banners. Where staff raised concerns the Trust ensures that these are addressed appropriately and that feedback is provided to the person raising the concern. The concerns raised are monitored for themes and trends, periodically reported to the Executive Team and the Trust Board and triangulated with KPIs and other data.

Developing Trust Leaders and Staff

- The Leadership, Talent Management and Succession Plan and the Trusts Training, Learning and Development Plan set out initiatives for improving the development of Trust leaders and staff. The formal leadership talent mapping and succession planning system created in 2017/18 which documents and supports the readiness of existing senior leaders for progression and identifies any areas of risk was integrated into the Trust's appraisal process during 2018 to provide talent conversations for staff at all levels.

- In 2018/19 the Trust's refreshed leadership development programmes and leadership framework were widely promoted and well received. The Trust's facilitators continued to be instrumental in the delivery of the Mary Seacole Leadership Development programme for the wider health and social care system. The Managers Induction Programme for new people managers and leaders in order to ensure a seamless transition into their leadership role with the Trust was embedded and a range of Tool Box talks were introduced to support managers to more effectively engage, motivate and manage staff.

- The Trust also embarked on the NHS Improvement/King's Fund Culture and Leadership Programme, completing the diagnostic phase in 2018. The results have been triangulated with other data e.g. the NHS annual Staff Survey and Staff FFT results to create an action plan to be implemented in 2019/20.

National NHS Staff Survey – 2018

The Trust participates in the national NHS Staff Survey on an annual basis. The most recent survey was undertaken from the beginning of October until the 30th November 2018. For the second time the Trust elected to survey all staff and 2,789 responded giving a response rate of 62% compared to 57% in 2017 and 41% in 2016. The average response rate for acute trusts' in England was 44%. The increase in response rate for the national staff survey is replicated in the Staff Friends and Family Test indicating increased staff engagement.

Changes to national reporting arrangements for the National NHS Staff Survey

This year (2018), there are significant changes to the way in which the reports are analysed by the National Co-ordination Centre and it is not possible to identify whether or not the Trust is in the best or worst 20%. Only comparisons with the average and best and worst performers are possible. This means that the Trust is not able to report against some of its anticipated Key Performance Indicators; however, some aspects of the new national reports enable the Trust to better visualise and interrogate the results.

Overview

Below are the first five of the 10 key indicator areas. This shows that the Trust scored above average in four of the five areas and score at the average in the fifth.

(Score 1 - 10)	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
Best (Acute Trusts in England)	9.6	6.7	7.3	6.7	6.5
Trust (SFH)	9.2	5.9	7.0	6.4	5.6
Average (Acute Trusts in England)	9.1	5.9	6.7	6.1	5.4
Worst (Acute Trusts in England)	8.1	5.2	6.2	5.4	4.6

(Score 1 - 10) Trust comparison	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
2017 score	9.3	5.9	6.9		5.4
2018 score	9.2	5.9	7.0	6.4	5.6
Trust comparison statistically significant change		Not significant		N/A	

Two areas; support from immediate managers and the quality of appraisals were above average and had improved from 2017. This may reflect the re-launch and retraining offered on appraisals and the focus on leadership training during 2018. The equality, diversity and inclusion score had fallen slightly compared to 2017. However, it still remained above average and was over 10% better than the worst performing acute trust. Below are the second five of the ten key indicator areas. Three scores are above average; one is at the average and one (safe environment) – violence is below average. The latter score has not changed since 2017.

The staff engagement score has positively increased, together with the safety culture score. Both are appreciably better than average and significantly better than the worst score.

(Score 1 - 10)	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
Best (Acute Trusts in England)	8.1	8.5	9.6	7.2	7.6
Trust (SFH)	7.8	7.9	9.3	6.8	7.3
Average (Acute Trusts in England)	7.4	7.9	9.4	6.6	7.0
Worst (Acute Trusts in England)	7.0	7.1	9.2	6.0	6.4

(Score 1 - 10) Trust comparison	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
2017 score	7.8	8.0	9.3	6.7	7.2
2018 score	7.8	7.9	9.3	6.8	7.3
Trust comparison statistically significant change	Not significant		Not significant		

Recommendation of the Trust as a place to work and to receive care

One of the most important measures is whether or not our own staff would recommend the Trust as a place to work or receive care. The Trust has seen a positive year on year improvement. The Staff Friends and Family Test undertaken each quarter enables the Trust to monitor this key indicator.

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) has been in place since April 2014 and was designed as a tool to support local improvement. Results are submitted to NHS England and are published nationally. All staff must have the opportunity to respond at least once in the year. In 2018 the Trust decided to survey all staff each quarter. 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 Quarter Three NHS Staff Survey questions are slightly different:

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

It is a requirement to provide a free-text follow up question for each of the two FFT questions, 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.

The following table compares the Staff FFT and the national NHS Staff Survey results for staff saying they would be likely, or extremely likely to recommend the Trust 2017/18 and 2018/19.

	Q1 Staff FFT		Q2 Staff FFT		Q3 Staff Survey		Q4 Staff FFT	
	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	85.71%	88.%	89.69%	88.47%	78%	80%*	89.26%	88.41%
How likely would you be to recommend this organisation to friends and family as a place to work?	71.43%	77%	71.82%	76.69%	70%	70%*	77.23%	78.15%
Number of respondents	21	1,140	291	1,180	2,515	2,739	1,172	1,208

*Taken from raw data results.

The 2018 Staff Survey results for the Staff Friends and Family Test questions shown with the new 1 – 10 scoring are:

a) **I would recommend my organisation as a place to work**

	2014	2015	2016	2017	2018
Best	77.1%	77.4%	76.1%	76.9%	81.0%
Your org	50.9%	46.6%	67.9%	69.5%	70.5%
Average	58.0%	60.3%	61.1%	60.7%	62.6%
Worst	31.9%	41.6%	41.5%	42.7%	39.2%

This indicated a very positive step change for the Trust in 2016 and since then there has been incremental improvement. This score is well above average for an acute Trust in England and has positive implications for our recruitment and retention activities.

b) If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

	2014	2015	2016	2017	2018
Best	89.5%	86.1%	84.8%	85.3%	87.3%
Your org	61.6%	57.1%	73.2%	77.6%	79.4%
Average	65.4%	69.3%	69.1%	70.8%	71.3%
Worst	37.9%	45.8%	48.5%	46.4%	39.8%

This indicated a very positive step change for the Trust in 2016 and since then there has been incremental improvement. This score is well above average for an acute Trust in England and is very significantly above the worst scoring acute trust.

Another metric in this suite relates to whether or not staff believe that the care of patients / service users is the Trust's top priority.

c) Care of patients / service users is my organisations top priority

	2014	2015	2016	2017	2018
Best	87.6%	87.1%	87.8%	87.1%	88.3%
Your org	65.6%	70.0%	80.9%	80.5%	84.1%
Average	70.5%	75.0%	76.2%	75.5%	76.7%
Worst	42.6%	55.6%	57.1%	59.6%	60.2%

This question has seen a 20% improvement since 2014 and confirms that the Trust is trying hard to put the patient at the heart of all its decisions and actions. This is very close to the top scoring acute Trust and significantly above average. It is a good indicator of the perceived culture of the Trust.

Performance in the five key areas

The score distribution across the five key areas of the survey is shown below.

	Your Job	Your Manager	Your Health, Wellbeing & Safety	Your Personal Development	Your Organisation
Above average	30	11	20	6	12
Average	0	0	2	0	0
Below average	0	0	15	2	0

All the scores relating to the member of staff's own job, their manager and the Trust are above average for an acute Trust in England. The scores relating to health, wellbeing and safety are much more variable, with almost half at average or below average. These questions reflect similar themes of concern to previous years around the staff member's experience of violence and aggression, stress, feeling under pressure to come to work, working long hours, bullying from colleagues, discrimination and being treated fairly. The personal development scores largely reflect the position that staff have regular appraisals and that their work is valued, but that appraisals do not always help them to do their job or identify their training needs.

Where the Trust has performed significantly above average

The results have been analysed and the Trust performed very close to the best performing acute Trust in a number of areas such as the two below:

d) I am enthusiastic about my job

	2014	2015	2016	2017	2018
Best	79.6%	85.0%	80.3%	79.2%	81.7%
Your org	72.0%	72.2%	78.4%	76.0%	78.9%
Average	69.4%	75.0%	75.2%	74.1%	74.8%
Worst	58.9%	67.0%	69.7%	67.9%	69.3%

The Trust has performed well in this question since 2016.

e) I feel that my role makes a difference to patients / service users

	2015	2016	2017	2018
Best	95.0%	93.8%	92.8%	92.9%
Your org	90.8%	92.1%	91.1%	91.8%
Average	90.4%	90.4%	90.1%	89.5%
Worst	85.8%	87.9%	86.0%	84.1%

SFH is just over 1% less than the best score for this. The results for this question correlate with the high scores for staff recommending the Trust as a place to receive care and that staff report that they believe that the care of patients / service users is the Trust's top priority.

Where staff experience is significantly below average

The areas where the Trust is significantly below average (more than 3% adverse to average) all appear to be clustered in the questions relating to health, safety and wellbeing. A couple of examples are shown below:

f) On average how many additional paid hours do you work per week for this organisation over and above your contracted hours?

	2014	2015	2016	2017	2018
Worst	45.5%	45.0%	48.4%	46.7%	46.0%
Your org	37.0%	36.0%	37.6%	37.3%	43.0%
Average	33.4%	35.1%	34.9%	35.7%	37.1%
Best	25.3%	20.3%	26.6%	26.5%	27.7%

This has increased by 6% over the last 5 years. It is potentially an indicator of the amount of overtime and bank shifts that substantive members of staff are voluntarily undertaking in the Trust to cover gaps in rotas. It is well below average and indicating that SFH staff members are working more hours than the average acute Trust member of staff. However, it is positive that these are PAID hours. On the question concerning excessive UNPAID hours, the Trust is reporting slightly better than average performance.

g) Have you felt pressure from your manager to come to work?

	2014	2015	2016	2017	2018
Worst	44.0%	41.1%	33.2%	35.1%	35.2%
Your org	39.6%	41.1%	33.2%	33.9%	35.2%
Average	33.3%	29.5%	27.1%	26.7%	25.9%
Best	20.8%	18.3%	18.2%	17.0%	19.1%

We are the worst performing acute Trust here. The theme of staff feeling pressurised to come to work when they feel unwell, is a prevalent theme, often linked to the Trust's sickness absence policy. However, when the trend analysis is scrutinised, it shows that there has actually been improvement in SFH when compared to 2014 and 2015.

h) In the last 12 months how many times have you experienced physical violence at work from patients/services users, their relatives or some other members of the public?

	2014	2015	2016	2017	2018
Worst	21.3%	22.1%	21.0%	22.2%	21.2%
Your org	21.3%	14.3%	19.1%	19.5%	20.0%
Average	14.9%	14.6%	15.7%	15.1%	14.3%
Best	8.4%	9.8%	8.2%	9.6%	10.1%

Whilst not the worst performing acute Trust, Sherwood Forest Hospitals is significantly below average with staff appearing twice as likely to experience violence and aggression in comparison to best performing acute Trust. This appeared to improve significantly in 2014, but then rose again to previous levels.

Leaver interviews

Staff leaving the Trust's employment are offered a leaver interview. This can be with their line manager, higher line manager, a member of Human Resources (HR) or a trained volunteer. In April 2018 a new process was implemented for medical staff whereby staff leaving (excluding junior doctors rotation as part of the training programme) are invited to an face to face exit interview with a member of the Medical Workforce Team. In addition in April 2018 a new on line process was developed for all staff, which is incorporated within the termination process. Staff who leave will automatically be sent an email link requesting their completion of an exit questionnaire via a survey monkey. Part of this work reduced the number of questions asked of exiting employees and on average it takes less than 3 minutes to complete the survey.

This helps us to understand the staff experience more effectively. HR Business Partners (HRBP) and Assistant HR Business Partners (AHRBP) utilise this information to identify trends, inform initiatives and support the coaching and mentoring work they undertake with managers. Where a leaver's feedback raises a concern or identifies an issue, work is undertaken discretely to explore and address the problem. Any significant concerns initiate an investigation.

Whilst all medical leavers do attend a face to face meeting, the number of other staff agreeing to give feedback via the on line survey as they leave has decreased and remains low. Ongoing work is considering how to improve the number of responses to the exit questionnaire.

Summary

The improvements in the 2018 staff survey results, especially the positive overall score for staff engagement, are heartening and give the Trust a good platform upon which to both consolidate and build upon to support our journey to outstanding over the coming year. The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by:

Actions and Monitoring

- The results are to be communicated to staff in a number of ways including electronic and face to face briefings.

- The reports are being further analysed. This includes scrutiny of the individual (anonymous) comments that were captured in the free text as these provide further important context. Analysis is also available by staff group and site.

- The Trust's Divisions are being sent a copy of the overarching report, their Divisional results and the free text comments. They are expected to explore the themes further with their staff and develop action plans pertinent to their Division to address areas of concern. This also applies to corporate areas.

- The results will also be triangulated with other data sources such as the quarterly pulse surveys; workforce KPI's and speaking up concerns. This will enable more targeted actions and interventions to be identified, supported by the Trust's OD Team and HR Business Partners

- There will be Trust wide initiatives for incorporation into the Workforce Strategy 2019/20 Implementation Plans, particularly in relation to the Trust's culture and leadership work. These will include a strong focus on staff health, safety and well-being and diversity and inclusivity aimed at addressing recurrent themes. Some of the positive results will also feature in Trust recruitment campaigns.

- The results will be discussed at the Staff Communication and Engagement Forum and with the Trust's staff side in order to obtain their views on priority actions.

Speaking Up

Sherwood Forest Hospitals NHS Foundation Trust is committed to taking seriously all concerns raised and in ensuring that an open and honest culture is embedded within the Trust. It will ensure staff have access to support and are encouraged to speak up at an early stage.

The Trust has developed and implemented the Speaking up Policy, which is sometimes referred to as Raising Concerns or Whistle-blowing and is primarily for concerns involving risk, malpractice or wrongdoing, which is harming or could harm the service that the Trust delivers.

The Trust recognised the importance of providing a safe and confidential mechanism for staff to raise any concerns appointing a number of Freedom to Speak Up Guardians who undertook this role as part of their day to day responsibilities.

In March 2019 the Trust appointed a substantive Freedom to speak Up Guardian who will work closely with the National Guardian's Office.

Concerns can be raised through a number of mechanisms. These are:

- Line manager
- Staff side representatives
- Designated senior management contacts
- The Chief Executive
- Non-Executive Directors
- Independent advice can be sought through public concern at work
- Care Quality Commission
- NHS Improvement
- Health and Safety Executive
- 360 Assurance

The Trust Speaking Up Policy makes it clear to staff that all concerns raised will be treated in the strictest confidence without fear of retribution.

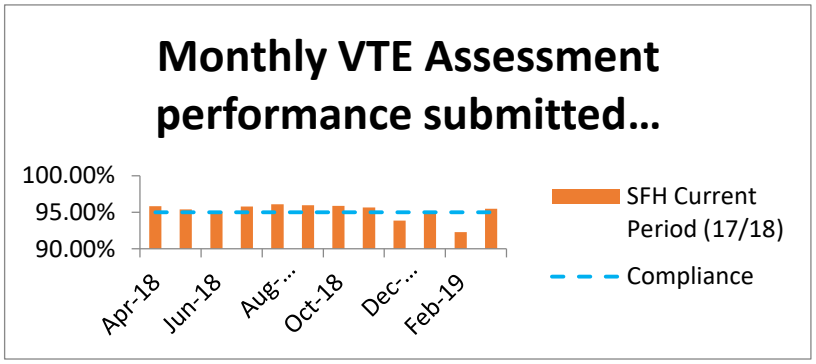
6 Venous Thromboembolism (VTE)

A VTE is a blood clot (thrombus) that forms within a vein that can cause occlusion within the lung (pulmonary embolism) or in the deep leg veins (deep vein thrombus). The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical and surgical care. VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long term morbidities is associated with considerable cost to the health service.

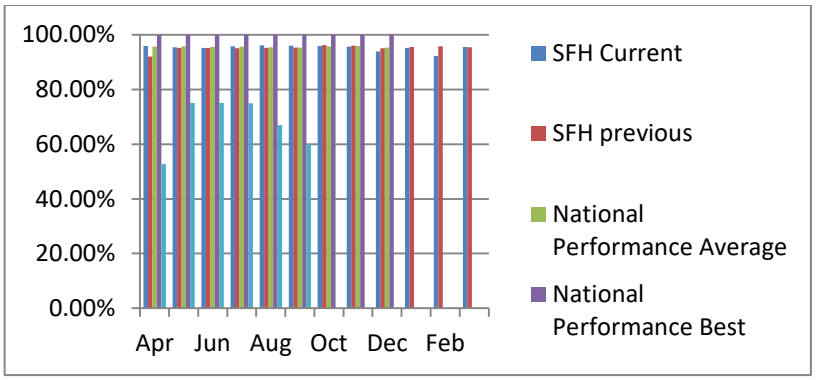
The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- All adult patients should have a VTE risk assessment on admission to hospital using a nationally recognised risk assessment tool.
- The Trust aims to achieve 95% or above compliance with this standard. During the reporting period March 2018 – February 2019 indicates 95% compliance was met each month with the exception of December 2018. This was not achieved in this month due to the risk assessment not being completed or not found in the medical records. The Trust can report there was one hospital acquired deep vein thrombosis incident during this period, which underwent a Divisional investigation to establish learning and action required.

Monthly VTE assessment rate (April 2018- March 2019)



95% of patients risk- assessed for VTE



The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by:

- All patients' records are manually checked for completed VTE risk assessments. To reduce the number of missed or blank VTE forms in patient records a targeted supplementary follow up has been initiated in specific areas to follow up and collect the previous days missed or blank assessments. This will increase local compliance to 95% which will enhance the overall Trust position.

- Additional actions are in place and consist of reviewing patients who have a potential or confirmed VTE to identify if there were any missed risk assessments. A random sample of patient records is also undertaken to ensure that all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. To date this review demonstrates that appropriate VTE prophylaxis is being initiated.

