Sherwood Forest Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 201516

Quality *for all*

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2015/16

Presented to Parliament pursuant to Schedule 7,
paragraph 25(4)(a) of the National Health Service Act 2006

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Part 1
Forward from the Chairman and Chief Executive


Peter Herring


Sean Lyons

We are pleased to present to you our Annual Report and Accounts for the financial year 2015/16, which provide a picture of the challenges and successes of the past 12 months.

There is no doubt that 2015/16 was an extremely challenging year due to the very disappointing Care Quality Commission (CQC) report we received in October, following our June inspection. Despite our efforts following the previous report, we were given an overall rating of 'inadequate' and the CQC recommended that the Trust remain in special measures.

We are writing this year's report very much from the perspective of having made great strides in improvements in many areas of the Trust and the knowledge that, despite the rating, the CQC inspectors acknowledged this as a caring organisation. The caring element provided by our staff across all three hospitals was rated as 'good' and staff were found to be passionate and hardworking, providing care that is kind and respectful and having good interactions with patients.

Several areas of the Trust's work were found to be outstanding and showing innovative practice. One example was the way that staff went out of their way to meet patients in the critical care unit. Feedback from patients and visitors was that they were generally happy with the service they received and felt that staff involved them in the care they received.

During the past 12 months, we have made real improvements, and some of our results rank with the best in the country. Waiting times in the emergency department have fallen to the point where King's Mill is among the top quartile of the 135 acute hospitals in England, and mortality as measured by HSMR is consistently below 100.

We also continued to improve on our target for the Commissioning for Quality and Innovation (CQUIN) excellence framework for administering sepsis antibiotics on admission to hospital for more than 90 per cent of patients.

We have achieved our financial forecasts and, during the year, we delivered Cost Improvement Savings of £6.89m against a target of £6.5m.
There is still a great deal to do and many challenges yet to come. These include:

- ending our reliance on agency staff, which has impacted on budgeting
- continuing to improve the way we collect and manage information
- improving the way that we report and learn from incidents across the Trust
- increasing our efforts in nurse and junior doctor recruitment and retention
- improving how we manage and care for patients whose condition is deteriorating
- improving how we care for patients who are dying
- ensuring a robust and systematic patient safety culture
- improving how we assess and care for patients with delirium
- improving how we engage with our staff across the Trust

In February 2016, we announced that we would be entering into a long term partnership with Nottingham University Hospitals NHS Trust during 2016/17. This was the result of an invitation to bid we offered NHS Trusts we considered would be able to support us through the improvements we needed to make to patient care and services.

As 2015/16 came to an end, we welcomed clinical colleagues from NUH as they started to work with us and help to shape the partnership that will lead to the merger. We are also in the position of being able to share with NUH colleagues the good practices in health care that are recognised by our regulators, particularly in areas where NUH seeks to improve, making this very much a partnership.

None of this would be possible without the drive and dedication of our own staff. We are grateful for their continued support during the past year and the challenging tasks we face in the months ahead. We are proud to have recognised some of their individual and team efforts through our award schemes, as well as those of our volunteers whose unstinting fundraising has been of such great benefit to patients, visitors and staff during the past year.

We are also grateful for support of our Members and Council of Governors, who have praised where deserved and challenged where needed. Like our staff side members, commissioners, MPs, local governors and the many stakeholders in the local and regional and social care economy, they help to keep this Trust and its staff firmly sighted on the patients and local community that we serve.
This organisation is improving and there is a lot to be optimistic about in the next year.

Peter Herring
Interim Chief Executive Officer

Sean Lyons
Chairman

Part 2
Performance Report

2.1 Overview

Statement from CEO on performance during 15/16
Statement on purpose and activities of the FT
History of the FT and its statutory background
Issues and risks affecting SFH's ability to deliver its objectives

Chief Executive Statement on 2015/16 performance

Sherwood Forest Hospitals NHS Foundation Trust (SFH) strives to provide safe, efficient, personalised and consistent care for the people who use its services. We are facing unique challenges following the recent Care Quality Commission (CQC) inspection which rated the Trust as 'Inadequate' overall, whilst recognising the caring nature of our services.

The inspection outcome, combined with a worse than planned financial position, led the CQC and the sector regulator, Monitor, to conclude that the Trust should remain in 'special measures', whilst seeking a long term partnership with another acute Trust. In February 2016, Nottingham University Hospitals (NUH) was announced as our preferred partner and this will lead to the creation of a new organisation that will be responsible for the delivery of safe and sustainable clinical services for mid-Nottinghamshire, and the other communities currently served by SFH. Ahead of a formal partnership transaction being agreed in the coming financial year, the team at NUH has already started to provide us with support.

Since the CQC inspection, we have delivered a number of significant improvements, including a sustained reduction in our Hospital Standardised Mortality Ratio (HSMR). As a result of improvements to clinical care pathways, record keeping and coding, our HSMR has been at, or below, 100 for six consecutive months. Considerable progress has also been made in the management of sepsis. For example, compliance with sepsis screening within our admission areas reached 99.3% in the third quarter of 2015/16, against a CQUIN target of 90%.

We are reporting a deficit of £55.0m before the reversal of an impairment. This includes costs of £2.0m, agreed with Monitor, to find a long term partner and support the first stages of working towards a long term partnership with NUH. This represents a deterioration of £10.5m compared to plan, but is in line with the forecast agreed with Monitor in September 2015. The deterioration compared to plan is primarily as a result of the continuing recruitment challenges with both medical and nursing staff and the corresponding need for premium rate pay. Nevertheless, improved financial discipline has meant the Trust's Cost Improvement Programme (CIP) has delivered £6.8m of savings.

Peter Herring
Interim Chief Executive Officer
26th May 2016

Our history and structure

SFH was formed in 2001 and gained Foundation Trust status in 2007. We are the main acute hospital trust for the local population, providing care for people across north and mid-Nottinghamshire, as well as parts of Derbyshire and Lincolnshire.

In addition to our two main hospital sites - King's Mill and Newark - we provide community and outpatient services from Mansfield Community Hospital.

During 2015/16, we revised our clinical divisional structure, moving from three clinical divisions to five. The five divisions (Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Diagnostics and Outpatients) are now benefitting from enhanced clinical leadership and greater levels of managerial support. The clinical divisions continue to be supported by a corporate division.

The Trust is managed by the Board of Directors, which is responsible for setting the vision and strategy for the Trust and ensuring its effective implementation. As a Foundation Trust, we have a Council of Governors which holds the Board of Directors to account. We are currently in the process of seeking new Governors to fill 19 vacancies. They will commence in post during the spring/summer of 2016.

What we do

Our comprehensive range of services is designed to meet the needs of our local population, as we provide planned and emergency surgery, inpatient and outpatient care and services in the community and our hospitals. In the last year, we have provided over 427,000 outpatient appointments, had more than 146,000 attendances at our Emergency Department and Minor Injuries Unit (MIU) and delivered over 3,500 babies.

However, we recognise that we cannot meet the health and social care needs of local residents alone, and as such we work in partnership with other organisations in the area. SFH is an active partner in the mid-Nottinghamshire Better Together programme, which seeks to provide care closer to patients' homes and aims to ensure that effective care is not inhibited by organisational boundaries.

During 2015/16, the Better Together programme has seen the development of a commissioner-provider alliance, which will move into a new phase in 2016/17. The Alliance consists of mid-Nottinghamshire Clinical Commissioner Groups (CCGs), local healthcare providers (including SFH), social care and the third sector. An 'Alliance Agreement', which sets out the aims and objectives for 2016 onwards, was signed in March 2016. The principles set out in the agreement underpin our collective commitment to work together for the benefit of local citizens.

Our values

All that we do is underpinned by our 'Quality for All' values, which describe our ethos and the attributes that we aim to consistently exhibit. The Quality for All values are

- Communicating and working together
- Aspiring and improving
- Respectful and caring
- Efficient and safe.

Our objectives

In response to the challenges and developments in 2015/16, we have reframed our strategic objectives. They are to:

- ensure the **highest standards** of **safe care** are consistently delivered by, and for, individuals, teams and departments
- ensure that **patients experience** the **very best care,** building on good practice and listening and learning from negative and positive feedback and events
- provide **timely access** to diagnosis, treatment and care when people need it and safely reduce the time patients spend in hospital
- raise the level of **staff engagement** through strong leadership, communication, feedback and recognition
- reduce the scale of our financial deficit by reducing costs, improving utilisation of resources and **productivity,** and achieving **best value for money** (VFM)
- work in **partnership** to keep people well in the community, and enable them to return as soon as they are ready to leave hospital
- develop and implement a programme of work in conjunction with NUH **to create a new, combined organisation**

Current risks, issues and mitigations

Despite the progress made in 2015/16 (as described above) we continue to face clinical, financial and workforce challenges that affect our sustainability and ability to meet these objectives. The partnership with NUH provides a long term solution to a number of these. In particular, it will help address longstanding workforce and care quality issues by providing a stable leadership team, improvements in governance and an opportunity to focus efforts and expertise on the areas where the CQC identified serious concerns.

The partnership will help with the recruitment and retention of staff, giving greater career development prospects for the workforce and making our hospitals increasingly attractive places to work. Furthermore, the partnership will provide opportunities for collective action to address our longstanding financial issues, through the sharing of resources and best practice.