7 Clostridium Difficile Infections

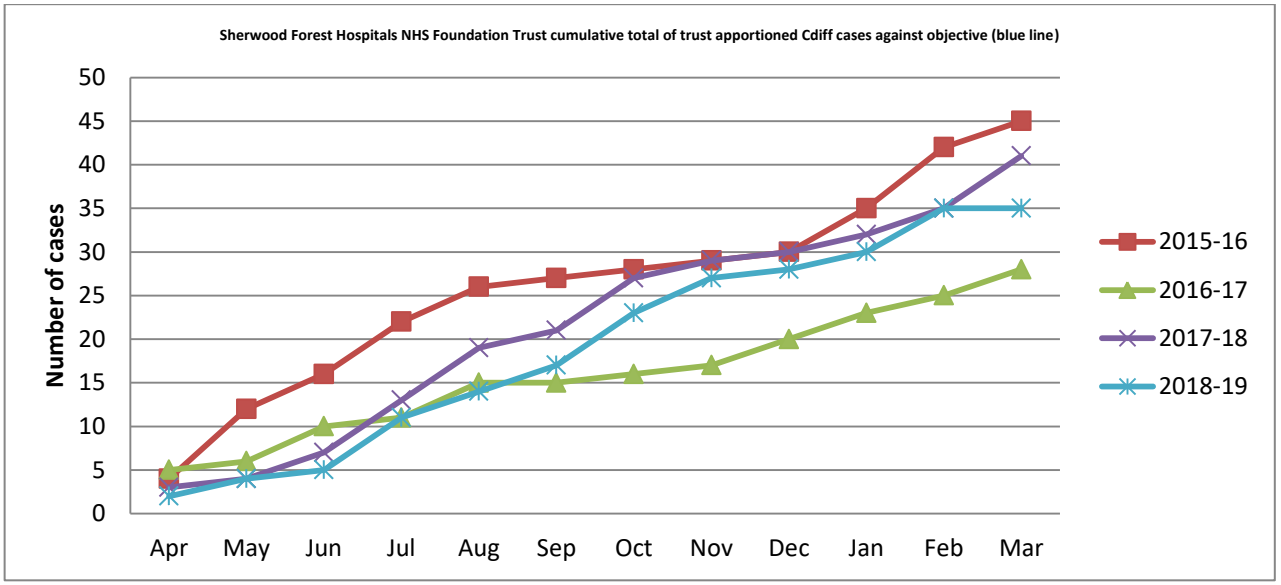
The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Clostridium Difficile infection is acknowledged as a problem that impacts upon the whole health economy. The partnership working between colleagues from primary care commenced during 2014/15 and has evolved to consider all potential aspects causing infections across the health economy and includes joint working to promote infection prevention messages. The Trust aims for 2018/19 are outlined below:

- Review and identify common themes across organisations within the whole healthcare economy.
- Share relevant learning between the local infection prevention teams.
- Ensure that Trust attributable cases in the reporting period remain below 47.

How Was This Achieved

In 2018/2019 the numbers of cases identified were 35. A rise in numbers was identified during Quarter two and three and is displayed in the graph below.

Cumulative total of trust apportioned Cdiff cases



C-Difficile Rates per 100,000 bed days

Period	April	May	June	July	August	September	October	November	December	January	February	March
2013/14	9.0	18.4	9.9	9.2	19.0	18.9	22.3	23.6	9.0	8.5	4.7	21.5
2014/15	22.6	26.5	23.7	30.9	22.9	31.5	13.6	32.7	41.6	12.9	28.4	18.1
2015/16	20.4	38.9	20.4	30.8	20.7	5.3	5.2	5.3	5.4	25.4	38.8	15.2
2016/17	26.8	5.6	22.3	5.4	21.7	0.0	5.5	5.4	15.7	14.9	11.4	16.0
2017/18	17.6	5.7	18.8	36.1	36.5	11.8	22.2	11.1	5.4	10.2	17.0	30.9
2018/19	10.9	10.9	5.9	33.9	16.7	17.2	32.9	22.2	5.8	10.4	28.6	0.0

A full review of all cases was performed to establish if there were any common themes, at this point no link was established to suggest that there was any cross transmission. Lapses of care were monitored for all cases and there has been a reduction in number from 2017/2018 when there were 15 compared to nine in 2018/2019.

There has been high levels of influenza with secondary bacterial infections, therefore many more patients were susceptible to *Clostridium difficile*. This issue demonstrates the importance of aggressive monitoring of *Clostridium difficile* and response during times of high levels of activity.

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

The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages, and so the quality of its services by placing even greater emphasis on Clostridium difficile management and implementing the interventions outlined below:

- All wards are visited a minimum of bi weekly to monitor patients and their environment.
- Multidisciplinary ward round including Infection Prevention, Microbiology, and Antimicrobial Pharmacist occurred once a week.
- Antimicrobial Stewardship rounds including the Microbiologist, Antimicrobial Pharmacist and Sepsis Nurse are undertaken twice a week.
- Where lapses of care (Graph 1) have been identified, targeted actions in relevant areas have been undertaken and these actions are monitored at respective Divisional Governance meetings.

Education and Training:

- All educational programmes highlighted the importance of preventing primary infections to avoid increased use of unnecessary antibiotics.
- Regular information was provided to all divisional, speciality governance forums.
- Weekly update to nursing teams, identifying key practice points requiring address.
- Trolley dash around the wards highlighting the importance of timely sampling and isolation of patients with diarrhoea
- Information given to staff, patients and visitors as part of Infection Prevention and Control Week

Cleanliness:

The standard of cleaning is fundamental in reducing the risks of transferring *Clostridium difficile*. This year the IPCT continued to work closely with Medirest and Skanska and have re implemented the decant deep clean programme. This programme commenced in September and 5 wards have currently been moved. The IPCT continue to work with Medirest, Skanska, Trust colleagues and commercial companies to improve the consistency of the cleaning processes throughout the rest of the organisation and ensure that all staff are aware of their responsibilities.

Auditing:

This is an important part of both monitoring existing practice and driving improvements in those areas required. The IPCT performs standardised audits, providing photographic evidence of issues identified; detailed specific immediate feedback and education at time of audit has been provided. In addition Medirest monitor against National Standards for Cleanliness:

- Continued improved compliance was noted with commode cleanliness where in 2015/2016 most wards failed on a weekly/monthly basis to 2018/2019 were 1 or 2 wards failed 1 commode a month.
- Delays in sampling/diagnosis continues to be the main reason for lapses in care identified (graph 1) In April 2015, a stool proforma was introduced to direct staff when and when not to send samples, during 2017/2018 the overall rate has averaged at 79%, with areas achieving much higher rates at time.
- All microbiology samples that are rejected when getting to the laboratory have been monitored and the teams informed to ensure timely diagnosis and treatment of the patients is not delayed excessively.

Monitoring and reporting

All cases of *clostridium difficile* infections within the Trust are reported to Public Health England (PHE) they have undergone a root cause analysis (RCA) to establish the underlying reasons why the patients have succumbed to the infection and whether the infection was avoidable. These have been reported back within both internal corporate and divisional governance structures and externally. Themes have been identified and work undertaken to review and manage those actions both in the immediate and for future planning.

The threshold for 2019/20 is a maximum of 79 cases. This figure has increased on the 2018/19 figure due to the changes in Public health England definitions of trust acquired cases. The Trust will now be required to include healthcare associated as well as healthcare attributed cases. Any case will be attributed to the Trust 48 hours following admission. Previously cases were attributed 72 hours post admission. Although this will provide us with an on-going challenge it also gives us an opportunity to build on the improvements already achieved. Monitoring will continue through the Infection Prevention and Control Committee.

8 Patient Safety Incidents

The Sherwood Forests Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Sherwood Forests Hospitals NHS Foundation Trust is committed to reporting and investigating 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.

The data provided by the NRLS shows that the Trust is below the median average of reporters in terms of incidents reported per 1,000 bed days. Where there are discrepancies between the number of incidents recorded by the Trust and the number published by the NRLS these are reported to NHS Improvement.

The NRLS report no longer includes median average of reporter data. This has been replaced with a reporting culture indicator. This indicates on the latest report that there is no evidence for potential under reporting.

The table below shows the comparative level of patient safety incident reporting within Sherwood Forests Hospitals compared with other non-specialist acute providers:

Level of Patient Safety Reporting

Sherwood Forest Hospitals NHS Foundation Trust (SFH)				**All non-specialist Acute Providers**
Period	**Number of incidents uploaded to NRLS from SFH**	**Number of incidents reported by NRLS**	**Rate per 1000 bed days reported by NRLS**	**Median average rate per 1000 bed days**
1 October 2015 -31 March 2016	3687	3657	34.63	39.31
1 April 2016 – 30 September 2016	3397	3339	32.82	40.02
1 October 2016 – 31 March 2017	3581	3507	33.51	40.14
1 April 2017 – 30 September 2017	3277	3180	34.09	The report indicates no evidence for under reporting
1 October 2017 – 31 March 2018	3563	3406	32.64	The report indicates no evidence for under reporting

The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services by:

- Improving the timeliness of reporting and the quality of the data submitted to the NRLS. As a result of this, provisional data from the NRLS shows the Trust has reduced the person identifiable information upload breaches from 2% in 2017/18 to the current figure of 1% for 2018/19, which is 2% above the best practice standard of 3%.

From the 1 April 2018 to 31 March 2019 the Trust declared a total of 29 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 29 incidents, 1 was deemed to be a NEVER Event.

All Serious Incidents were investigated and action plans developed to mitigate the risk of recurrence. The number of Serious Incidents reported by the Trust has not changed significantly since the previous year. The type of Serious Incident remains largely static except for patient falls, which meet the Serious Incident criteria. For these there has been a decrease from seven in 17/18 to two in the current year, which is a positive indicator as learning from falls incidents during 2017/18 has been sustained.

100% of investigation reports were submitted to the CCG within agreed timeframes during the current year.

The Trust has continued to invest in all aspects of the Datix system with developments throughout the year, working to enhance the reporting and investigation processes and improve the provision of essential management information at divisional and ward level to support informed, evidence-based decision making and robust accountability. This includes a review of the Datix dashboards; these allow the user to interrogate incident trends and themes. Implementation of a ward 'Daily Incidents Dashboard' has been piloted on two wards to enable ward staff to have greater awareness of incidents in their area. Whilst these pilots have not increased incident and near miss reporting they have had a beneficial effect as staff feel they enable improved communication of key safety messages and incidents.

The Datix system is also utilised by Legal Services with regular use of the DatixWeb Legal module, which has enhanced recording of information and shared communication. The Patient Experience module is still being developed to ensure it is fit for purpose to assist with recording and sharing information related to complaints and patient experience.

Duty of Candour

The Trust has a statutory responsibility to formally offer an apology, verbally (within 10 working days) and in writing, for any patient safety incident which is graded moderate, severe or catastrophic harm and for any Serious Incident.

Of the 60 incidents meeting these criteria, the Trust has provided Duty of Candour in 100% of these. The Trust also provided an apology as a response to an incident in a further 105 cases demonstrating our commitment to openness and transparency.

The Internal Audit 360 Assurance review in October 2018 demonstrated assurance for four of seven key indicators. Further assurance is being provided to meet the remaining three indicators.

9 Seven Day Hospital Services

Sherwood Forests Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Sherwood Forest Hospitals is one of the best Trusts when it comes to treating patients whom are admitted to hospital through the Emergency Department quickly, no matter what day of the week it is. The Trust performs in top 25th percentile nationally and the best of the East Midlands Trusts.

The Seven Day Services Programme, introduced by NHS Improvement in 2016 set out to ensure that patients receive consistent high quality care regardless of day of the week or time of the day.

The Programme is made up of 10 clinical standards in total, which trusts must meet to demonstrate they provide a good seven-day emergency service. Four of the standards are deemed as priority standards and the Trust has specifically focussed on achieving excellent performance against these in 2018.

When a patient comes in to the Emergency Department at King's Mill Hospital they are seen by a doctor and either discharged or admitted to a ward within the hospital. If they are admitted, our audit results show that a very high proportion are reviewed by a Consultant within 14 hours, meaning that a plan for further investigations or treatment can be put in place quickly, ultimately resulting in the patient spending less time spent in hospital and discharged with the best possible outcome.

The Trust recognised the importance of ensuring the safety and quality of care provided and access to senior decision-makers across seven days a number of years ago. We had already aligned Consultant job plans to ensure we maximised cover particularly out of hours and over weekend and bank holiday periods, specifically job-planned 'hot week' working. We had already seen a positive impact of this on our weekday versus weekend mortality and this has remained constant since 2015. The performance described below covers the reporting period April 2018.

- **Clinical Standard 2 –** Time to 1st Consultant Review (Patients reviewed within 14 hours of admission to hospital). We have performed consistently above the national average and within the top quartile within the East Midlands region. It is expected that our performance will continue to improve through 2019/20 as we are widening the cohort of patients across all five of our clinical divisions. Our current proportion has been impacted by the disproportionate number of paediatric and orthopaedic patients within the sample group.

- **Clinical Standard 5 –** Access to Diagnostics (for patients admitted as an emergency or with critical care needs). The Trust fully met this standard as we provide the full complement of consultant directed diagnostics on-site for both weekdays and the weekend.

- **Clinical Standard 6** – Access to Diagnostics (for inpatients). The Trust fully met this standard as we provide the full complement of consultant directed diagnostics on-site for both weekdays and the weekend.

- **Clinical Standard 8** – Consultant daily reviews (twice daily review, once daily review). The Trust has fully met the 'twice daily' consultant review whereby all patients requiring a twice daily review by a consultant or designated senior clinician received one. Ensuring that 'all' patients were reviewed by a Consultant or designated senior clinician is more challenging, particularly over weekend and bank holiday periods as the most acutely unwell patients and new admissions must take priority. The Trust still performed amongst the best nationally against this element of the standard.
- The Sherwood Forest Hospitals NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services by;
- Widening the cohort of patients across clinical divisions to reduce patient review times

- Ensuring the Trust provides a full complement of consultant directed diagnostics for week days and weekends

- Continue to progress twice daily consultant reviews/senior clinician seven days a week

Medical Rota Gaps

The Guardian of Safe Working provides a quarterly report to the Board of Directors highlighting current and potential rota gaps with mitigating actions. The Trust has a robust Medical Staffing team managing and monitoring all medical staffing issues in line with local and regional processes to ensure safe medical staffing at all times.

Part 3 - Other information – Additional Quality Priorities

3.1 Safety – Improving the Safety of our Patients

Patient Safety Culture Programme

Aims for 2018/19

In terms of improving quality and safety, the Patient Safety Culture Programme is identified as a priority within the organisation. The programme has delivered a series of outputs to support the organisation to identify current cultural levers and barriers to delivering safe care via the PASCAL Patient Safety Culture surveys undertaken with staff in ED, Maternity and Theatres. It has both supported and spread 'safe' opportunities for staff to share their experiences of delivering care, in often difficult circumstances; this has been delivered via 'kitchen table' events delivered in local areas, and via implementation of the organisation-wide Schwartz Rounds.

Performance against this Target

- An Associate Director for Service Improvement was appointed by the Trust in March 2018, with a specific remit to deliver the Patient Safety Culture programme.
- Over 500 clinical and nonclinical staff in ED, Maternity and Theatres have had the opportunity to complete a survey involving several domains that influence patient safety (teamwork, job satisfaction, working conditions, response to errors etc). This has been followed up by 1-2-1 sessions to share the results with staff, and to build on the response and identify any actions needing to be undertaken. Results are reported directly to the Trust Management Team.
- Over 30 Kitchen Table events held in local areas across the three hospital sites.
- National recognition for SFHFT's focus on patient safety in the Sign Up To Safety Newsletters.
- The Patient Safety Culture Programme was presented at the East Midlands QI Network event in May 2018 and was well received and evaluated by delegates. It was also presented at the East Midlands Patient Safety Collaborative Network event for the Neonates/Maternity work stream.
- Schwartz Rounds commenced in 2018 with dates as below:

  - 18 October 2018
  - 16 January 2019
  - 8 March 2019

- Over 30 'kitchen table' events have been held across the organisation, in support of the national 'Sign Up To Safety' campaign. The work undertaken at Sherwood Forest Hospitals NHS Foundation Trust was recognised by the national 'Sign Up To Safety' team via social media.

How Was This Achieved

- The Trust supported and appointed an Associate Director of Service Improvement which was critical to providing a coordinating role and additional resource to drive the Patient Safety Culture Programme forward. The focus has been on providing a 'safe' environment where staff feel supported and listened to. All outputs from the programme are shared with people who can influence decisions and who can progress actions, for example, local and senior managers. The Trust Executive team are committed to this work, and provide input and support to help it to achieve its goals.

- Collaboration and commitment from staff, the Trust and the Sherwood Forest Hospitals NHS Foundation Trust Charities to support and progress individual Schwartz Rounds. Clinical and non-clinical staff offered positive evaluations of the Schwartz Rounds and expressed the value of having the opportunity to discuss the emotional and social impacts of their work.

- The Trust has implemented a tiered approach to gaining staff feedback on patient safety, and these include being advocates and local champions for the national Sign Up To Safety campaign, from delivering Kitchen Table events in local areas and in providing more structured feedback as part of the PASCAL Patient Safety Culture surveys

Monitoring and Reporting for Sustained Improvement

- There is a robust governance process that links the outputs of the Patient Safety Culture Programme to the Quality Committee and the Patient Safety Quality Group, which have executive representation. It is also a key lead for the delivery of the Trusts strategic aim 'Inspiring Excellence' which reports quarterly to the Trust Board.

- Schwartz Round dates have been agreed, and are in place to occur bi-monthly in 2019/20 with funds to support training and refreshments for staff. The outputs and themes of this work reports in to Quality Committee.

- The 'kitchen table' approach to patient safety takes an organic approach and is being led more and more by frontline staff, who are hosting and delivering sessions in their own clinical areas.

- There is a commitment to re-survey the 1200 staff involved in the PASCAL surveys from 2020, and to continue this work going forward. Outputs are reported to the Trust Management Team, and are monitored via the Divisional Performance.

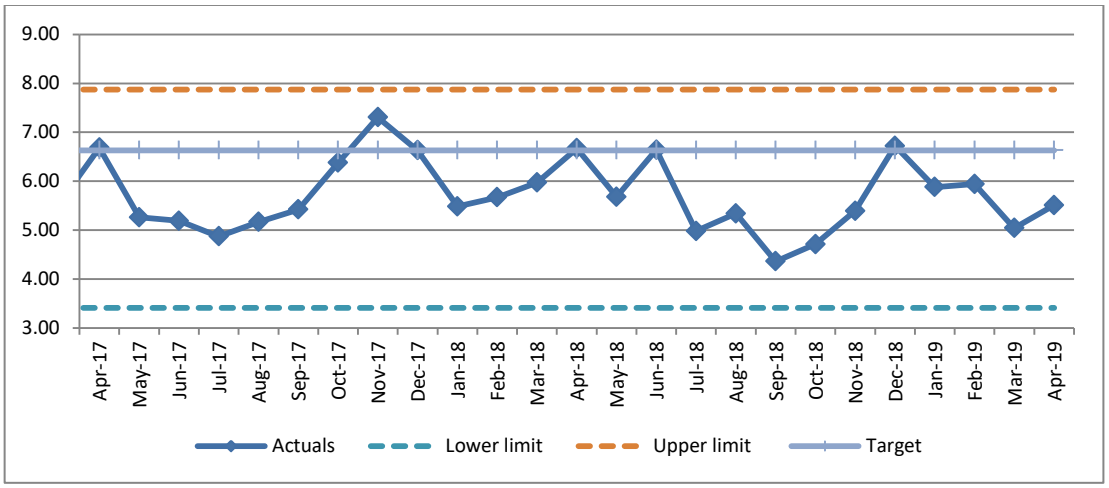
3.2 Safety – Reducing Harm from Falls

Aims for 2018/19

- To reduce the number of inpatient falls and falls with harm to less than the national average and agreed on Trust targets.
- To improve how the Trust learns from falls related incidents through the delivery of a safety improvement programme developed from best practice.
- Introduce the 2017 National Inpatient Falls Audit recommendations.
- Ensure falls improvement and prevention is guided by recommendations within the Trust 2018/21 Multi-Disciplinary Falls Prevention Strategy.
- Ensure improvement activities are underpinned by a structured audit process and re-audit progress using the Royal College of Physician's Falls Audit Tool.