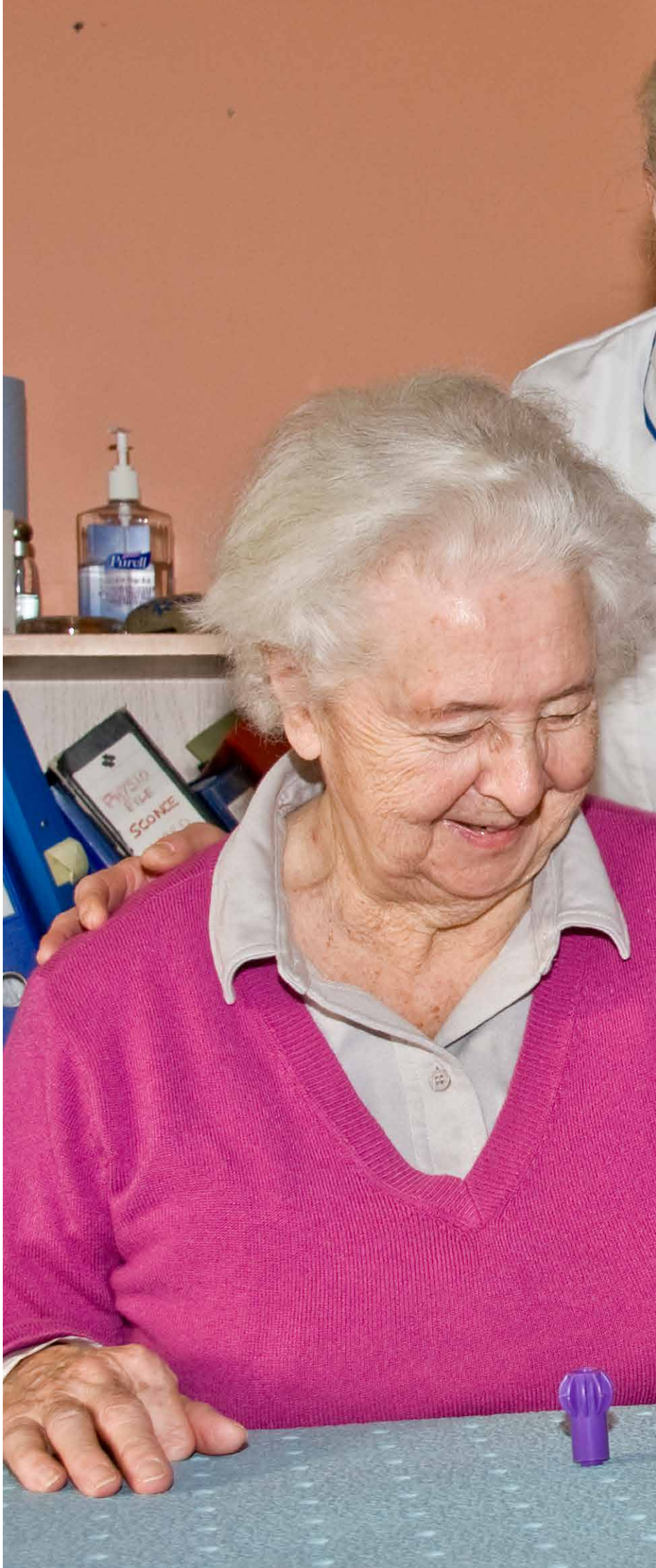
In addition to progressing the partnership with NUH during 2015/16, we have developed a comprehensive Quality Improvement Plan (QIP). This incorporates our response to all of the issues raised in the recent and previous CQC reports and the issues highlighted within the enforcement actions mandated by Monitor. As we develop the partnership with NUH, we must ensure we deliver all the actions within the QIP and maintain our focus on the Trust's strategic objectives.

Going concern

In preparing the annual accounts the Trust is required to assess the basis of their preparation, specifically questioning the status of the Trust as a sustainable trading entity. This assessment takes into consideration all the information available about the future prospects of the Trust and also covers financial, governance and commissioner requested (mandatory) service risks. The Trust continues to adopt the presumption of going concern in the preparation of its accounts.

In adopting the going concern basis for preparation of the financial statements, the directors have considered the business activities as well as the principal risks and uncertainties. Although access to cash support is not yet finalised, the Trust is agreeing to the deficit control total for 2016/17 of (£41.1m) set by NHS Improvement. Therefore, after making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Following the CQC inspection and the outcome of 'inadequate', the Trust recognised that it needed to seek a Long Term Partner to support quality improvements across the organisation. In February 2016 the Board of Directors nominated Nottingham University Hospitals NHS Trust as its preferred partner. Together the two Trusts are working to establish the business case for a full integration of the organisations. The form of any integration is not yet known and full approval from NHS Improvement and the Department of Health is not yet agreed. It is anticipated that if agreed the integration of the two Trusts will take place in 2016/17.




Sherwood Forest Hospitals
NHS
Foundation Trust
Have I washed my hands?

2.2 Performance Analysis

Operational performance

Our achievements during 2015/16 and our quality performance are detailed in our Quality Report.

Emergency Care

The following details how emergency activity and performance has changed since 2014/15:

	2014/15	2015/16	Change
ED attendances			
Q1	36,990	36,772	1% decrease
Q2	36,296	36,079	1% decrease
Q3	35,415	35,580	0.5% increase
Q4	34,736	37,906	9% increase
Ambulance arrivals at ED			
Q1	7,329	7,473	2% increase
Q2	7,187	7,444	4% increase
Q3	7,725	7,781	1% increase
Q4	7,681	8,073	5% increase
Emergency Admissions from ED			
Q1	8,033	8,314	3% increase
Q2	8,159	8,417	3% increase
Q3	8,342	8,914	7% increase
Q4	8,464	9,178	8% increase
ED 4 hour Performance			
Q1	94.27%	96.01%	
Q2	93.99%	95.91%	
Q3	88.52%	94.77%	
Q4	92.43%	91.17%	

A large increase in demand through the emergency department (ED) and via ambulances resulted in a higher number of emergency admissions and significant challenges to the 'flow' of patients through their clinical pathways towards discharge. This is reflected in a reduced performance in the ED 4 hour target for Q4 compared to earlier quarters and Q4 2014/15. When patient flow is compromised patients spend longer in ED waiting to be moved to an inpatient bed.

Referral to Treatment

In October 2015 the national target for the 18 week referral to treatment (RTT) changed to exclude the individual targets for admitted and for non-admitted patients. The target for 'Incomplete' pathways, those patients who are waiting for treatment, remained as the only target. The target is 92%.

	2014/15	2015/16
RTT 'Incompletes'		
Q1	92.0%	92.0%
Q2	94.2%	92.3%
Q3	92.6%	92.0%
Q4	89.4%	93.8%

Cancer Treatment

	Target	2014/15	2015/16
2 week wait: all cancers	93%	93.5%	95.2%
2 week wait: breast symptomatic	93%	95.1%	95.2%
31 day wait: from diagnosis to first treatment	96%	98.8%	98.3%
31 day wait: for subsequent treatment – surgery	94%	97.8%	99.0%
31 day wait: for subsequent treatment – drugs	98%	99.7%	99.7%
62 day wait: urgent referral to treatment	85%	86.4%	84.0%
62 day wait: for first treatment – screening	90%	95.5%	96.4%

Waits for Urgent referral to treatment within 62 days was below the required standard for Quarters 1-3. In Quarter 4 the Trust achieved the target with 87%.

Diagnostics

The target for a diagnostic test (DM01) to be completed for physiology, radiology and endoscopy is 99%.

	2014/15	2015/16
DM01		
Q1	99.7%	95.5%
Q2	99.5%	96.1%
Q3	96.4%	98.2%
Q4	96.4%	98.7%

Demand and capacity issues in both sleep studies and endoscopy caused failure of the target from Quarter 3 of 2014/15. Work to create additional capacity in endoscopy has resulted in a return to required performance in 2016/17.

Stroke

The Stroke Sentinel Audit is a mark of the quality of care provided to patients who are suffering from, or who have suffered from, a stroke. The grading is measured between 'A' which is the highest mark and 'D' which is the lowest mark.

	2014/15	2015/16
SSA		
Q1	D	B
Q2	D	A
Q3	D	A
Q4	D	A

Service and quality improvements

During 2015/16 we have applied significant focus to improving the quality of our services. Whilst much of the progress that we have made is described in more detail in our Quality Reports, it is important to highlight a number of developments here.

Firstly, our Quality Improvement Plan. This was developed following the CQC visit and includes all the outstanding actions required and demonstrates and evidences progress across a number of important areas, broken into key themes which are:

- Leadership
- Governance
- Recruitment & Retention
- Personalised Care
- Safety Culture
- Timely Access
- Mandatory Training
- Staff Engagement
- Maternity
- Newark Hospital

In addition we have:

- Strengthened governance arrangements, including the appointment of an interim Director of Governance
- Strengthened medicines management systems, which continues to be an area of focus.
- Reduced falls within the Trust
- Opened a bespoke dementia care unit – Woodland Ward
- Improved our processes for identifying and providing timely treatment to patients with sepsis
- Strengthened our infrastructure to monitor safer staffing, ensuring appropriate escalation and resolution of issues
- Implemented new leadership development programmes and opportunities
- Implemented an end of life care action plan and training programme to ensure that end of life care is responsive to patients' needs and preferences
- Reduced the length of stay for many of our patients groups

Financial analysis

The Trust is reporting a deficit of £55.0m before the reversal of impairments for the year ended 31 March 2016. This is £10.5m worse than the planned deficit of £44.5m set at the beginning of the year. During the summer months a revised plan was pulled together that more accurately reflected the challenges faced by the Trust and the consequences of implementation of CQC recommendations. This revised plan, supported by Monitor, was for a forecast deficit of £53.3m. Subsequent to the revised plan costs have been incurred in seeking a long term partner and in beginning work with NUH. These costs total £2.0m and the control total deficit of £53.3m was moved to £55.0m to accommodate these costs. As such, the reported deficit is £0.3m better than the control total.

Following the revision to the plan, we engaged the support of PWC to undertake a detailed analysis on the underlying position to ensure the validity of the forecast. Following extensive work, PWC reported that the forecast range was between £52.0m and £54.0m and as such the revised plan of £53.3m was reasonable and achievable.