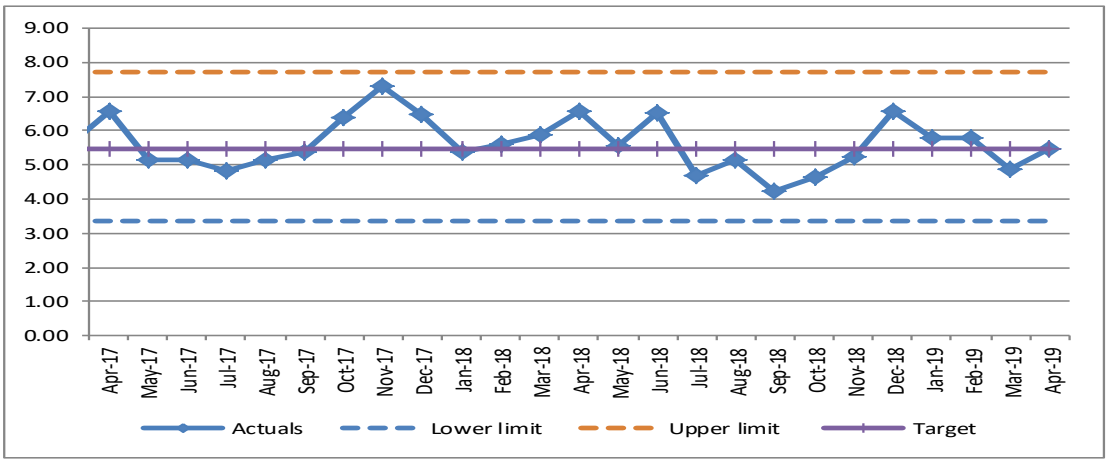
Reducing harm from falls is identified as a quality priority in line with the Quality Strategy. The graphs below show the percentage of falls calculated by 1000 occupied bed days (OBDs) as per the National Audit of Inpatient falls (2015) criteria. Currently, the Trust performance indicates 5.51 falls/per 1000 occupied bed days in comparison to 6.63 nationally up to and including April 2019.

Falls per 1000 OBDs days



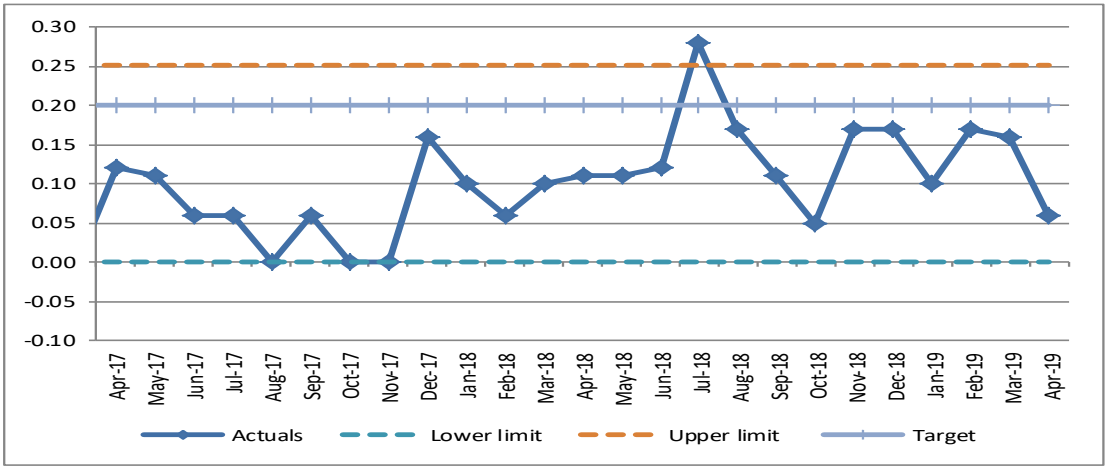
The number of falls up to and including April 2019 resulting in low or no harm/1000 bed days is 5.5 against an internal target of 5.5 falls/1000 bed days.

Falls per 1000 OBDs resulting in Low or No Harm



The number of falls up to and including April 2019 resulting in moderate or severe harm/1000 bed days is 0.1 against an internal target of 0.2 falls/1000 bed days.

Falls per 1000 OBDs resulting in Moderate or Severe Harm



How Was This Achieved

Falls prevention and improvement is guided by recommendations contained in the Trust 2018- 21 Multi-Disciplinary Falls Prevention Strategy. The Strategy outlines the best practice approach to mitigating falls in hospitals. The Strategy includes actions related to falls mitigation, risk, and interventions for mitigating injury.

- A falls related patient story was incorporated into the fundamentals of care study day and focused on risk assessment and post-fall best practice.
- An experiential learning study day was developed and focused on issues such as poor eyesight, nutrition and deconditioning etc. concerning falls.
- Red Safety Cards were issued to clinical areas, so relatives and carers could make staff aware that they were leaving a patient unsupervised.
- The development and introduction of the Colour Me Safe programme to help mitigate falls and increase staff awareness of patient mobility requirements.
- Development of care plans that incorporate falls awareness, for example continence and moving and handling.
- The sharing of completed investigation reports at the Mobility and Falls group to enable further awareness and learning from the report.
- The incorporation of the Royal College of Physicians training programmes such as Fallsafe information and training video (FallSafe is a quality improvement programme that helps staff to deliver evidence-based falls prevention).
- The development and introduction of an interactive e-learning falls package.
- Mobility, falls and moving and handling have been brought together in the Trust induction programme to provide a holistic training package that is structured around a patient story.
- Worked collaboratively with the Health and Well-being leads to incorporate smoking and falls mitigation structured around a patient story.
- Highlighted the importance of discouraging deconditioning of patients and its relationship to mobility and falls.
- The falls risk assessment has been digitalised and transferred onto NerveCentre.
- Ensured there were rapid and timely assessments for the risk of falls.
- Embedded and sustained falls prevention strategies across the Trust.
- Ensured the safe and effective management of patients following a fall or a repeat fall.
- Ensured the Trust has an ongoing audit and reporting programme for falls and falls mitigation.
- Development of multi-disciplinary study days that are focused on ensuring the 'Every Contact Counts" message.
- Involvement of the Falls Lead Nurse in investigations and discussions regarding falls and harm.
- Development of a culture change going forward to embed mobility in conjunction with falls mitigation.
- Incorporation of patient stories, themes and trends are incorporated in training and development materials.
- Development of an educational programme which ensures patients have appropriate access to the correct mobility aid.
- Use of a structured audit process and re-audit progress using the Royal College of Physician's Falls Audit Tool.
- Monitor and report falls performance through monthly ward assurance meetings where metrics performance is discussed and challenged.
- Registration with the 2019 Royal College of Physicians audit-inpatients who fall in the Trust and fracture their neck of femur.

Monitoring and Reporting for Sustained Improvement

In 2018/19 performance was reported through the Mobility and Falls Group. This group led the implementation of the Falls Mitigation and Post Falls Care Strategy 2018/21. Progress is reported through the Patient Safety and Quality Board chaired by the Executive Medical Director. Falls performance was also monitored through monthly ward assurance meetings, the Harm Free Care Group and is reported on the ward communication boards. Progress is reviewed, and systems are in place to challenge poor practice. The Falls Lead Nurse produced and shared a monthly report with all clinical areas highlighting key themes.

What do we aim to achieve in 2019/20

- Achieve the National CQUIN description within the Trust -Receiving key falls prevention actions.
- Continue to progress with evidence based practice. Develop improvement programmes through networking with neighbouring Trusts to develop innovations and best practice.
- Develop and progress the Trusts Falls Mitigation Strategy 2018/2020.

3.3 Safety – To Reduce the Number of Infections

Aims for 2018/19

- To ensure effective antimicrobial stewardships is in place and that prescribing practice is clearly documented and reviewed with a clear plan documented in the medical notes/medication chart within 48- 72 hours.

- To achieve a 10% reduction of post 48 hour Escherichia coliform (E.coli) bacteraemia associated with urinary tract infection using the 2016/2017 rate as a benchmark. This is in line with NHSI recommendations.

- To minimise the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark.

Performance against this Target

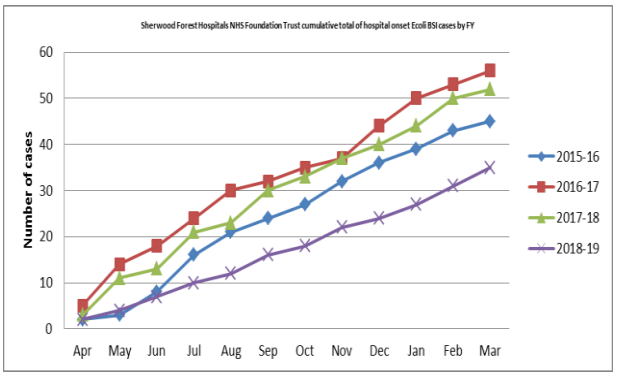
Below is a summary of the performance against the three aims outlined above:

- Within 72 hours, a senior clinical antibiotic review is required and information collected on patients that have a confirmed diagnosis of severe sepsis. In 2018/19, over 87% of prescriptions were reviewed within the 72-hour timeframe. The efficacy of antimicrobial stewardship can be measured through antibiotic prescribing and measures to reduce consumption are continuous. The microbiology ward rounds continue to drive a multi-disciplinary approach to the review of patients with sepsis, complex infections and targeting specific antibiotic prescribing. It provides an expert service involving advice and guidance to clinical teams with opportunities for real-time education and audit. This information is submitted through Public Health England and is publicly available via the fingertips website.

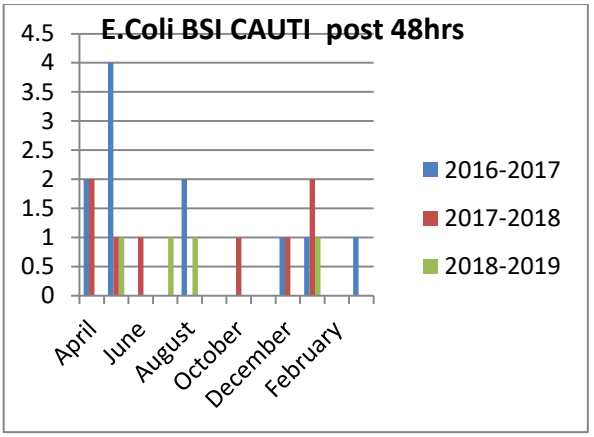
- Nationally there is a focus on the reduction of gram-negative blood stream infections (GNBSI) with an ambition to reduce these by 50% across our CCG's by 2021. The main causative organism is Escherichia coliform (E. coli). Data published by Public Health England suggest that most E. coli's tested at the Trust are not Trust apportioned. The primary causative factor remains urine, focussed within the community. Work throughout Nottinghamshire has been targeted to reduce this, including a county-wide hydration programme. The 2018 summer heat created a number of problems including increased dehydration and subsequent admission. The specific standard required relates to a reduction in E. coli blood stream infections against data from 2017/2018. Graph 1, provides a comparison with all E. coli blood stream infections identified from 2018/2019 against the results from the preceding three years. In 2018/2019 there has been a reduction of about 33% this suggests a sustained reduction over the last 2 years. This progress has been supported by a number of initiatives over the past few years to reduce Catheter-Associated Urinary Tract Infections (CAUTI) and urinary tract Infections (UTIs). Audit and surveillance data continue to demonstrate that the results remain low when compared to national data and was 2% in March 2019. A paper depicting the trusts work to reduce CAUTI has been published within the British Journal of Nursing January 2019 and members of the infection Prevention Team have been involved in sharing this good practice more widely.

Campaigns to improve urinary tract health through better hydration and hygiene have been promoted within the trust during 2018/2019 with considerable interest from the general public. In addition the trust was invited to participate in the second NHSI UTI collaborative to support a broader whole health economy approach the 'to.dip.or.not.to.dip' programme was implemented within ED to improve diagnostic stewardship for urinary tract infections and this programme dovetails against the work within the county and demonstrates cross organisational working. This improvement has been translated into the numbers of blood stream infections directly attributed to a urinary catheter, (Graph 2) which, in 2018/2019 saw continuing reduction to five cases.

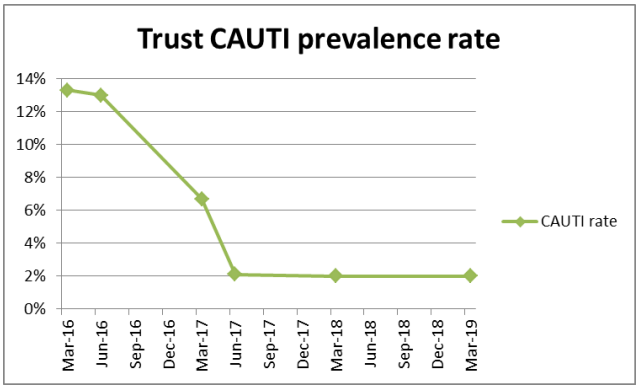
Graph 1



Graph 2



Graph 3



- The report from Public Health England for October – December (see table below) indicates that for last 4 periods the Trust continue to perform in line and slightly better than with national benchmarking. The table indicates the summary result that suggests in all 3 fields the Trust has a rate lower than the amalgamated average.

Surveillance site	% inpatient/readmission infected Sherwood Forest Hospitals		% inpatient/readmission infected All Hospitals
	October - December	Last 4 periods	Last 5 years
Total Hip Replacement	0.0	0.6	0.9
Total Knee Replacement	1.1 (1 case)	0.6	1.3
Neck of Femur	1.0	1.0	1.2

Monitoring and Reporting for Sustained Improvement

- All elements identified above are monitored and reported externally by Public Health England and NHS England.
- Internally these are scrutinised and challenged via the Trusts own governance processes.
- Information on infection rates is available publically via Public Health England via the link https://fingertips.phe.org.uk. This website provides data against which the Trust can evaluate performance against the national dataset.

What do we aim to achieve in 2019/20

- To improve practice standards identified in audits and progress work to develop device related bundles.
- To achieve the new Clostridium Difficile target of 79 cases.
- Review all cases of Clostridium Difficile identified in patients who have been inpatients within the previous four weeks.
- To work to reduce the Trusts EColi in line with national targets.

3.4 Effectiveness – Improving the Effectiveness of Clinical Care

Improve the Effectiveness of Discharge Planning
Aims for 2018/19

- To develop new and improved ways of working to promote safe, timely discharge with the philosophy of 'home first.'
- Continue to work in partnership with local health and social care providers to ensure safe and appropriate discharges.
- Support patients to continue to live independently at home where possible.

Performance against this Target

During 2018/19 the Trust has developed new and improved ways of working, along with continuing to work in partnership with local health and social care providers to promote safe, timely discharge with the philosophy of 'home first', supporting patients to continue to live independently at home wherever possible. Further to previous initiatives, good practices have been identified to build upon the integrated discharge model:

- Review of Sherwood Forest Hospital Trust Discharge Policy
- Continue close working relationships with the Patient Experience Team in order to identify improvements that could be made to the Trust discharge planning arrangements
- Working in partnership with our Community Services – daily Hub Meeting
- Continuing the existing good practice such as the ASSIST scheme from Mansfield District Housing which supports patients with housing needs, in particular the Homeless

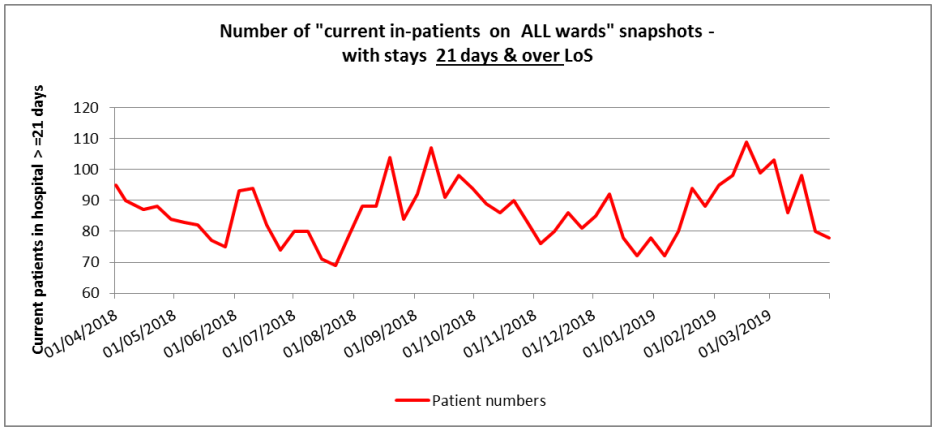
How Was This Achieved

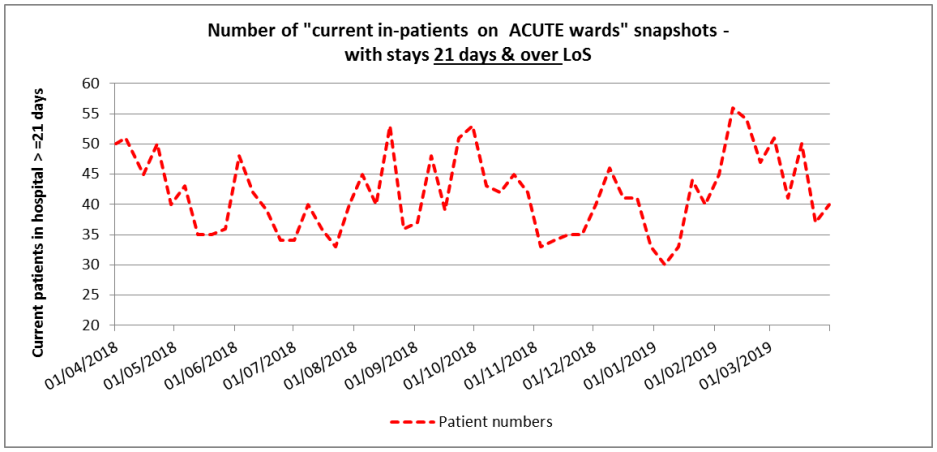
- Onward referral to Community Services where appropriate via Call 4 Care – Request for Holistic Assessments, District Nursing Team, CURTT
- Working alongside Call 4 Care to promote hospital avoidance and utilisation of EDASS to support vulnerable patients, and enable them to remain safe at home until longer term plans can be put in place
- Dedicated referral line via Call 4 Care for End of Life / Specialist Palliative Nurses (both Community and Hospital teams)
- The introduction of the "Interoperability" system within SystmOne to enable staff to ascertain promptly the name and details of a patients care provider
- Nerve Centre - ensure patients are identified and placed on the appropriate pathway needed (in real time)
- Instigation of the "Home First – Planning your transfer leaflet" for all patients to keep them fully informed of the discharge process
- Long stay Wednesday, where all patients are reviewed weekly by Senior Nursing Staff that have a length of stay of more than 21 days
- Specific "Transfer of Care" letters for patients that are transferred back to a Care Home setting
- Purchase of winter beds in a variety of Care Home settings to promote patient flow and allow Social Care assessments to take place outside the Acute Hospital setting.