PWC also undertook work to establish the causes of the Trust's deficit. They found an underlying deficit of £52m of which £19m related to structural causes which were outside the immediate control of the Trust or health economy, £14.6m of strategic causes which were in the control of the health economy and £18.4m of operational causes that were in the control of the Trust. The Better Together programme is key to addressing the strategic causes. Our CIP programme has been set at a target of £12.6m in the 2016/17 financial plan, representing 4% of spend; an amount it is agreed can be safely delivered.

For 2016/17 we have been set a control total by NHS Improvement of a maximum deficit of £41.1m, which includes £10.3m of sustainability and transformation funding, monies nationally available to Trusts to support delivery. We believe we can deliver this control total following continuing improvements in financial governance and control and a robust financial planning and budget setting process. Budgets have been built based on detailed reviews of establishments, recruitment plans and requirements to deliver quality and financial improvement. We have invested heavily in resources to support the delivery of improved quality and safety following the CQC report. Additional costs above the initial plan were £2.3m with a further investment in 2016/17 of £1.5m, bringing total investment to £3.8m. Agency spend within the Trust remains exceptionally high at £24.4m in 2015/16 (13% of total pay spend) and reduction is key to delivery of an improved and more sustainable financial position in 2016/17.

Income and expenditure

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

Operating income

Total operating income excluding reversal of impairments for the year was £264.1m (£265.0m in 2014/15). Income from patient care activities was £226.5m (£224.2m in 2014/15). Non-clinical income received contributes to the operating costs of the Trust and the provision of healthcare services. The Trust confirms that income from the provision of goods and services for the purposes of healthcare is greater than income from other services.

Operating expenses

Our total operating expenses (excluding impairments and depreciation) rose during the year to £291.50m from £272.5m in 2014/15, an increase of 6.9% from the previous year. Of this £18.7m increase, £13.0m was due to increased staff costs and primarily in variable and agency pay. This is driven by the high number of vacancies in the Trust as well as increased pay costs to deliver CQC recommendations. Other increases were due to pay and non-pay inflation and changes to the application of CNST costs by the NHS Litigation Authority, which increased premiums by £2.6m.

Of the total operating expenses, £185.4m (63.7%) was spent on staff costs. This included 555 medical and dental staff, 1,300 registered nurses and midwives, 453 scientific, technical and therapeutic staff and 1,832 other health professions and non-clinical staff.

A total of 16% of our expenditure (excluding depreciation and impairments) was on drugs and clinical supplies and services.

The remaining 20% of spend is primarily on PFI operating costs (£37.1m), legal requirements such as CNST premiums and rates.

Fixed assets

During 2015/16 the Trust invested £7.4m in its fixed asset infrastructure (£8.9m in 2014/15). This included £2.5m on buildings and the estate, £1.9m on equipment and £2.6m on IT infrastructure. Of the total expenditure £5.6m was received from the Department of Health in the form of a loan.

Spend included upgrading or acquiring new medical equipment essential for the day-to-day operation of the Trust (£2.0m) and improvements in information systems and technology in conjunction with the Nottinghamshire health economy for which the Trust provides information technology (IT) and information support services (£4.48m). The significant element of IT expenditure related to the replacement of the integrated care records system.

Charitable funds

The Trust recognised £547k (£204k in 2014/15) of charitable income in the statement of comprehensive income to match the value of purchasing equivalent medical equipment from charitable funds. This included funding of the Dementia ward, for which a specific fundraising project was undertaken by the charity and volunteers in year.

The Trustees were able to make further grants of £257k (£204k total in 2014/15) to support the activities of the Trust and for the welfare of patients and staff.

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

Private Finance Initiative (PFI) – King's Mill Hospital

As a result of the adoption of International Financial Reporting Standards (IFRS) in 2009/10, the PFI scheme is on the Trust's balance sheet. This continues to have a significant adverse impact on the balance sheet as a result of the associated financing arrangements and the asset values being relatively low in comparison. The long term borrowings on the balance sheet associated with PFI have reduced slightly to £333.6m (£339.3m in 2014/15) but the scale of this liability is a primary reason, along with the increasing income and expenditure deficit reserve, that the total/ taxpayers' equity is (£142.5m). Payments of £42.8m were made in year, of which £37.1m was recognised in income and expenditure.

Cash, liquidity and financial support

The Trust forecast a deficit for the year and as such agreed cash borrowings with the Department of Health. A capital loan of £5.6m was agreed and drawn to support investment in fixed assets. To support the I&E position a revenue loan of £47.8m was agreed and drawn and working capital facility drawn of £12.3m.

The capital loan is repayable in equal instalments to February 2021 at an interest rate of 1.79%. The revenue loan is repayable on instalment in 2020 and interest rate payable of 1.5%. The working capital facility has an interest rate of 3.5% and has no repayment period, effectively representing temporary borrowing. The Trust will work with NHS improvement to convert this to loans in 2016/17.

Principal risks and uncertainties

The Trust continued to strengthen its approach to risk management during 2015/16, with the implementation of a Board Risk Committee to ensure strategic risks are addressed and managed. This covers risk and opportunities within the Trust, including those associated with treating and caring for patients, employing staff, innovation, reputation, maintenance of premises and managing finances.

Financial risks

We are planning to deliver to the NHS Improvement control total of £41.1m in 2016/17. Whilst this control total has been accepted as deliverable and plans set accordingly we still face a number of risks:

- We have been offered a maximum of £10.3m from the national sustainability and transformation fund. Access to this fund is conditional, however the process and requirements for access are not yet finalised by the NHS Improvement. We will be required to deliver against trajectories we have agreed with CCGs for RTT, ED waits and cancer. In addition NHS Improvement have set a ceiling for agency spend of £17.9m, representing a decrease of 27% on spend in 2015/16
- The delivery of the plan requires an efficiency of 4%, £12.6m. This represents a significant increase on delivery in 2015/16, however this is building on the effective programme management office (PMO) processes and structures and improved financial governance and control across the organisation
- Recruitment to substantive posts has continued to be a challenge in 2015/16 and will continue to be so in 2016/17. Recruitment to posts is vital for delivery of quality and financial objectives as the continued reliance on agency and locum staff is significant. Recruitment plans are on-going, along with ensuring improved controls on rostering and cover of vacant posts to ensure agency spend is controlled and minimised as far as possible.
- The Board has agreed to pursue a long term partnership with NUH to ensure improved quality and sustainability. In the short term there will be costs incurred. These are being identified and discussed with NHS Improvement to agree expenditure and appropriate mechanisms for funding. In addition, in the short term this may make recruitment more challenging, meaning reduction in agency spend becomes more difficult to achieve.

The Board Assurance Framework document (BAF) details the principal risks for the Trust. Strategic Priority 5 is to reduce the scale of our financial deficit by minimising reliance on expensive agency staff, improving the utilisation and productivity of our resources and achieving best value for money for every pound spent. This is regularly reviewed by the Board of Directors. Any gaps in assurance are addressed through detailed action plans.

Environmental matters

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, the smart and efficient use of natural resources and 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 even in the context of rising cost of natural resources.

In order to fulfil our responsibilities for the role we play, Sherwood Forest Hospitals NHS Foundation Trust has the following sustainability mission statement located in our sustainable development management plan (SDMP):

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

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

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Trust has produced a draft SDMP in consultation with all departments which will be presented to the Board for final approval within the next 12 months so our ambitions for a sustainable future are well known within the organisation and will be clearly laid out.

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 staff.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

We have not currently established any strategic partnerships. For commissioned services here is the sustainability comparator for our CCGs:

Organisation Name	SDMP	GCC	Adaptation	SD Reporting score
NHS Mansfield and Ashfield CCG	No	No	0	Excellent
NHS Newark & Sherwood CCG	No	No	0	Minimum

More information on these measures is available here:
http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

Performance

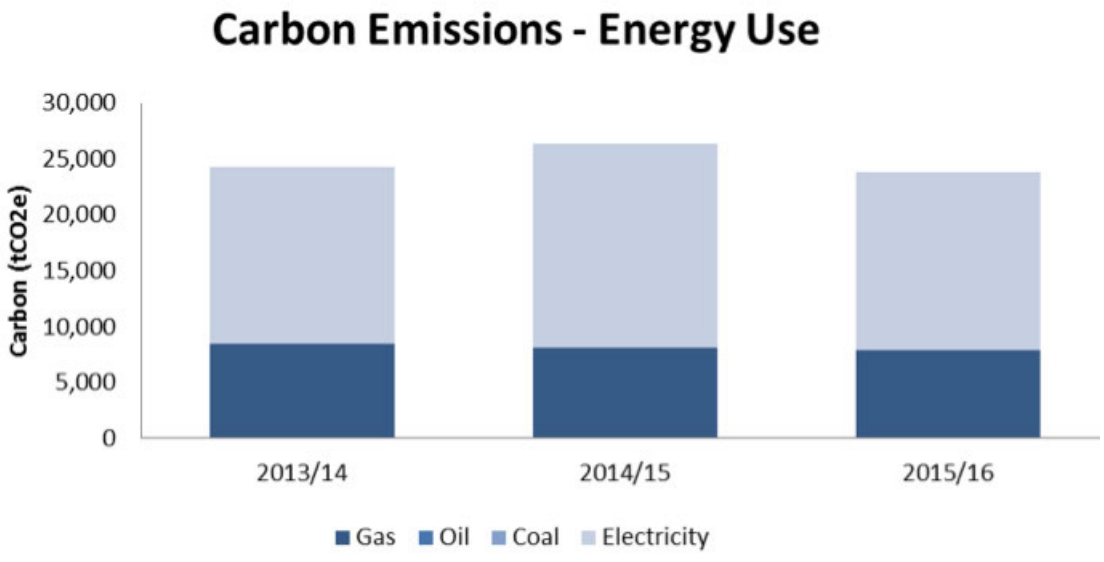
Organisation

Since the 2013 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

Context info	2013/14	2014/15	2015/16
Floor Space (m^2)	129,481	129,481	129,481
Number of Staff	3,400	3,400	3,400