Monitoring and Reporting for Sustained Improvement

The discharge dashboard continues to provide the Integrated Discharge Team with real time information on the current discharge status of every in-patient across the Trust, including the identification of simple and complex discharges and delayed transfers of care.

With this monitoring process, the Trust is able to gather accurate real-time information regarding length of stay and any delays. This information is also used to identify gaps in capacity across the local health and social care system.





3.5 Effectiveness – Improve our Care and Learning from Mortality Review

Through 2018/19 the Trust continued to improve the care we deliver to our patients by ensuring widespread learning from the review of care delivered to those patients who die whilst inpatients in the hospital.

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

The Trust Mortality Surveillance Group (MSG) is well established. Meeting monthly, chaired by the Executive Medical Director, it is the focal point for understanding the safety and quality of care provided to patients in the days leading up to their death and importantly identifying the learning opportunities, ensuring the learning is shared across the wider clinical teams.

The Trust has a well-established Mortality Review Process comprising an electronic Mortality Review Tool, used to capture initial information immediately following a death. It is mandated that all deaths are recorded on this tool.

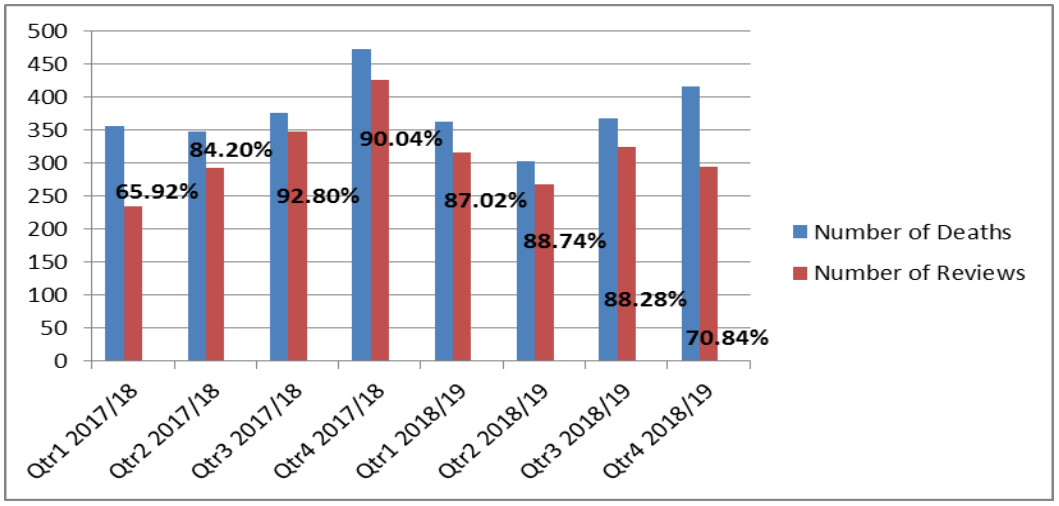
The Royal College of Physician's Structured Judgement Review (SJR) methodology has been in place since April 2017 as the preferred vehicle for conducting more in-depth Mortality reviews should this be required. The SJR facilitates the discussion between the clinical teams, specifically relating to the safety and quality of care delivered in the days leading

up to a patient's death and importantly identifies where there may have been lapses in care or avoidable factors associated with the death.

The benefits of conducting a review using a consistent, validated methodology ensures that care is recorded in the same way whether it is good or bad. This will hopefully generate concise statements (both positive and negative), yielding a rich store of information to identify areas where there is excellent practice but also identify those areas for further improvements. A 'Learning from Deaths' Report is presented to the Board of Directors each quarter with an Annual Summary Report produced in May. Performance against the Learning from Deaths Guidance for 2018/19 is indicated below:

Learning from Deaths Dashboard 2018/19

Inpatient & Emergency Department Deaths	**Total**	**Reviews completed**	**% Reviewed**	**Avoidability Assessments**
Jan-19	151	130	86.09%	2
Feb-19	131	87	66.41%	1
Mar-19	133	77	57.89%	0
Qtr 1	362	315	87.02%	3
Qtr 2	302	268	88.74%	2
Qtr 3	367	324	88.28%	3
Qtr 4	415	294	70.84%	3
Year 18/19	**1446**	**1201**	**83.06%**	**11**
Year 17/18	*1550*	*1300*	*83.87%*	*21*



The way in which we engage with bereaved families is a priority for the Trust. We aim to work closely with relatives and carers to ensure a consistent level of timely, meaningful and compassionate support and engagement is delivered at every stage from notification of death to an investigation and lessons learned if relevant. We must be able to provide a high standard of bereavement care, including support, information and guidance.

We must provide a clear, honest and sensitive response to bereavement in a sympathetic environment. We already work closely with bereaved families, offering them an opportunity to meet with the clinical team who cared for their loved one, in the days and weeks following the death to answer any questions and allow them the space to raise any issues or concerns.

Aims for 2019/20

We have made good progress throughout the year and continue to demonstrate improvements along our mortality journey. Our work to date has demonstrated overall improvements across the Trust; however 2019/20 will start to focus on specific services, in particular looking to improve our mortality rates for patients admitted with a cerebrovascular or cardiovascular diagnosis, a fractured neck of femur, known learning disability or a mental health condition.

The Trust recognises that learning from the care given to patients in their final days is to enable us to understand where we have provided excellent care but also where there are additional opportunities for learning and improvement. It is vital to recognise that acknowledging the care given to patients at such a difficult time will improve the standard of care for all patients.

3.6 Effectiveness – To improve the experience of patients who are coming to the end of their life

Improving palliative and end of life care (EOLC) remains a public priority across the country and for our local communities. The Trust is committed to support 'advance care planning' (ACP) and training staff to listen to patient's choices and preference for their treatment or care and help support people who are bereaved. This commitment is set out in the Trust EOLC strategy and builds on the 'Ambitions for Palliative and End of Life Care' national framework (2015-2020).

Aims for 2018/19

The quality of palliative & EOLC for patients and those important to them remains a quality priority for the Trust and is a focus for improvement. The priorities identified by the Trust are outlined below:

- Roadshows in clinical areas and introducing 'Talking Point'
- Implementation of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
- Collaboration in the new 'End of Life Care Together' Service as part of the Better & Together Alliance
- Addition of EOLC measures as part of the Ward Accreditation
- QELCA© (Quality End of Life Care for All) project
- Collaborative Education & Training programme across the Alliance in line with new national frameworks
- Participation in the National Audit for Care at End of Life (NACEL)

Performance against this Target

- **Roadshows and Talking Point -** Prior to starting ReSPECT (see below) we conducted an engagement process in the Trust. We visited a number of areas with the pop up banner to support the process of getting patients, public and staff to talk to us about a range of issues about treatment and care including care of the dying.

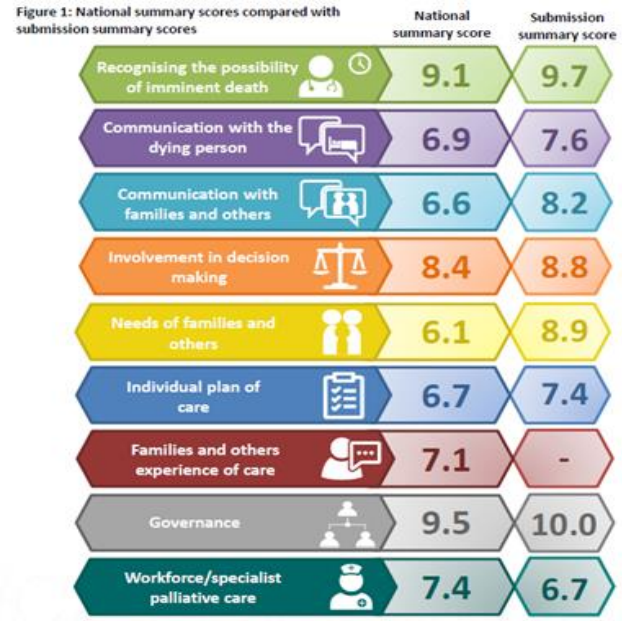
- **Implementation of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) –** The Trust is on track to implement this new process in April 2019. ReSPECT is a new national voluntary clinical standard, which is being adopted in many parts of the UK. The resources from the national team have been used to plan this implementation. This preparation for this clinical change has helped the Trust in many ways including raising the profile of better, more proactive and shared decision making and where necessary helped to teach about the transition into EOLC when treatment no longer works. This is part of the Trust strategy to develop the culture and leadership about EOLC.

- **Collaboration in the new End of Life Care Service as part of the Better & Together Alliance -** During this year the Trust completed its Alliance commitment and launched in October 2018 a new 'End of Life Care Together' service. This is helping patients, their carers and staff by providing a single point of access through 'Call for Care' which as a single point of access helps manage the referrals to and the responses of the many services involved in caring for the dying. It is helping us coordinate the delivery of services for people's every day needs as well as responding in a crisis. This is helping us to identify patients and register their needs earlier; it has improved the way care has been delivered, reduced admissions to hospital and aided the patients to be discharged earlier from hospital.

- **Collaborative Education & Training -** This work is progressing through the 'End of Life Together' service and seeks to develop an understanding of the education & training needs of all health & social care providers across the Alliance. It has been acknowledged this will take some time to develop and will require extra resource. The Trust continues to support training with Specialist Palliative Care (SPC) colleagues, for example, junior doctor training and on the 'Dying to Communicate' course, which is hosted at John Eastwood Hospice. In addition, the Trust recently hosted the 'Human Rights in End of Life Care' course and colleagues from across the Alliance attended. A further 'train the trainer' course will be hosted in May 2019. Access to this training is extended to Alliance professionals. Learning together is part of the wider vision of working seamlessly for the benefit of patients and their families.

- **Participation in the National Audit for Care at End of Life (NACEL) -** In 2018/19 the Trust participated in this National Audit for Care at the End of Life (NACEL). Figure 1 below presents the Trusts performance against the clinical standards. Out of the eight domains, the Trust was significantly better than the national average in seven. The Trust was below average for the workforce/specialist palliative care domain. However, this issue was already known about and related to specialists in palliative care. This did not reduce the Trusts performance in the other quality domains. The results of the audit were shared with the Trust in February 2019 and actions are being taken through the Alliance. A detailed analysis of the results is ongoing and will be triangulated with other information sources, including the CQC inspection findings.

Figure 1: National summary scores compared with submission summary scores



- **Addition of EOLC measures as part of the Ward Accreditation -** Work is underway to develop standards for EOLC as part of the Trusts Ward Accreditation process. The descriptors are being finalised and will be piloted before being fully embedded into the process to check for feasibility and acceptability.
- **Quality of end of Life Care for All (QELCA) Project -** An intensive training course, QELCA©, has been incorporated into the EOLC training portfolio. Six nurses from across the Trust have engaged in this programme,

which combines structured teaching with experiential learning. The nurses attend monthly, facilitated Action Learning Sets, sharing examples of positive changes in EOLC practice and provide peer support to each other.

Monitoring and Reporting for Sustained Improvement

Throughout the year the Trust has continued to monitor the number of hospital deaths. In 2018/19 1446 patients died in hospital. This is a lower number than last year. The Trust mortality statistics are included in the quality account.

CQC Inspection and Findings

The 2018 CQC Report rated the EOLC service as good for all the five domains of safe, effective, caring, responsive and well-led. This is significantly more positive than the report in 2015. The evidence cited provides detailed quantitative and qualitative information, which was benchmarked where possible. The report focussed on three areas of improvement:

- **Do Not Attempt Cardio-Pulmonary Resuscitation (Allow a Natural Death)**
  The main theme for improvement related to the quality of assessment and recording of mental capacity status of patients when decisions relating to CPR were being made. We acknowledge that this requires improvement. There was no evidence cited however that this had undermined the safety of care of patients. The National Cardiac Arrest Audit and Datix information do not show us as an outlier. The local data also showed high compliance with consultant endorsement.
  Prior to inspection we had acknowledged the need to change the AND process and adopt the ReSPECT tool. We feel the implementation process (involving significant Trust wide education) and the format of the form will address this risk. This 'should do' and the actions to address this are reported to the Trust and are on track for delivery.
- **Tracking End of Life Care Patients**
  The report acknowledges the improvements we have made through tagging patients on Nerve Centre. At the time of inspection the 'End of Life Care Together' service had not launched. This service includes the development of a standard Patient Identification Strategy. This will take time to embed in the hospital in-patient and out-patient phases of care and across the health communities in mid Nottinghamshire.
- **End of Life Care Strategy**
  This Trust had a 4-year organisational strategy (2016-20) in place at the time of inspection, which was written to improve the quality of end of life care. CQC ratings help us to triangulate our long-term work to develop & deliver our strategy. Local data, peer feedback, peer review also support the evidence of improvement.
  The strategy prioritised these improvements aims:
  1. Culture and leadership
  2. Capability (through skill mix and education)
  3. Capacity (by increasing the capability of generalists)
  4. Maximising the impact of Specialist Palliative Care and latterly through the adopted EoL Care Together new service strategy.

During the inspection process it was suggested that staff should be more aware of the details of the strategy. We acknowledge more could have been done to reinforce this despite out attempts through the current education and development processes. During ReSPECT implementation and other programmes all staff will be reminded appropriately of the national, local and Trust strategies for EOLC commensurate to their role. Since writing this strategy there has been fundamental changes to the service arrangements with the mid Nottinghamshire Alliance programme. In this new phase a new strategy needs to be written and adopted across the alliance with key local objectives described by each provider. Common reporting key performance indicators (KPI) of this programme and local KPIs are planned. The Trust has greatly influenced strategic change in mid Nottinghamshire and across the whole city and county.

Fast Track Continuing Health Care Discharges from hospital

Identifying and discharging dying patients quickly from hospital to their preferred place of care (PPC) is a complex process requiring many services to organise at short-notice. The improvement target is 85% (of those with a successful application to achieve discharge to their PPC).

- Q1 - 84% achieved
- Q2 - 72% achieved
- Q3 – 81% achieved
- Q4 -84% achieved

During this year changes in service provision had a significant impact in the performance of the process. During the second half of this year there have been a number of improvements delivered though the Advancing Quality Programme, which has recovered the performance. These have included providing medical teams with better information and resources to improve the identification of suitable patients and in a timely manner and make more specific applications. Further Alliance work is set to make further system changes to support a longer-term achievement of at least 90% achievement through this process.

Training & Education

The Trust continues to deliver a mandatory training programme for EOLC. Between 1 April 2018 and 31 March 2019, 474 new starters (Nursing & AHP) have attended the EOLC induction session. There have been bi-monthly EOLC Champions meetings throughout the year with a core group of Registered Nurses, HCA's and AHP's attending.

This is an educational, sharing and supportive forum focused on enabling frontline staff to deliver outstanding EOLC.

We have participated in the clinical phase two and three medical student training sessions in addition to collaborating in Foundation and Core Medical doctor training & 'Dying to Communicate' courses with the Specialist Palliative Care Team.

Whilst there has been significant emphasis and resource dedicated to the ReSPECT Training Programme this year, the EOLC team continue to support bespoke requests for training & education for wards & departments. Themes that have been requested this year are around Last Days of Life care planning, having 'courageous conversations' support with mortality reviews & learning from deaths.

In order to take developments forward, the EOLC Team has been successful in obtaining a grant from Macmillan Cancer Support to fund a 2-year project. This will enable us to increase the Nursing & Administrative establishment of the EOLC Team in order to:

- Proactively identify patients admitted to hospital who are in the last year of life
- Focus on discharge & reduced length of stay
- Work collaboratively with partners to keep palliative care patients well for longer and enable resilience of carers
- Support patients to die in their preferred place of care through advance care planning
- Educate & support colleagues to develop EOLC practices in acute sector
- Scope intelligence and evidence to support the benefits of the project

Aims for 2019/20

- Progress Alliance programme of work
- Launch the Macmillan Project
- Embed EOLC elements from ReSPECT
- Participate in the next cycle of NACEL
- Update all medical and nursing EOLC plans and documentation

3.7 Patient Experience – Improve the Experience of Care for Dementia Patients and their Carers

Care for patients with dementia is part of the Trust's core business. Approximately two thirds of in-patient beds are occupied by people aged over 65 years and up to 40% of these individuals will have dementia and/or delirium. The guiding principle for the Trust is to deliver safe, high quality, compassionate, person-centred care for people with known or suspected dementia or delirium and their carers.

To deliver this the Trust is required to undertake to following key activities:

- Dementia screening of those patients over 75 years admitted as an emergency and who have stay longer than 72 hours. This screening was initially part of the CQUIN monitoring but is now an embedded national dataset. The Trust is required to ensure over 90% of eligible patients are screened within the set timescales.

- To ensure staff are trained to a level that enables them to provide 'outstanding care'- acknowledging the impact dementia has upon the lives of the patients and their carers. A range of training is provided and the uptake is as follows for the period between 1st April 2018 and December 2019.

- To ensure that the environments within the Trust are appropriate for the patients living with dementia whilst being cared for by the Trust.

Performance against this Target

The dementia screening data has consistently remained above the required 90%. Moving forward it has been identified that we need to ensure this is done efficiently and effectively. It is anticipated that from 19/3/19 the dementia screening will move to nerve centre. The module is currently being reviewed for any implementation problems. To ensure that the change in screening does not impact upon the data for 1 month post implementation we will continue to monitor the screening and manually address any gaps.

We have developed our integration with RRLP and this has improved the referral and formal assessment processes which are the last elements of the screening process but also ensure we do the best we can to support patients who may be suffering from dementia.

Training

The training programme continues to support education within this area. Mandatory training this year has included the voice of a patient's carer. The perspective of a patient's journey and that of his carer has been very empowering and informative and has raised awareness greatly. This has been reflected in the training evaluations. The dementia specialist nurse inputs into the Mental Capacity Act training, supporting the use of scenarios involving patients who are living with dementia and how this may impact upon their decision-making abilities. All staff upon commencing work with the Trust attend a dementia awareness session and the compliance for this is consistently 100%.

The table below outlines the training figures between April 2018 and March 2019

Training Opportunity	Stakeholders captured
Orientation – Dementia Awareness (Tier 1)	752
Contemporary Issues (Tier 2)	42
Mandatory training	2535

Environments

The Trust continues to work and implement services along the criteria aligned to Johns Campaign. This is a core function of the dementia service. The dementia champion's network is used to promote this Trust wide. The dementia champions meet quarterly and are updated regarding dementia care developments on an on-going basis.

The Specialist Nurse for Dementia has worked with the CCG to implement the 'Red Bag scheme to ensure that patients when attending Trust services are equipped with the relevant information and medication to aid their care.

The Trust has begun to erect bus stops around the hospital's sites; these have been found to be very effective for many patients including those living with dementia. These are areas where patients can stop and talk or if confused or lost have been found to alert staff to their needs and support.

The Trust continues to develop areas in wards and departments, which are 'dementia friendly' and have facilities that provide a calmer and securer environment and reduce distress patients may experience when attending unfamiliar facilities.

'This is me' is a nationally accepted document that accompanies patient s throughout their care journey. The Trust ensures that any patients who require this document and do not have it are given one. It is updated to inform staff and carers about the patients, how they may respond to certain situations and gives an overview of their experience of dementia. This acknowledges that there are a large number of variations of presentation within the dementia category and the symptoms and the way in which patients experience this varies. This helps us to ensure that each patient receives individualised care that meets their own individual needs.

The Forget Me Not magnet continues to be used to identify patients with dementia aiding support where needed in a sensitive manner.

How was this achieved?

- The dementia service is overseen by the dementia steering group which feeds into the safeguarding steering group. This steering group leads the identification and implementation of strategies to maintain and improve service provision for patients living with dementia. The steering group and the dementia champions drive the development and response to initiatives such as the Bus Stops and Red Bags and where needed escalate any areas of concern.
- Dementia training is monitored via reporting mechanisms and training evaluations. It is reviewed to ensure it meets local and national guidance.
- Dementia screening is presently undertaken manually but as previously described following a business case to the Trust Digital Strategy Group this will move to a more efficient electronic monitoring process.

Monitoring and Reporting for Sustained Improvement

- Any developments required will continue to be overseen by the dementia steering group.
- The Trust will continue to monitor training, attendance and evaluations to ensure it is aligned to local and national standards.
- The Trust will continue to develop the work of the dementia champions and ensure they remain engaged and informed.
- The Trust will monitor closely the implementation of the dementia-screening module on nerve centre.
- The Trust will continue to work closely with RRLP to ensure that the dementia screening assessment process is timely and effective.

Aims for 2019/20

- The Trust will review the dementia service in 2019 and identify any gaps, development needs and areas of good practice and improvement.

3.8 Patient Experience – Using Feedback from Patients and Carers

Patient Experience is very important to the Trust and feedback from patients, family and friends is actively sought and welcomed. The Trust values the views of feedback as an opportunity to listen and learn from patients and families in order to make improvements to the care and services provided. The Trust has a number of mechanisms to gather

feedback. These include Friends and Family Test (FFT), National Patient Surveys, Care Opinion and speciality specific surveys to understand how patients feel about our services.

All Trust staff, particularly clinical staff (doctors, nurses and allied health professionals) play a central role in encouraging and motivating patients, their family and friends to provide feedback regarding their experience. In the last period of time a number of approaches have been developed within the Trust and with the support of Meridian to improve feedback from patients, family and friends.

Friends and Family (FFT)

Friends and Family Test is truly embedded into the patient feedback mechanisms, which is shown by the continued consistency in the response and recommendation rates during 2018/19. National performance requirements are highlighted in the table. The FFT response and recommendation for 2017/18 is below:

Performance against this Target
The FFT response and recommendation rates are reported to Trust Board monthly as a KPI, and the table below shows the performance for 2018/19 against the Trust internal targets:

Indicator	**Trust Target**	**YTD Actuals 2017/18**	**YTD Actuals 2018/19**
Response Rate: Friends and Family Inpatients	≥24.1%	23.15%	33.4%
Recommended Rate: Friends and Family Inpatients	97%	98.3%	97.8%
Response Rate: Friends and Family Emergency Department	≥12.8%	6.81%	12.9%
Recommended Rate: Friends and Family Accident and Emergency	87%	92.2%	94%
Recommended Rate: Friends and Family Maternity	96%	96.7%	95.5%
Recommended Rate: Friends and Family Outpatients	96%	94.3%	94.1%

How was this achieved?
The FFT response and recommendation rates continue to be reported as a key performance indicator at the Trust Board meetings and exception reports are submitted relating to any areas where internal standards are not met.
The FFT is monitored monthly as part of the Nursing Ward Assurance Group, with agreed plans for areas of non-compliance.
All FFT data is reported weekly to all relevant teams, managers and the Divisional Triumphant for review and action, all negative responses and narrative around the patient experience is included in the reporting and areas for improvement are identified.
Themes highlighted in the FFT reporting for improvement include:

- Car Parking capacity
- Delays in Outpatient Clinics and lack of communication
- Attitude and communication of staff
- Signage in the Outpatient departments
- Delays in results

- Delay in medical notes in Outpatient Clinic
- Rude reception staff within Sexual Health Service
- As a result of the feedback, a number of improvements have been implemented:
- Signage concerns have been submitted as a case of need which was approved; however Head of Estates procured the necessary signage within the Outpatient Department.
- Delays in radiology reporting are reported by exception report, this will be monitored as unclear at this time what this feedback is relating to and not been an issue previously specific to Newark, and does not triangulate with feedback via complaints or concerns.
- Any reported incidents of missing notes are reviewed and monitored monthly. The Trust were currently achieving 99% of all case notes were available and prepped for clinic.
- Car Parking capacity and charges are escalated to the Car Parking Group for further review.
- All reception staff within Sexual Health Services are undertaking training sessions relating to customer care, with additional training for dealing with difficult customers/patients

Trust wide response rates have improved however there has been significant increase and sustainability in the Emergency Department. This has been due to a number of factors, including implementing method of collection to include, paper surveys, iPads with the support of volunteers and text messaging to collect feedback. Staff receives monthly FFT feedback and continue to engage with patients to aim to meet the target which is reviewed as part of the monthly ward assurance meeting

Monitoring and Reporting for Sustained Improvement

In order to continue to understand how patient experience and maintaining high standards, we continue to strive to provide feedback received from complaints, concerns, compliments, and Friends and Family data. Complaints, concerns and compliments will continue to be triangulated with incidents, legal claims and Coroners' Inquests to identify themes and trends. The learning from complaints is managed by action plans that are tracked with divisions to ensure learning is embedded and evidenced.

All patient experience data will continue to be reported monthly and quarterly to the various groups within the governance structure, which will identify how well we are doing against the standard operating frameworks targets and understand our patients, relatives and carers experiences when using our services.

Aims for 2019/20

- The PET are working in partnership with divisions to further embed the complaints processes and procedures, including enhanced training for the Heads of Nursing and investigators to ensure all responsible staff are competent to undertake and complete investigations.
- The PET will continue to provide training at induction and leadership events to raise awareness of the importance of supportive and effective complaint management across the Trust.

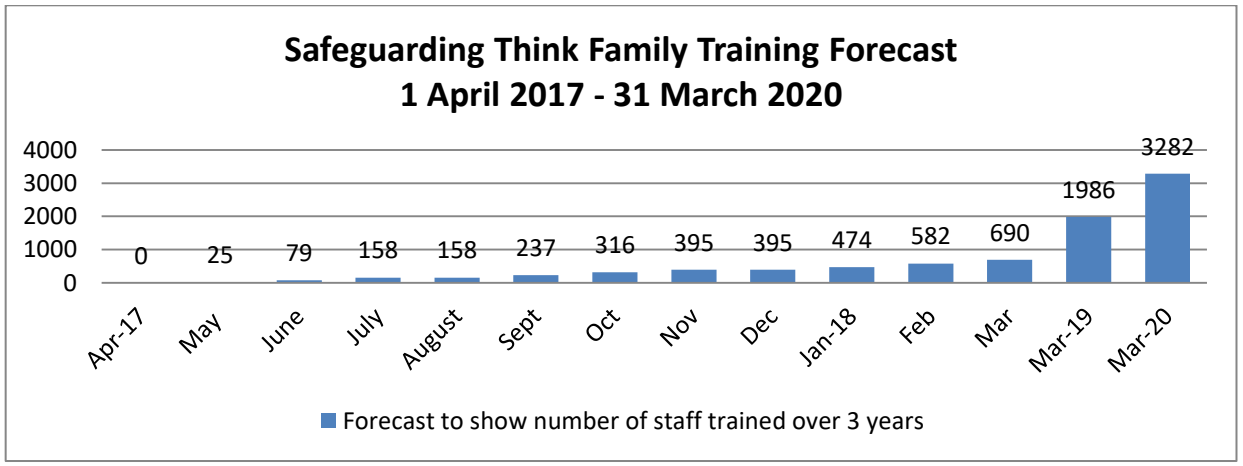
3.9 Patient Experience – Safeguarding Vulnerable People

Aims for 2018/19

- To promote and maintain safe practice in respect of safeguarding and ensure staff are aware of their responsibility to the safety of patients, carers, family and employees.
- To evidence the effectiveness of the care provided to vulnerable children, young people and adults.
- To implement initiatives that enhance service user experiences and demonstrate person-centred care, with a focus on best interest, less restrictive interventions and improving the transition from child to adult care delivery.

Performance against this Target

- The Trust reviewed and strengthened the safeguarding training strategy and aligned this with the 'Think Family' safeguarding strategy. This included a review of the training delivery and ensured this was aligned to the national statutory guidance in relation to children and supporting guidance for safeguarding adults. To this end the training is now delivered on a clinical or non-clinical basis.
- All staff commencing work in Trust attends Think Family Safeguarding induction training in the first month of employment.
- Where staff are already employed by the Trust there is a 3 year training trajectory to ensure all staff have attended Think Family Safeguarding training. It is expected that by the March 2020 all clinical staff will be trained to the required levels. These figures are monitored monthly by and reported to the Safeguarding Steering Group and Patient Safety and Quality Group. The table below highlights the training trajectory.



- The MCA/DOLS training day has commenced as indicated in last year's report, this was strengthened to support staff dealing with more challenging and complex cases.

Wider Safeguarding Support

- Duty –advice line support – Monday to Friday 9am -5pm- the subject of calls is closely monitored and any trends or themes addressed or additional training provided.
- Safeguarding referrals are monitored and where required the safeguarding team work in partnership with the local authorities and partner agencies. Where challenge or escalation is required the divisions are supported to escalate in line with policy and procedure to ensure the best interests of the patients, families or carers are met.
- The Trust participate in multiagency reviews and ensures learning is shared in order to support service developments

Audit and Assurance

- The MCA/DOLS audit continues on an ongoing basis – learning is fed to the divisions, areas and overseen by the Safeguarding Steering group any wider learning is escalated more widely as required.
- We provide assurance to the commissioners, CQC and safeguarding boards via our Safeguarding Adults Assurance framework and Section 11 safeguarding children reviews, the outcomes of these reviews are overseen via the safeguarding steering group.
- We participate in multi-agency audits for both children and adults the key areas audited during this year included

- MASH referral for children that conclude in no further action
- Bruising in non-mobile babies
- Familial sexual abuse
- Missing children
- S.136 Mental Health Act 1983
- Harmful sexual behaviour
- Child sexual exploitation

This is fed into training, procedure and practice development where relevant. The Safeguarding governance process again oversees this. All policies and procedures are reviewed and are in date, these reflect new local and national guidance. We continue to work with the divisions to support transitions between service's for service users and families and where needed provide expert input into the relevant case meetings.

Monitoring and reporting for sustained improvement

- We continue to use and refine our quarterly reporting mechanisms. These are drawn together to provide an overarching annual report (each Trust is required to provide safeguarding annual report and the quarterly reporting process used to support this is evidence of best practice).
- The data we draw from the reporting processes are used to analyse areas for development, intervention but also evidence we (The Trust) are doing a 'good job'.
- Training attendance will continue to be reviewed and forms part of our standardised reporting mechanisms, non-compliance and issues are escalated via the steering group, PSQG and divisional reporting mechanisms where needed.
- We continue to review and update training content to enable us to learn from internal and external issues and guidance.

Aims for 2019/20

- The Trust will continue to ensure where there are safeguarding concerns adults, children and carers are recognised as partners in the outcomes they wish to happen.
- Develop partnership working with Nottinghamshire Womens Aid to deliver a hospital Independent Domestic Violence Advocate (IDVA) model of recognising and responding to domestic abuse.
- The Trust will continue to embed the developments in respect of MCA/DOLS and evidence the work undertaken and respond to the changes in the Mental Capacity Act bill.
- The Trust will work in partnership with external partners regarding the Trust response to the safeguarding agenda; aligning this to the proposed Safeguarding Assurances Tool (SAT) in NHS England Midlands and East region.

3.10 Mandatory Key Performance Indicators

Indicators identified within the Single Oversight Framework	**Target**	**Performance**	
		Yr2017/18	Yr2018/19
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	91.5	90.2%

Ⓐ A&E : maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	92.3%	94.2%
Cancer 2 week wait: all cancers	93%	96.1%	96.1%
Cancer 2 week wait: breast symptomatic	93%	97.2%	95.1%
Cancer 31 day wait: from diagnosis to first treatment	96%	98.6%	98.1%
Cancer 31 day wait: for subsequent treatment – surgery	94%	90.9%	93.3%
Cancer 31 day wait: for subsequent treatment –drugs	98%	100.0%	95.6%
Ⓐ Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85%	84.1%	81.4%
Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90%	84.9%	92.5%
Maximum 6- Week wait for diagnostic procedures	99%	98.9%	99.1%
Clostridium difficile variance from plan	48	39	35
**Summary Hospital-level Mortality Indicator (SHMI)	100	101.62	96.72 October 2017 – September 2018
VTE Risk assessment	95%	95%	95%

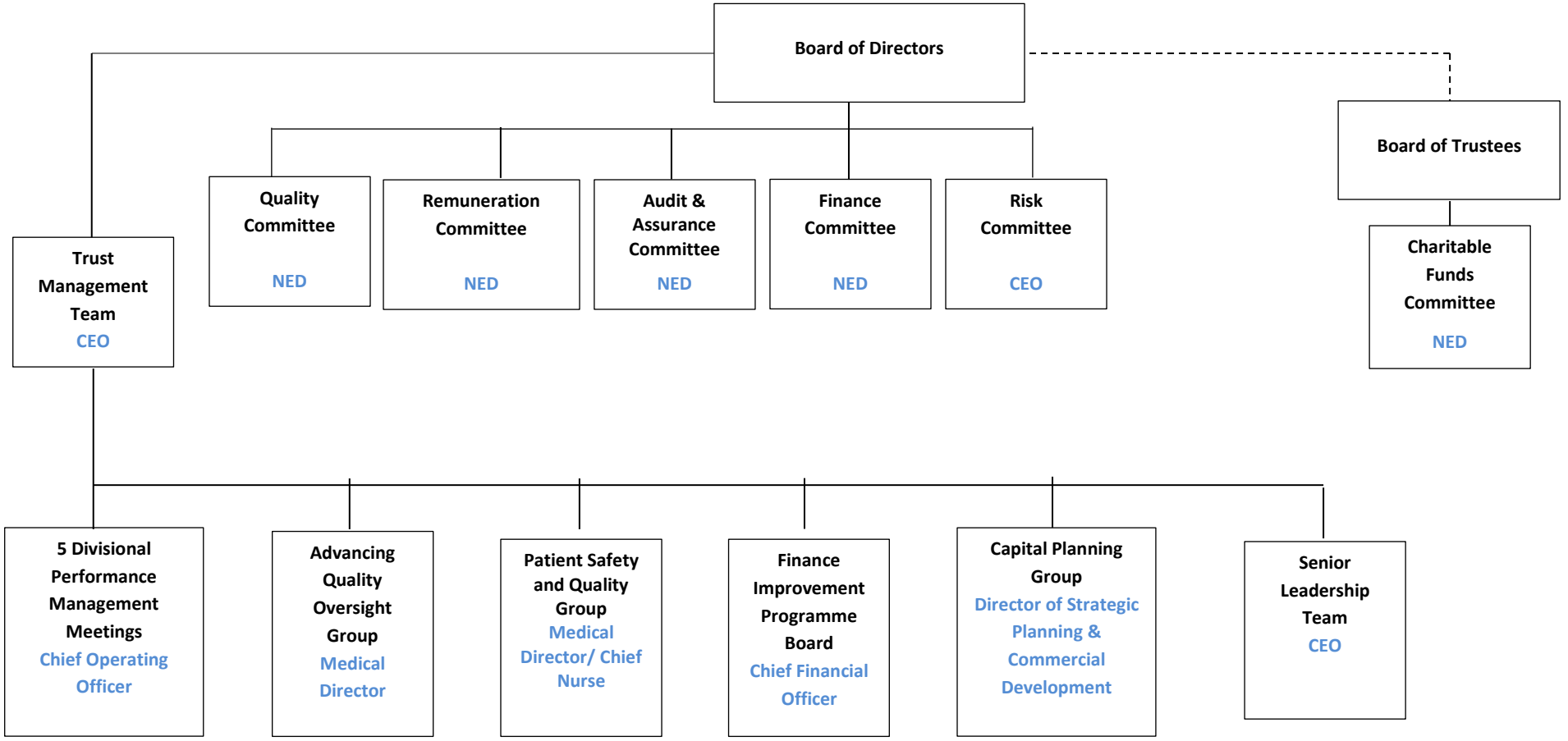
Further detail of assurance over mandated and selected local indicators can be found in Appendix 3.