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition, set in 2014, of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year. Here's how we have done:

Resource		2013/14	2014/15	2015/16
Gas	Use (kWh)	39,752,274	38,895,055	37,768,434
	tCO_2e	8,433	8,160	7,924
Oil	Use (kWh)	93,102	15,001	51,056
	tCO_2e	30	5	16
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	28,383,949	29,389,922	27,722,561
	tCO_2e	15,892	18,202	15,938
Green Electricity	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Total Energy CO_2e		24,355	26,367	23,879
Total Energy Spend		£ 3,542,701	£ 3,697,048	£ 3,789,474



Performance

Using a scaled model based on work carried out by the NHS Sustainable Development Unit (SDU), the estimated total carbon footprint for 2015/16 is 23,879 tonnes of equivalent carbon emissions. This is a 10% down on 2014/15, and 2% down on baseline year 2013/14 from which we are targeting a 28% reduction by 2020 as per the latest SDU Strategic Plan.
Our energy performances have also resulted in the Trust dropping out of the CRCEES through the small emitter route in 2015/16.

Commentary

Various items have impacted on the energy carbon footprint performance. Carbon emissions from gas consumption have decreased year-on-year since 2013/14, this is in part due to a 1.1% carbon factor reduction in 2014/15, but also from year-on-year reductions in gas consumption. Further investigation is required to understand whether this is weather related.

2014/15 saw a 4% increase in electricity consumption and an 11% increase in the electricity carbon factor, resulting in an overall increase in electricity carbon emissions of 15% on baseline year emissions. 2015/16 saw a decrease in the carbon factor, but it was still an overall increase on 2013/14 by 3%. Therefore, despite achieving an electricity consumption (dropped by -2% on 2013/14 figures), the carbon emissions for electricity consumption are still up on 2013/14 levels by 0.31%. It is typical of this method of foot-printing to see yearly changes to electrical carbon factors as it is an aggregate of the previous year's power generation. The gas carbon factors tend to be more stable.

It is the intention of the Trust to install a connection from the Alkane gas plant to the King's Mill energy centre to provide additional use of the coal mine methane gas for a source of energy. There is a planned extension of the geothermal system within the King's Mill reservoir to increase the heating/cooling capacity to the Hospital. The geothermal system provides heating and cooling to the King's Mill Hospital. When providing heat to the building, the geothermal system takes heat from the King's Mill reservoir. When cooling the building, the geothermal system rejects heat to the reservoir.

Initiatives are gathering pace to address the increase in emissions across the estate, through an awareness campaign and trials of LED lighting and improved controls to reduce energy use.

An awareness campaign to be rolled out in summer 2015 follows the first road show for NHS Sustainability Day. It embraces the suggestions of attendees at that event, and good practice available from the NHS sustainable development unit.

With the overall saving in carbon emissions from 2013/14, this performance will put the Trust in a good position to receive carbon saver accreditation.

Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our services.
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

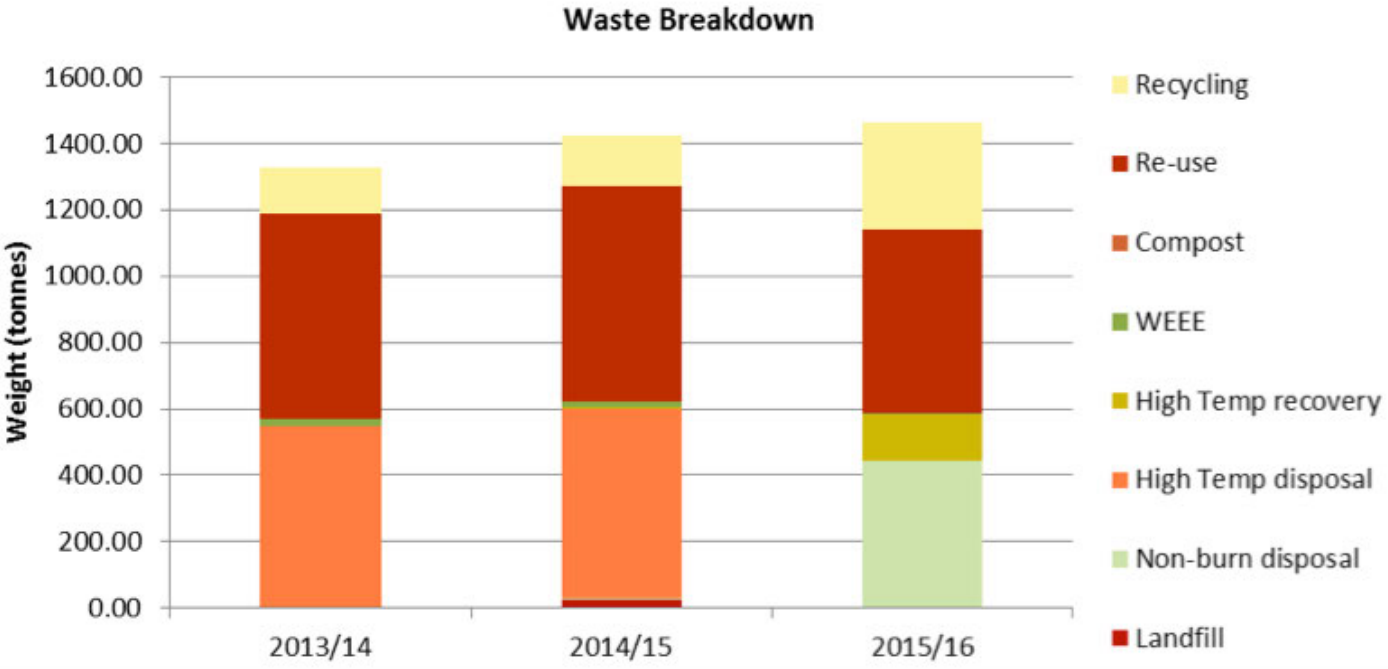
Category	Mode	2013/14	2014/15	2015/16
Category	Mode	2013/14	2014/15	2015/16
Staff commute	km	5,023,781	5,256,278	5,256,278
	tCO2e	1,153	1,200	1,181