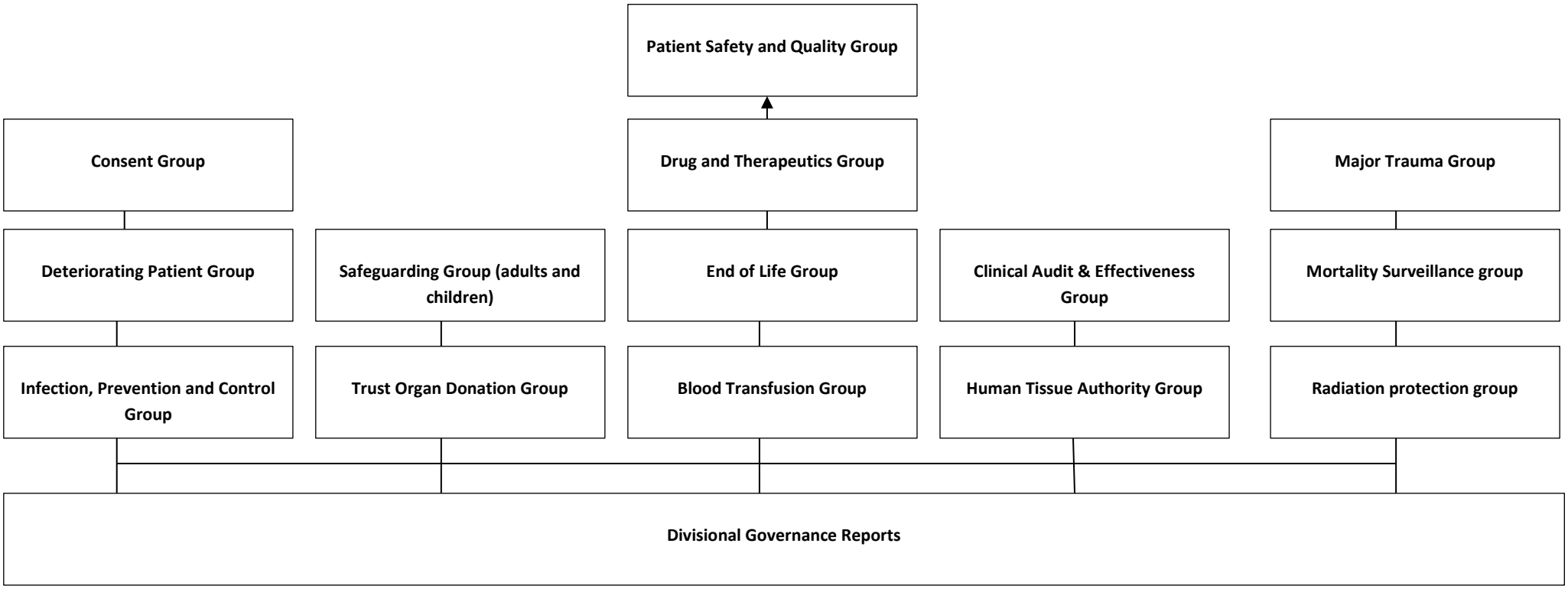
** Local Indicator - The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available:

- 102.21 July 2016 to June 2017
- 101.62 October 2016 - September 2017
- 97.72 July 2017 to June 2018
- 96.72 October 2017 – September 2018

Appendix 1

Sherwood Forest NHS Foundation Trust –Committee Structure – 2018/19





The Patient Safety Quality Group (PSQG) meet on the second Wednesday of every month. PSQG is the key Governance Committee that operationally supports the delivery of safe, high quality care to patients. PSQG also provides an Assurance Report from each meeting to the Board of Directors via the Quality Committee.

Appendix 2 Assurance over Mandated Indicators

Percentage of Patients with a Total Time in A&E of Four Hours of Less from Arrival to Admission, Transfer or Discharge

Detailed Descriptor – Numerator: The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (total number of unplanned A&E attendances) - (total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge). Denominator: The total number of unplanned A&E attendances:

Criteria for indicator:

- The indicator is defined within the technical definitions that accompany 'Everyone counts: planning for patients 2014-15 – 2018-19' and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def1415-1819.pdf
- Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances- Emergency-Definitions-v2.0-Final.pdf.

The total population is based on all patients recorded as attending A&E and patients who have not been identified as such have not been considered within the calculation.

For walk-in patients arrival time is recorded as the time the patient is booked in on EDIS (Emergency Department Information System) at reception.

For Ambulance patients the Trust records arrival time as the unadjusted booking in time recorded on EDIS. There is no facility to record the ambulance handover time. The Trust is therefore reporting a longer time than required for this measure for ambulance patients. The Trust is planning on implementing a new system in ED in 2017-18 which will enable the recording of ambulance handover times and has been working with East Midlands Ambulance Service NHS Trust to ensure accurate data is captured for ambulance arrival in 2017-18.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

This is an indicator chosen by the Governors and subsequently looked at by the external auditors as part of their quality inspection audit (not subject to the assurance) and update to management.

Detailed descriptor

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition: all cancer two month urgent referral to treatment wait

Numerator: number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator: total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Criteria for indicator: The total population is based on all patients referred to the Trust with suspected cancer and patients who have not been identified as such have not been considered within the calculation.

Local Indicator

Summary Hospital Level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

Criteria for indicator: The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly by NHS Digital.

Annex 1 – Statements from Commissioners, Health Scrutiny Committee and Healthwatch

This section includes the statements from our stakeholders about the Trusts quality performance during 2018/19 following review by Stakeholders.

Statement from Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Groups (CCGs)

Sherwood Forest Hospitals Foundation Trust have delivered sustained positive performance against a number of patient safety, quality and staffing metrics throughout 2018/19. They continue to learn from incidents and complaints; this learning has informed and improved changes in practice.

The Trust performed well against the national A+E target with over 94.2% of patients treated within 4 hours over the last twelve months, even though urgent care attendances remained high following the winter period and against a backdrop of an increase in attendances via ambulance. We acknowledge the improvements made by the Trust in ambulance handover times. This has been achieved by close working with partners to ensure a collaborative approach to minimise the impact on patient waiting times.

Sherwood Forest Hospitals Foundation Trust met or exceeded staff appraisal and mandatory training rate targets for the majority of the year. It is clear staff well-being is a priority for the Trust and this is demonstrated not only by performance around staff Flu vaccinations, but also initiatives implemented throughout the year aimed at supporting staff to maintain good emotional well-being. The CCG welcomes the Trust's continued focus on improving staff well-being as a priority for 2019/20.

The CCG recognise the innovative work that the Trust has implemented to improve the health of the local population and reduce health inequalities through their nationally recognised work to support patients with a learning disability and a local street health programme.

There have been some more challenging areas around referral to treatment and cancer waiting times and our expectations are that the Trust will continue to focus on these areas in 2019/20 and build upon the initial steps taken to address these areas. As commissioners we will require and monitor improvement during the coming year.

The Trust's role in the Mid Nottinghamshire Integrated Care Partnership has allowed the local system to integrate systems across the health community leading to continued improvement to services for our population.

Statement from the Health Scrutiny Committee

The Nottinghamshire Health Scrutiny has confirmed that it is not providing a comment for inclusion this year.

Statement from Healthwatch

Statement in response to the Sherwood Forest Hospital Trust Quality Account 2018-2019

As the independent watchdog for health and care in Nottingham and Nottinghamshire, we aim to ensure patient and carer voices are heard by both commissioners and providers. We are grateful for the opportunity to view and comment on the Sherwood Forest Hospital Trust Quality Account 2018-19. Our focus in reviewing the report was on quality improvement priorities and patient engagement.

The report provides a good overview of the progress made against the 2018/19 quality priorities, including how each priority was measured, progress to date and examples of changes that have been introduced. This includes a focus on explaining care to patients in an understandable way and improvements to measures of safe care.

Quality priorities for 2019/20 are outlined clearly, and include a positive patient experience, safer care, clinically effective care and 'We stand out'. The Trust has adopted an approach to quality improvement based on an internationally recognised model, and a training programme for staff is currently being rolled out. There has been a strategic focus on staff engagement which has contributed to high levels of performance against national performance targets, for example on Emergency Department access targets and readmissions.

The report reflects feedback from patients in the national inpatient survey and key themes are identified around patient information, waiting times for admission, communication and information for carers, with evidence about how these are being addressed. Themes arising from patient complaints are not detailed nor what learning there was from complaints.

It is not clear from the report if patients and citizens were involved in the development of the quality agenda and strategy, although there have been improvements in specific services that have been developed in discussion with patients and carers (e.g. in learning difficulties services, intensive care and on respiratory wards).

It is recommended that the approach to engaging with patients and carers and how this was used to develop quality improvement priorities is outlined in future reports. We also see an opportunity for involving patients and carers in the training and implementation of the quality improvement model.

To note:
No changes to the 2018/19 Quality Account following receipt of statements from Commissioners, the Health Scrutiny Committee and Healthwatch.

Annex 2 - Statement of Directors responsibilities for the Quality Report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality report, directors are required to take steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 20178/19 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 2018 to the date of this statement ("the period");
- Papers relating to quality reported to board over the period April 2018 to the period of this statement;
- Feedback from the Commissioners dated 20th May 2019;
- Feedback from local Healthwatch organisation dated 20th May 2019;
- Feedback from Overview and Scrutiny Committee dated 20th May 2019;
- The Trust's 2017/18 complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009, dated July 2018;
- The National inpatient survey 2017 management report, National cancer patient experience survey dated September 2018 and Women's experience of maternity care survey dated 5th October 2017;
- The 2018 national staff survey dated February 2019;
- The Head of Internal Audit's annual opinion of the trust's control environment dated May 2019; and
- CQC Inspection report dated 15th August 2018

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

The performance information reported in the Quality report is reliable and accurate

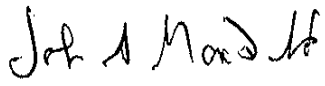
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

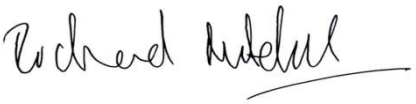
The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board





Chair 23rd May 2019

Chief Executive Officer 23rd May 2019

Glossary of Terms Used

Term	Description
A&E	Accident & emergency
AKI	Acute kidney injury
CCG	Clinical Commissioning Group
C Diff	Clostridium difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRT	Cardiac resynchronisation therapy
COPD	Chronic obstructive pulmonary disease
DH	Department of Health
ECHO	Echocardiogram
ED	Emergency department
EDASS	Emergency department avoidance support service
EMPSC	East Midlands Academic Health Science Network
EPACCS	Electronic palliative care co-ordination system
EPMA	Electronic prescribing and administration
FFT	Friends and Family Test
GP	General practitioner
HSCIC	Health & Social Care Information Centre
HSMR	Hospital standardised mortality ratio
IDAT	Integrated discharge advisory team
IG	Information governance
LCRN	Local clinical research network
LOS	Length of stay
LTC	Long term condition

MRSA	Methicillin resistant staphylococcus aureus
MSO	Medicines safety officer
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
NRIG	Nottinghamshire records information group
NRLS	National Reporting and Learning System
OBD	Occupied bed days
PDD	Predicted date of discharge
PEAT	Patient environment action team
PLACE	Patient led assessment care environment
PROMS	Patient reported outcome measures
PSIG	Patient safety improvement group
QIP	Quality improvement plan
RCA	Root cause analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Children's Health
SFH	Sherwood Forest Hospitals
SHMI	Summary hospital mortality index
SSI	Surgical site infection
TTO	To take out
VTE	Venous thromboembolism
WHO	World Health Organisation
WTE	Whole time equivalent

Independent Auditors' Limited Assurance Report to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sherwood Forest Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria*
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Appendix 2 of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Appendix 2 of the Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing this limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this limited assurance report;
- Feedback from the Commissioners dated 20th May 2019;

- Feedback from local Healthwatch organisation dated 20th May 2019;
- Feedback from the Overview and Scrutiny Committee dated 20th May 2019;
- The Trust's 2017/18 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2018;
- The National inpatient survey 2017 management report, National cancer patient experience survey dated September 2018 and Women's experience of maternity care survey dated 5th October 2017;
- The 2018 national staff survey dated February 2019;
- Care Quality Commission inspection report, dated 15th August 2018, and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sherwood Forest Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sherwood Forest Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicator and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management and personnel;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and

- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Sherwood Forest Hospitals NHS Foundation Trust.

Basis for Disclaimer Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We found that start clocks for ambulance arrivals are not being captured in line with NHSI's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge", which specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier. Sherwood Forest Hospitals NHS Foundation Trust currently uses the arrival time in department without adjustment, which would fall after ambulance arrival but before handover.

Clock start and stop times are recorded directly in to SystemOne, the system used by Sherwood Forest Hospitals NHS Foundation Trust in A&E. The Trust uses a Strategic Reporting tool which shows the times that clock start and clock stops were entered on to SystemOne. We reviewed the Strategic Reporting for the items in our sample and found that two out of fifteen clock stop times had been entered a period of time after the reported discharge time, however there was no explanation recorded for the delays in inputting the clock stops. We were unable to confirm the clock start and stops back to supporting evidence outside SystemOne as this is not retained.

Disclaimer of conclusion

Because of the significance of the matters described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the four hour waits in A&E indicator.

Based on the results of our procedures, nothing else has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports 2018/19";

- the Quality Report is not consistent in all material respects with the documents specified above; and
- the 'Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' indicator has not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP, Donington Court, Pegasus Business Park, Castle Donington, DE74 2UZ

29 May 2019

The maintenance and integrity of the Sherwood Forest Hospitals NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

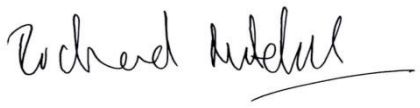
Sherwood Forest Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 **Richard Mitchell**
Job title **Chief Executive Officer**
Date **23 May 2019**

Statement of Comprehensive Income
For the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	2	262,441	249,726
Other operating income	3	56,184	54,955
Operating expenses	5, 7	(314,265)	(276,866)
Operating surplus from continuing operations		**4,360**	**27,815**
Finance income	10	82	33
Finance expenses	11	(17,049)	(14,467)
Net finance costs		**(16,967)**	**(14,434)**
Other losses	12	(64)	(73)
(Deficit) / Surplus for the year		**(12,671)**	**13,308**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	2,698
Revaluations	16	1,999	-
Total comprehensive (expense) / income for the period		**(10,672)**	**16,006**

(Deficit) / Surplus for the year as stated above		**(12,671)**	**13,308**
Reversal of impairment	6	(14,156)	(37,277)
Impairment	6	-	756
Deficit from continuing operations excluding the impact of impairments.		**(26,827)**	**(23,213)**

Statement of Financial Position

As at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	3,356	4,279
Property, plant and equipment	14	283,981	265,362
Receivables	18	602	358
Other assets	19	-	-
Total non-current assets		**287,939**	**269,999**
Current assets			
Inventories	17	3,422	3,119
Receivables	18	28,530	26,175
Cash and cash equivalents	19	4,255	8,905
Total current assets		**36,207**	**38,199**
Current liabilities			
Trade and other payables	20	(28,482)	(27,765)
Borrowings	22	(79,254)	(11,289)
Provisions	23	(1,502)	(1,104)
Other liabilities	21	(1,814)	(2,419)
Total current liabilities		**(111,052)**	**(42,577)**
Total assets less current liabilities		**213,094**	**265,621**
Non-current liabilities			
Trade and other payables	20	(500)	(715)
Borrowings	22	(393,238)	(435,513)
Provisions	23	(318)	(828)
Total non-current liabilities		**(394,056)**	**(437,056)**
Total assets employed		**(180,962)**	**(171,435)**
Financed by			
Public dividend capital		147,560	146,415
Revaluation reserve		16,314	14,517
Income and expenditure reserve		(344,836)	(332,367)
Total taxpayers' equity		**(180,962)**	**(171,435)**

The notes on pages 197 to 243 form part of these accounts and were approved by the Board and signed on its behalf:

Name **Richard Mitchell**
Position **Chief Executive Officer**
Date **23 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**146,415**	**14,517**	**(332,367)**	**(171,435)**
Deficit for the year	-	-	(12,671)	**(12,671)**
Other transfers between reserves	-	(201)	201	**-**
Revaluations	-	1,999	-	**1,999**
Transfer to retained earnings on disposal of assets	-	(1)	1	**-**
Public dividend capital received	1,145	-	-	**1,145**
Taxpayers' equity at 31 March 2019	**147,560**	**16,314**	**(344,836)**	**(180,962)**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**146,139**	**11,942**	**(345,798)**	**(187,717)**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**146,139**	**11,942**	**(345,798)**	**(187,717)**
Surplus for the year	-	-	13,308	**13,308**
Other transfers between reserves	-	(122)	122	**-**
Impairments	-	2,698	-	**2,698**
Transfer to retained earnings on disposal of assets	-	(1)	1	**-**
Public dividend capital received	276	-	-	**276**
Taxpayers' equity at 31 March 2018	**146,415**	**14,517**	**(332,367)**	**(171,435)**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. No charges have been payable by the trust, to the Department of Health.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		4,360	27,815
Non-cash income and expense:			
Depreciation and amortisation	5.1	9,055	10,043
Net impairments	6	(14,156)	(36,521)
Income recognised in respect of capital donations	3	(542)	(241)
Increase in receivables and other assets		(2,600)	(4,142)
(Increase) / decrease in inventories		(303)	258
Increase / (decrease) in payables and other liabilities		1,745	(6,175)
(Decrease) / Increase in provisions		(105)	8
Other movements in operating cash flows		(1)	-
Net cash used in operating activities		**(2,547)**	**(8,955)**
Cash flows from investing activities			
Interest received		80	27
Purchase of intangible assets		(2,745)	(275)
Purchase of property, plant, equipment and investment property		(8,776)	(6,045)
Sales of property, plant, equipment and investment property		113	32
Net cash used in investing activities		**(11,328)**	**(6,261)**
Cash flows from financing activities			
Public dividend capital received		1,145	276
Movement on loans from the Department of Health and Social Care		34,573	45,696
Capital element of PFI, LIFT and other service concession payments		(9,581)	(11,283)
Interest on loans		(2,722)	(2,246)
Other interest		(1)	-
Interest paid on PFI, LIFT and other service concession obligations		(14,189)	(12,221)
Net cash generated from financing activities		**9,225**	**20,222**
(Decrease) / Increase in cash and cash equivalents		**(4,650)**	**5,006**
Cash and cash equivalents at 1 April - brought forward		**8,905**	**3,899**
Cash and cash equivalents at 31 March	19.1	**4,255**	**8,905**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The going concern concept is further covered in IAS 1 – 'Presentation of Financial Statements'. IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. In the event that a Foundation Trust is dissolved by Monitor any property or liabilities of the Trust may be transferred to another Foundation Trust, an NHS Trust or the Secretary of State.

For the year ending 2018/19 the Trust is reporting a deficit of £12.67m which includes the impact of impairments on the valuation of buildings. Removing this gain, which was £14.16m, we are reporting a deficit of (£26.83m). This is favourable to the plan by £6.62m. In year the Trust received £18.9m for Provider Sustainability Funding (PSF), which was £1.07m less than plan due to the non-receipt of the Q2-4 Integrated Care System PSF and forecast Q4 ED PSF.

To support this financial position the Trust has received £40.29m, and repaid £4.01m of revenue support term loans. No capital borrowing was incurred, however, in year repayments of £1.7m were made against existing capital loans.

NHS Improvement has set a control total of a maximum deficit of (£14.9m) in 2019/20, which includes receipt of £6.5m PSF and £14.8m of Financial Recovery Fund (FRF). To qualify for this funding the Trust must:-

• Accept its control total, agreed by Board of Directors Q4 2018/19.
• Deliver the agreed year to date financial performance compared to plan.

To support this deficit £14.9m of cash support will be required. NHS Improvement (NHSI) is aware of the need for cash support and the value has formally been notified via the submission of the financial plan on 12th February 2019, and updated plan submitted 4th April 2019. This has not formally been agreed, however cash borrowing has been received on the basis of this plan in the early months of 2019/20.

Due to PFI liabilities, depreciation does not self-fund the capital expenditure. The Trust will be submitting a separate capital loan application for £2.7m which will be reviewed in detail by NHS Improvement and the Project Appraisal Unit. Approval has been received from NHSI for inclusion of forecast capital borrowing in the financial plan.

The Trust Board agreed a financial plan that would deliver the control total on 28th February 2019 and further ratified this when commissioner contract values were known on 27th March 2019. Included within this is assumed financial improvement programme (FIP) delivery £12.8m. Development and delivery of the FIP programme includes dedicated support from the Project Management Team with a workstream lead identified for each area of the programme. Targets have been identified for each workstream based on opportunities with continuous processes moving schemes into delivery.

Given the evidence available to the Board of Directors as summarised within this report, there are circumstances that indicate the existence of a material uncertainty that may cast doubt about the Trust's ability to continue as a going concern. However the Trust has accepted its control total as issued by NHSI, revenue borrowing has been received for the early months of 2019/20 and the Trust has adopted a plan with clear assumptions of requirements to deliver, including a CIP programme of £12.8m for which an infrastructure is in place to support delivery. On this basis the accounts have been prepared on a going concern basis. The Board of Directors has taken steps to ensure this remains the case for the next 12 months.

Note 1.1.3 Critical judgements in applying accounting policies

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

Assumptions have been made regarding the treatment of Lifecycle costs which have all been capitalised in year, £1.3m based on the PFI model.

Equal pay - Agenda for change annual leave provision £1.16m based on entilement to remaining leave and allowing for the differing leave periods of medical staff.

Note 1.2 Sources of estimation uncertainty

There are no assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidated as the balances are not deemed material, however, the revenue and capital grants are reflected in the accounts.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Standard credit terms apply to invoiced revenue with all NHS debt due for payment within 14 days and all non NHS receivables due within 30 days of the invoice date. Invoices are not raised where revenue is recognised on performance of a contractual obligation until this has been met.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

(1) As per paragraph 121 of the Standard, the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives. The Trust following advice form the District Valuer does not separatly recognise any components within the PFI property as it is the responsibity of the PFI provider to maintain all assets at condition B until the date of transfer to the Trust in 2043.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. All property assets are revierwed by an independent valuer. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

The annual contract payments are apportioned between the service charge (charged to operating expenses), lifecycle replacement cost and the finance lease liability. The finance lease liability is further split into the principal repaid, the loan interest expense and the contingent rent in accordance with IAS 17, and reflects the fact that the lease rental may increase due to uncertain factors.

Lifecycle replacement costs are reviewed and charged to revenue or capital when they meet the capital definition and are then accounted for as part of the annual valuation assessment." In 2018/19 all lifecycle replacment costs were capitalised in line with the PFI model.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives 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 life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

In year an exercise was undertaken with external advice to assess the remaining life of plant and machinery inlcuding medical equipment. This has amended the remaining life of a large number of assets which has been reflected in the Trust's capital asset register.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.8.2 Measurement

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

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

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

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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	**Max life Years**
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	5	10
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is valued on the basis of a first in first out basis. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

Financial assets are de-recognised Vv'hen the contractual rights to receive cash flovvs from the assets have expired or the Trust has transferred substantially all the risks and rewards of OVvflership.

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

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax
No liability for corporation tax has been recognised or incurred when applying the current legislation.

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

Change published	Financial year for which the change first applies
IFRS 14 Regulatory Deferral Accounts	Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Tr	Application required for accounting periods beginning on or after 1 January 2019.

Note 1.24 Operating Segments

No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Diagnostics & Outpatients. In addition there is a supporting corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

A detailed analysis of all income is disclosed in note 2 to these accounts.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 2.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	35,562	36,171
Non elective income	96,741	86,683
First outpatient income	22,527	18,670
Follow up outpatient income	21,556	31,763
A & E income	17,232	16,012
High cost drugs income from commissioners (excluding pass-through costs)	16,784	13,483
Other NHS clinical income	47,568	45,810
Private patient income	94	88
Agenda for Change pay award central funding	3,586	-
Other clinical income	791	1,046
Total income from activities	**262,441**	**249,726**

There have been reclassification adjustments in 2018/19 for outpatient and follow up outpatient income. However overall outpatient income has fallen due to reduced activity and National Tariff reductions.

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	12,953	12,943
Clinical commissioning groups	241,504	231,455
Department of Health and Social Care	3,586	-
Other NHS providers	605	1,455
NHS other	138	9
Local authorities	2,770	2,730
Non-NHS: private patients	94	88
Non-NHS: overseas patients (chargeable to patient)	42	24
Injury cost recovery scheme	749	1,022
Non NHS: other	-	-
Total income from activities	**262,441**	**249,726**
Of which:		
Related to continuing operations	262,441	249,726
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 21.89% to reflect expected rates of collection. (22.84% 2017/18)

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	42	24
Cash payments received in-year	12	6
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	22	5

Note 3 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	737	731
Education and training (excluding notional apprenticeship levy income)	11,268	11,177
Non-patient care services to other bodies	7,187	9,397
Provider sustainability / sustainability and transformation fund income (PSF / STF)	18,908	17,335
Income in respect of employee benefits accounted on a gross basis	311	-
Other contract income	16,290	14,242
Other non-contract operating income		
Receipt of capital grants and donations	542	241
Charitable and other contributions to expenditure	248	357
Rental revenue from operating leases	690	1,475
Other non-contract income	3	-
Total other operating income	**56,184**	**54,955**
Of which:		
Related to continuing operations	56,184	54,955
Related to discontinued operations	-	-

Provider Sustainability / Sustainability and Transformation Fund income relates to income received for meeting agreed operational and financial targets.

Note 4.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	605
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	632
after one year, not later than five years	1,182
after five years	-
Total revenue allocated to remaining performance obligations	**1,814**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	(262,441)	(249,726)
Income from services not designated as commissioner requested services	885	1,110
Total	**(261,556)**	**(248,616)**

Note 4.4 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 5.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	473	857
Purchase of healthcare from non-NHS and non-DHSC bodies	1,203	1,589
Purchase of social care	-	-
Staff and executive directors costs	205,847	195,414
Remuneration of non-executive directors	136	144
Supplies and services - clinical (excluding drugs costs)	26,534	25,488
Supplies and services - general	3,168	2,919
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	24,355	22,187
Inventories written down	(75)	-
Consultancy costs	430	97
Establishment	3,220	2,881
Premises	17,342	17,297
Transport (including patient travel)	668	641
Depreciation on property, plant and equipment	7,357	8,411
Amortisation on intangible assets	1,698	1,632
Net impairments	(14,156)	(36,521)
Movement in credit loss allowance: contract receivables / contract assets	(110)	
Movement in credit loss allowance: all other receivables and investments	-	50
Increase/(decrease) in other provisions	(253)	299
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	78	77
other auditor remuneration (external auditor only)	9	8
Internal audit costs	124	121
Clinical negligence	13,031	10,738
Legal fees	75	138
Education and training	575	522
Rentals under operating leases	332	338
Early retirements	52	29
Redundancy	4	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	21,156	20,919
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	156	131
Hospitality	183	140
Losses, ex gratia & special payments	-	36
Other	653	284
Total	**314,265**	**276,866**
Of which:		
Related to continuing operations	314,265	276,866
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditors remuneration paid to the external auditors:		
2. Audit-related assurance services	9	8
Total	**9**	**8**

Note 5.3 Limitation on auditors' liability

The limitation on auditors' liability for external audit work is £1m (2017/18: £1m).

Note 6 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating deficit resulting from:		
Changes in market price	(14,156)	(36,521)
Total net impairments charged to operating deficit	**(14,156)**	**(36,521)**
Impairments charged to the revaluation reserve	-	(2,698)
Total net impairments	**(14,156)**	**(39,219)**

Land and Buildings are valued on an annual basis to reflect their market value. The valuations accords with the requirements of the Royal Institution of Chartered Surveyors RICS Valuation - (known as 'the Red Book') in so far as these are consistent with IFRS and NHS guidance. Any movements in the carrying value are reflected in the SOCIE / SOCIE Reserves as required.

Note 7 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	156,410	147,458
Social security costs	16,497	13,693
Apprenticeship levy	809	713
Employer's contributions to NHS pensions	18,133	17,125
Termination benefits	99	-
Temporary staff (including agency)	14,272	16,775
Total gross staff costs	**206,220**	**195,764**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**206,220**	**195,764**
Of which		
Costs capitalised as part of assets	317	299

Note 7.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £382k (£121k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9 Operating leases

Note 9.1 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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	690	1,475
Contingent rent	-	-
Other	-	-
Total	**690**	**1,475**

	2018/19 £000	2017/18 £000
Future minimum lease receipts due:		
- not later than one year;	487	547
- later than one year and not later than five years;	373	1,279
- later than five years.	24	32
Total	**884**	**1,858**

Note 9.2 Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sherwood Forest Hospitals NHS Foundation Trust is the lessee.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	332	338
Contingent rents	-	-
Less sublease payments received	-	-
Total	**332**	**338**

	2018/19 £000	2017/18 £000
Future minimum lease payments due:		
- not later than one year;	396	368
- later than one year and not later than five years;	155	327
- later than five years.	2	-
Total	**553**	**695**

Note 10 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	82	33
Total finance income	**82**	**33**

Note 11.1 Finance expense

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,866	2,246
Interest on late payment of commercial debt	1	-
Main finance costs on PFI and LIFT schemes obligations	6,153	4,835
Contingent finance costs on PFI and LIFT scheme obligations	8,036	7,386
Total interest expense	**17,056**	**14,467**
Unwinding of discount on provisions	(7)	-
Other finance costs	-	-
Total finance costs	**17,049**	**14,467**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	1	-

Note 12 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	113	32
Losses on disposal of assets	(177)	(105)
Total losses on disposal of assets	**(64)**	**(73)**

Note 13 Intangible assets - 2018/19	2018/19	2017/18
	Software licences	Software licences
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**14,105**	**13,021**
Valuation / gross cost at start of period for new FTs	**-**	
Transfers by absorption	-	
Additions	2,276	2,173
Impairments	-	
Reversals of impairments	-	
Revaluations	-	
Reclassifications	(1,501)	(1,089)
Valuation / gross cost at 31 March 2019	**14,880**	**14,105**
Amortisation at 1 April 2018 - brought forward	**9,826**	8,516
Provided during the year	1,698	1,632
Reclassifications	-	(322)
Amortisation at 31 March 2019	**11,524**	**9,826**
Net book value at 31 March 2019	**3,356**	**-**
Net book value at 1 April 2018	**-**	**4,279**

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**17,361**	**228,605**	**1,826**	**-**	**32,411**	**11,454**	**427**	**292,084**
Additions	-	4,064	174	-	2,928	1,252	79	**8,497**
Reversals of impairments	-	14,156	-	-	-	-	-	**14,156**
Revaluations	35	1,964	-	-	-	-	-	**1,999**
Reclassifications	-	-	-	-	-	1,501	-	**1,501**
Disposals / derecognition	-	-	-	-	(1,564)	(9)	-	**(1,573)**
Valuation/gross cost at 31 March 2019	**17,396**	**248,789**	**2,000**	**-**	**33,775**	**14,198**	**506**	**316,664**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**-**	**19,213**	**7,246**	**263**	**26,722**
Provided during the year	-	5,492	-	-	(66)	1,882	49	**7,357**
Disposals / derecognition	-	-	-	-	(1,387)	(9)	-	**(1,396)**
Accumulated depreciation at 31 March 2019	**-**	**5,492**	**-**	**-**	**17,760**	**9,119**	**312**	**32,683**
Net book value at 31 March 2019	**17,396**	**243,297**	**2,000**	**-**	**16,015**	**5,079**	**194**	**283,981**
Net book value at 1 April 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - restated	**17,291**	**191,072**	**1,658**	**525**	**33,311**	**9,596**	**425**	**253,878**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	2,459	168	-	3,368	1,598	2	**7,595**
Impairments	-	(756)	-	-	-	-	-	**(756)**
Reversals of impairments	70	39,905	-	-	-	-	-	**39,975**
Revaluations	-	(4,600)	-	-	-	-	-	**(4,600)**
Reclassifications	-	525	-	(525)	801	288	-	**1,089**
Disposals / derecognition	-	-	-	-	(5,069)	(28)	-	**(5,097)**
Valuation/gross cost at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**32,411**	**11,454**	**427**	**292,084**
Accumulated depreciation at 1 April 2017 - restated	**-**	**-**	**-**	**-**	**21,355**	**6,000**	**226**	**27,581**
Provided during the year	-	4,600	-	-	2,500	1,274	37	**8,411**
Revaluations	-	(4,600)	-	-	-	-	-	**(4,600)**
Reclassifications	-	-	-	-	322	-	-	**322**
Disposals / derecognition	-	-	-	-	(4,964)	(28)	-	**(4,992)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**19,213**	**7,246**	**263**	**26,722**
Net book value at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**
Net book value at 1 April 2017	**17,291**	**191,072**	**1,658**	**525**	**11,956**	**3,596**	**199**	**226,297**

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	17,396.0	11,226.0	-	-	14,645.0	5,072.0	173.0	**48,512**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	230,841	-	-	-	-	-	**230,841**
Off-SoFP PFI residual interests	-	-	2,000	-	-	-	-	**2,000**
Owned - donated	-	1,230	-	-	1,370	7	21	**2,628**
NBV total at 31 March 2019	**17,396**	**243,297**	**2,000**	**-**	**16,015**	**5,079**	**194**	**283,981**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	17,361	6,213	-	-	11,993	4,203	154	**39,924**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	221,427	-	-	-	-	-	**221,427**
Off-SoFP PFI residual interests	-	-	1,826	-	-	-	-	**1,826**
Owned - donated	-	965	-	-	1,205	5	10	**2,185**
NBV total at 31 March 2018	**17,361**	**228,605**	**1,826**	**-**	**13,198**	**4,208**	**164**	**265,362**

Note 15 Donations of property, plant and equipment

The Trust received donations during the year of £790k. (2017/18 £546k). No restrictions were placed on these donations of which £542k 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 2019.

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 based on the remaining usefule life advised by the District Valuer. This had minimal effect on remaining lives.

Note 17 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,315	1,245
Work In progress	-	-
Consumables	2,033	1,849
Energy	74	25
Other	-	-
Total inventories	**3,422**	**3,119**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £29,319k (2017/18: £26,678k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	25,755	-
Trade receivables*	-	6,339
Accrued income*		16,363
Allowance for impaired contract receivables / assets*	(278)	-
Allowance for other impaired receivables	-	(264)
Prepayments (non-PFI)	1,597	1,142
Interest receivable	8	6
VAT receivable	1,318	1,496
Other receivables	130	1,093
Total current trade and other receivables	**28,530**	**26,175**
Non-current		
Contract receivables*	1,097	-
Allowance for impaired contract receivables / assets*	(551)	-
Allowance for other impaired receivables	-	(784)
PFI lifecycle prepayments	56	59
Other receivables	-	1,083
Total non-current trade and other receivables	**602**	**358**
Of which receivables from NHS and DHSC group bodies:		
Current	20,876	21,086
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**1,048**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,048	(1,048)
New allowances arising	79	-
Changes in existing allowances	(189)	-
Utilisation of allowances (write offs)	(109)	-
Allowances as at 31 Mar 2019	**829**	**-**

Note 18.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - restated	**1,029**
Increase in provision	50
Amounts utilised	(31)
Allowances as at 31 Mar 2018	**1,048**

Note 18.4 Exposure to credit risk	31-Mar-19 Contract receivables and contract assets	31-Mar-18 Contract receivables and contract assets
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	24	21
30-60 Days	26	22
60-90 days	32	22
Over 90 days	747	983
	829	1,048
Ageing of non-impaired financial assets past their due date	**£000**	**£000**
0 - 30 days	25,023	19,973
30-60 Days	1,823	620
60-90 days	531	128
Over 90 days	1,755	3,563
	29,132	24,284

The majority of carrying debt relates to NHS organisations, therefore no significant credit risk is assumed in non impaired receivables.

Note 19.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**8,905**	**3,899**
Prior period adjustments	-	-
At 1 April (restated)	**8,905**	**3,899**
Transfers by absorption	-	-
Net change in year	(4,650)	5,006
At 31 March	**4,255**	**8,905**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	4,249	8,899
Total cash and cash equivalents as in SoFP	**4,255**	**8,905**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**4,255**	**8,905**

Note 19.2 Third party assets held by the trust

Sherwood Forest Hospitals NHS Foundation Trust held cash and cash equivalents of £1k which relate to monies held by the the foundation trust on behalf of patients or other parties (2017/18 £1k). This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Monies on deposit	1	1
Total third party assets	**1**	**1**

Note 20 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	4,292	4,276
Capital payables	4,723	6,016
Accruals	10,933	8,842
Receipts in advance (including payments on account)	20	26
Social security costs	2,211	2,082
Other taxes payable	1,867	1,721
Accrued interest on loans*	-	555
Other payables	4,436	4,247
Total current trade and other payables	**28,482**	**27,765**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
Other taxes payable	-	-
Other payables	500	715
Total non-current trade and other payables	**500**	**715**
Of which payables from NHS and DHSC group bodies:		
Current	4,582	4,562
Non-current	500	715

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 23. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 21 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,814	2,419
Total other current liabilities	**1,814**	**2,419**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 22 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	69,508	1,706
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	9,746	9,583
Total current borrowings	**79,254**	**11,289**
Non-current		
Loans from the Department of Health and Scoial Care	143,394	175,924
contracts	249,844	259,589
Total non-current borrowings	**393,238**	**435,513**

Note 22.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**177,630**	**269,172**	**446,802**
At start of period for new FTs	**-**	**-**	**-**
Cash movements:	-	-	**-**
Financing cash flows - payments and receipts of principal	34,573	(9,581)	**24,992**
Financing cash flows - payments of interest	(2,722)	(6,154)	**(8,876)**
Non-cash movements:	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	555	-	**555**
Application of effective interest rate	2,866	6,153	**9,019**
Carrying value at 31 March 2019	**212,902**	**259,590**	**472,492**

Note 23 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Equal Pay (including Agenda for Change)	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**365**	**73**	**75**	**977**	**442**	**1,932**
Arising during the year	47	-	-	182	-	**229**
Utilised during the year	(47)	(5)	23	-	-	**(29)**
Reversed unused	(47)	(9)	(28)	-	(221)	**(305)**
Unwinding of discount	(5)	(2)	-	-	-	**(7)**
At 31 March 2019	**313**	**57**	**70**	**1,159**	**221**	**1,820**
Expected timing of cash flows:						
- not later than one year;	47	5	70	1,159	221	**1,502**
- later than one year and not later than five years;	188	20	-	-	-	**208**
- later than five years.	78	32	-	-	-	**110**
Total	**313**	**57**	**70**	**1,159**	**221**	**1,820**

Pensions relate to liabilities for employees who retired pre 1994 for whom the Trust retains responsibility for the payments being made.

Equal Pay relates to untaken annual leave as at 31 March, which is due to employees and is being carried forward into the next financial year.

Other relates to outstanding liabilities with HMRC for Option to Tax VAT.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

Note 23.1 Clinical negligence liabilities

At 31 March 2019, £110,358k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2018: £115,177k).

Note 24 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(50)	(42)
Gross value of contingent liabilities	**(50)**	**(42)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(50)**	**(42)**
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 25 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	2,905	645
Intangible assets	-	-
Total	**2,905**	**645**

Note 26 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019 £000	31 March 2018 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

The Trust is currently committed to two on-statement of financial position PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the assets as if it were assets of the Trust.

Further details can be found in note 1.7.5.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA)*, to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a 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.

* Leicester Housing Association is now known as Paragon Asra Housing (PA Housing).

Note 27.1 Imputed finance lease obligations

Sherwood Forest Hospitals NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**717,676**	**742,323**
Of which liabilities are due		
- not later than one year;	24,307	23,810
- later than one year and not later than five years;	101,430	100,945
- later than five years.	591,939	617,568
Finance charges allocated to future periods	(458,086)	(473,151)
Net PFI, LIFT or other service concession arrangement obligation	**259,590**	**269,172**
- not later than one year;	9,746	9,583
- later than one year and not later than five years;	39,489	39,613
- later than five years.	210,355	219,976

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,597,022**	**1,646,000**
Of which liabilities are due:		
- not later than one year;	48,433	47,263
- later than one year and not later than five years;	208,155	203,574
- later than five years.	1,340,434	1,395,163

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**46,237**	**44,403**
Consisting of:		
- Interest charge	6,153	4,835
- Repayment of finance lease liability	9,583	11,283
- Service element and other charges to operating expenditure	21,146	20,186
- Capital lifecycle maintenance	1,319	-
- Revenue lifecycle maintenance	-	713
- Contingent rent	8,036	7,386
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	10	20
Total amount paid to service concession operator	**46,247**	**44,423**

Note 28 Off-SoFP PFI, LIFT and other service concession arrangements

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 PA 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 PA Housing Association. The capital value of the scheme was £6.7m.

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 PA Housing Association.

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2019	31 March 2018
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**156**	**131**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	317	309
- later than one year and not later than five years;	1,363	1,329
- later than five years.	4,582	4,930
Total	**6,262**	**6,568**

Note 29 Financial instruments

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

Note 29.1 Financial risk management

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Note 29.2 Currency Risk

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

Note 29.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

Note 29.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The Trust mitigates its exposure to credit risk relating to receivables from customers through regular review of debtor balances and by calculating a bad debt provision at the end of the year.

Note 29.5 Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Use of Resources Risk Rating' system created by NHSI, the Independent Regulator.

The Trust has identified a cash shortfall in its 2019/20 operational plan, and requires borrowing support from the Department of Health and Social Care. Monthly applications for cash support are made in line with the financial plan.
The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

Note 29.7 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	25,909	-	-	**25,909**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	4,255	-	-	**4,255**
Total at 31 March 2019	**30,164**	**-**	**-**	**30,164**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	22,113	-	-	-	**22,113**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	8,905	-	-	-	**8,905**
Total at 31 March 2018	**31,018**	**-**	**-**	**-**	**31,018**

Note 29.8 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	212,902	-	**212,902**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	259,590	-	**259,590**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	24,511	-	**24,511**
Other financial liabilities	-	-	**-**
Provisions under contract	1,820	-	**1,820**
Total at 31 March 2019	**498,823**	**-**	**498,823**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	177,630	-	**177,630**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	269,172	-	**269,172**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	28,480	-	**28,480**
Other financial liabilities	-	-	**-**
Provisions under contract	1,494	-	**1,494**
Total at 31 March 2018	**476,776**	**-**	**476,776**

Note 30 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	104,813	54,540
In more than one year but not more than two years	103,486	99,809
In more than two years but not more than five years	75,151	170,946
In more than five years	215,373	151,481
Total	**498,823**	**476,776**

Note 31 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	20	3	5	1
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	400	26	316	25
Stores losses and damage to property	8	-	5	17
Total losses	**428**	**29**	**326**	**43**
Special payments				
Compensation under court order or legally binding arbitration award	3	38	3	22
Extra-contractual payments	-	-	-	-
Ex-gratia payments	37	7	41	14
Special severence payments	2	65	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**42**	**110**	**44**	**36**
Total losses and special payments	**470**	**139**	**370**	**79**
Compensation payments received		-		-

Note 32 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. The Trust did not undertake that initial assessment as it was the view of the Trust that based on the carrying value of debts and impaired receivables any movement would be immaterial.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £555k, and trade payables correspondingly reduced.

Assessment of allowances under the expected credit loss model was not applied as disclosed above due to the immaterial value of applicable receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,723k.

Note 32.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. Related parties include but are not limited to

Department of Health and Social
Care ministers The Department of
Health and Social Care Board
members of the trust
Nottingham University Hospitals NHS
Trust University Hospitals of
Leicester NHS Trust Chesterfield
Royal Hospital NHS Foundation
Trust Nottinghamshire Healthcare
NHS Foundation Trust Northampton
General Hospital NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust
NHS Bassetlaw CCG NHS
Hardwick CCG
NHS Lincolnshire West CCG
NHS Mansfield and Ashfield CCG NHS
Newark and Sherwood CCG NHS North
Derbyshire CCG
NHS Nottingham City CCG
NHS Nottingham North
and East CCG NHS
Nottingham West CCG
NHS Rushcliffe CCG
NHS South West
Lincolnshire CCG
NHS Southern
Derbyshire CCG NHS
England
Health Education England
NHS Resolution
NHS Property Services
Department of Health and Social Care
HM Revenue & Customs
NHS Pension Scheme
NHS Blood and Transplant
Criminal Injuries Compensation Authority
Nottinghamshire County Council
NHS charitable funds (where not consolidated)

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund. Charitable Income of £790k (2017/18 £546k) has been recognised in these accounts of which £567k relates to Sherwood Forest Hospitals General Charitable Fund and £223k to other local Charities. In addition a recharge of £60k (2017/18 £53k) has been made to Sherwood Forest Hospitals General Charitable Fund in relation to management / staff costs.

The Trust made no payments to related parties for whom the Chair, Non Executive or Executive Directors are named Directors.

Note 34 Events after the reporting date

There are no non-adjusting events after the reporting period which affect the financial information and disclosures made in these accounts.

Independent Auditors' Report to the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Sherwood Forest Hospitals NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2019; the Statement of Comprehensive Income for the year ended 31 March 2019; the Statement of Cashflows for the year ended 31 March 2019; the Statement of Changes in Equity for the year ended 31 March 2019; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.1.2 to the financial statements concerning the Trust's ability to continue as a going concern.

Sherwood Forest Hospitals NHS Foundation Trust has been reliant on external cash support from the Department of Health and Social Care to meet its liabilities as they fall due and forecasts that significant financial support will be required for the foreseeable future.

These conditions, along with the other matters explained in note 1.1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

See note 1 to the financial statements for the directors' disclosures of the related accounting policies and note 1.1.2 for the directors' judgements relating to the going concern assumption for further information.

Sherwood Forest Hospitals NHS Foundation Trust recorded a deficit from continuing operations excluding the impact of impairment in 2018/19 of £26.8 million. The Trust is forecasting a deficit of £41.5 million in 2019/20 before the receipt of £26.7 million of Provider Sustainability Fund, Financial Recovery Fund and Marginal Rate Emergency Tariff income, which is dependent on meeting financial and performance targets.

Sherwood Forest Hospitals NHS Foundation Trust has been reliant on external cash support from the Department of Health and Social Care on a rolling monthly basis throughout 2018/19 and, based on its financial plan for 2019/20, significant external financial support will be required for the foreseeable future. The 2018/19 plan assumes £14.9 million in revenue loan support will be required.

What audit procedures we performed

We focused on whether it was appropriate for Sherwood Forest Hospitals NHS Foundation Trust financial statements to be prepared on a going concern basis and whether the disclosures in the Annual Report and the financial statements were sufficient for a user of the financial statements to clearly understand the reasons behind the Trust's deficit and the associated material uncertainty.

The Group Accounting Manual confirms that group bodies must 'prepare their accounts on a going concern basis unless informed by the relevant national body or the Department of Health and Social Care sponsor of the intention for dissolution without transfer of services or function to another entity'.

At the date of our audit report, we concur with the directors' view that the going concern basis of accounting is an appropriate basis for the preparation of these accounts; however we performed the following procedures to test the projections made by management:

- we compared the Trust's 2018/19 Cost Improvement Programme (CIP) performance outturn against the targeted savings and considered the degree to which the 2019/20 CIP programme has been developed;
- we identified that the Trust has signed income contracts with its main commissioner for the period up to 31 March 2020; and
- we obtained the financial plan submitted to NHS Improvement for 2019/20 and compared the 2018/19 outturn position to the planned financial performance in 2019/20.

We also read the disclosures included within note 1.1.2 and confirmed that these provided the user with sufficient information to understand the reasons behind the material uncertainty, in particular the need for future reliance on external support, which has not been formally agreed with the Department of Health and Social Care.

As a result of this work, we concluded that the forecasts used by Sherwood Forest Hospitals NHS Foundation Trust in its determination of the appropriateness of the going concern basis of accounting were consistent with the evidence available. We also concluded that there is a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern for the reasons above.

Our audit approach

Context

Sherwood Forest Hospitals NHS Foundation Trust provides acute healthcare services across Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. It is funded predominantly by local Clinical Commissioning Groups ("CCGs") and NHS England.

NHS Improvement has placed Sherwood Forest Hospitals NHS Foundation Trust in segment 2 of its Single Oversight Framework as at 31 March 2019. NHS Improvement's Single Oversight Framework is the framework for overseeing providers and identifying potential support needs. Segment 2 is described by NHS Improvement as 'Providers offered targeted support'.

Our audit for the year ended 31 March 2019 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged.

Overview

- Overall materiality: £5,876,000 (2018: £6,093,620) which represents 2% of total revenue in the annual plan (2018: 2% of total revenue in the draft accounts).
- All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statements.

Our key audit matters were:

- Going concern;
- Risk of fraud in revenue and expenditure recognition; and
- Valuation of property, plant and equipment.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to going concern, described in the 'Material uncertainty related to going concern' section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the key audit matter***
Risk of fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 2 - 5 for further information.* We focussed on this area because there is a heightened risk due to: • The risks surrounding the financial sustainability of Sherwood Forest Hospitals NHS Foundation Trust, as described in the section 'Material uncertainty relating to going concern'; and • Due to the wider financial challenge in the NHS, the pressure Sherwood Forest Hospitals NHS Foundation Trust is under to achieve its forecast 2018/19 deficit set out in its plan submitted to NHS Improvement and gain access to the available Provider Sustainability Funding ('PSF'); and therefore the incentive to recognise income for services which have not been delivered during the financial year, and to omit to recognise expenditure in 2018/19, to improve the reported financial position. We considered revenue recognition to be a risk, in particular revenue streams from the Clinical Commissioning Groups ("CCGs") and NHS England, which together comprise £254 million of the Trust's £319 million of income. The service level agreements with the CCGs consist of standard monthly instalments. A monthly adjustment is then negotiated with the CCGs to reflect actual levels of activity. The value of the adjustment is subject to management judgement. The Trust can also earn Commissioning for Quality and Innovation (CQUIN) revenue as a percentage of the contract value for demonstrating improvements in quality and innovation in specified areas of patient care. In 2018/19 the Trust had an increased incentive to achieve its financial Control Total, in order to receive PSF money. We considered the risk to be focussed on the existence of income from material CCG contracts. We also considered expenditure recognition to be a risk. Given the incentive described above we focussed on the completeness of expenditure in the Statement of Comprehensive Income and of liabilities recorded in the Statement of Financial Position. We focused our work on the elements of income and expenditure that are most susceptible to manipulation:	*Journals* We tested a sample of journal transactions that had been recognised in both income and expenditure, focussing in particular on those that arose from unexpected account combinations. We agreed the journal entries to supporting documentation, for example invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income and expenditure was recognised in the appropriate accounting period for the correct value. *Revenue and expenditure* For a sample of transactions recognised during the year and around the year-end (both before and after), we confirmed that income and expenditure had been recognised in line with the Trust's accounting policies and in the correct accounting period by agreeing transactions to the supporting invoice and cash receipts/payments where appropriate. We identified expenditure transactions to the value of £0.6 million which have been included in the 2019/20 financial year but which relate to the 2018/19 financial year. This is not material and the accounts were not changed. For a sample of CCG income, we obtained the signed contract and agreed its value to the income recognised during the year. For a sample of income from over and under performance against the contract we agreed the income to supporting evidence. This included inspecting information from the year-end intra-NHS balance agreement process to identify any significant differences between the income and accounts receivable reported with NHS organisations. No material issues were identified from the work performed. We performed testing to identify whether there were any unrecorded liabilities. We: • tested a sample of payments made and invoices received after 31 March 2019 to supporting documentation, to check that, where they related to the 2018/19 financial year, an accrual was recognised appropriately; and • compared accrued expenses recognised as at 31 March 2019 with that recognised in the prior year to identify differences in the accruals recognised year on year. We also inspected the information from the year-end intra-NHS balance agreement process to identify any significant

- non-standard journal transactions;
- expenditure accruals; and
- unrecorded liabilities.

differences between the expenditure and accounts payable reported with NHS organisations.

No material issues were identified from the work performed.

Valuation of property, plant and equipment

See note 14, and the full set of accounting policies to the financial statements (note 1.7) for details of the accounting policies applied in the valuation of land and buildings.

Property, plant and equipment represents one of the largest balances in the Statement of Financial Position. The valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions. Therefore our work has focused on whether the methodology, assumptions and underlying data used to determine the value of Property, Plant and Equipment were appropriate and correctly applied. Property, Plant and Equipment as at 31 March 2019 has a Net Book Value of £284 million of which £17.4 million is land and £243.3 million is buildings.

All Property, Plant and Equipment assets are measured initially at cost, with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by a professionally qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date.

A valuation of Sherwood Forest Hospitals NHS Foundation Trust's portfolio of land and buildings was undertaken as at 31 March 2019 by Sherwood Forest Hospitals NHS Foundation Trust's valuation expert.

We obtained the valuation reports directly from Sherwood Forest Hospitals NHS Foundation Trust's valuation expert and read the relevant sections of the reports. We confirmed that the valuer had relevant experience and was a member of a relevant professional body.

We used our valuation expertise to evaluate the assumptions and methodology applied in the valuation exercise. We concluded that the methodology and approach applied by the Trust's independent expert are reasonable.

We looked at the updated Useful Economic Lives the Trust has applied to Property Plant and Equipment during the year. The accounting treatment for the change in depreciation was incorrect, resulting in depreciation being understated by £2 million. The Trust did not update the accounts because this amount is not material.

We looked at the assumptions and inputs used in the valuation of specialised buildings. This included testing the floor area for a sample of assets upon which the valuer conducted their valuation. We investigated some differences between the information used by the Trust's valuer and the records held by the Estates department, and concluded the valuation was based on appropriate information. We also undertook a sample test to confirm whether buildings had been correctly identified as specialist or non-specialist. We found no material issues from these procedures.

We tested whether the change in valuation was correctly accounted for and appropriately disclosed in the financial statements and found that it was.

Other than the matters noted in the 'Basis for opinion', 'Material Uncertainty relating to going concern' and 'Arrangements for securing economy, efficiency, and effectiveness in the use of resources' paragraphs, we determined that there were no further key audit matters relating to the financial statements of the Trust and the Trust's arrangements for securing economy, efficiency, and effectiveness in the use of resources to communicate in our report.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

The audit was conducted at Sherwood Forest Hospitals NHS Foundation Trust's largest site in Mansfield (Kings Mill Hospital) where the main finance team is based.

Our risk assessment included consideration of management's analysis of the United Kingdom's withdrawal from the European Union in the Annual Governance Statement, but the terms on which this may occur are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£5,876,000 (2017/18: £6,093,620)
How we determined it	2% of revenue in the annual plan (2018: 2% of revenue in the draft accounts)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £293,000 (2018: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2018/19 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2019 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

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

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

We are required under Schedule 10 (1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Adverse opinion

As a result of these matters, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2019.

Basis for adverse opinion and Key Audit Matter

The Trust's outturn position for 2018/19 is a deficit from continuing operations excluding the impact of impairment in 2018/19 of £26.8 million. The Trust is forecasting a deficit of £41.5 million in 2019/20 before the receipt of £26.7 million of Provider Sustainability Fund, Financial Recovery Fund and Marginal Rate Emergency Tariff income, which is dependent on meeting financial and performance targets. The Trust has been reliant on external cash support from the Department of Health and Social Care on a rolling monthly basis throughout 2018/19 and based on its financial plan for 2019/20, significant external financial support will be required for the foreseeable future. The 2019/20 plan assumes £14.9 million in revenue loan support will be required. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable deployment of resources to deliver the Trust's strategic priorities.

The Trust was subject to a Section 111 license condition, which requires it to ensure that sufficient and effective management and clinical leadership capacity and capability is in place, for the period until 28 January 2019. This provides evidence of weaknesses in leadership which may impact on the Trust's ability to achieve its strategic objectives.

What procedures were performed

Refer to procedures performed as outlined in the "Material uncertainty relating to going concern" paragraph above.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors in the Accountability Report, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- The section of the Annual report, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 or is misleading or inconsistert with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or

had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court
Pegasus Business Park
Castle Donington

Date: 29 May 2019