Performance

Staff commute emission need to be finalised for 2015/16, currently they are estimated at 2014/15 levels and show a decrease in emissions which is determined by changes to the carbon factor.

Waste

Waste		2013/14	2014/15	2015/16
Recycling	(tonnes)	140.00	149.56	321.16
	tCO_2e	2.94	3.14	6.74
Re-use	(tonnes)	617.88	653.50	557.29
	tCO_2e	12.98	13.72	11.70
Compost	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
WEEE	(tonnes)	21.00	14.61	3.79
	tCO_2e	0.44	0.31	0.08
High Temp recovery	(tonnes)	0.00	4.49	136.39
	tCO_2e	0.00	0.09	2.86
High Temp disposal	(tonnes)	550.00	571.08	0.00
	tCO_2e	121.00	125.64	0.00
Non-burn disposal	(tonnes)	0.00	7.09	445.10
	tCO_2e	0.00	0.15	9.35
Landfill	(tonnes)	0.00	23.42	0.35
	tCO_2e	0.00	5.72	0.09
Total Waste (tonnes)		1328.88	1423.75	1464.08
% Recycled or Re-used		57%	56%	60%
Total Waste tCO_2e		137.36	148.78	30.82



Commentary

The waste produced by the Trust has risen slightly in comparison to the previous year; however significant efforts have been made over the last year to implement a pro-active audit programme of hazardous waste to reduce the amount of waste requiring high temperature disposal as shown in the above graph.

A significant programme of recycling is in motion with cardboard packaging being separated at source and compacted on site, vastly reducing traditional landfill or incineration quantities.
Other local waste sources continue to be assessed with a local supplier to be disposed as 'co-mingled' waste, which is resulting in a significantly increased rate of recycling leaving minimal waste going for landfill or incineration.

Since going live in March 2015 this initiative has delivered a 79% reduction in carbon emissions.

Finite resource use – Water

Water		2013/14	2014/15	2015/16
Mains	m3	129275	145608	137442
	tCO2e	118	133	125
Water & Sewage Spend		£334,597	£290,419	£436,502

Performance

Water consumption saw a significant rise in 2014/15 and then a slight reduction which was still an overall increase on 2013/14 base year emissions.

Commentary

Despite actions being taken on water management, including the fitment of inline flow restrictors to shower hoses/heads, it is clear that further actions need to be taken.

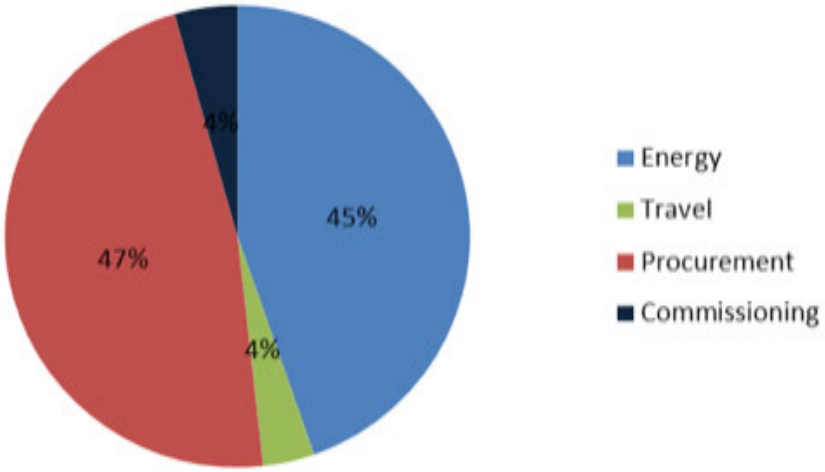
Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

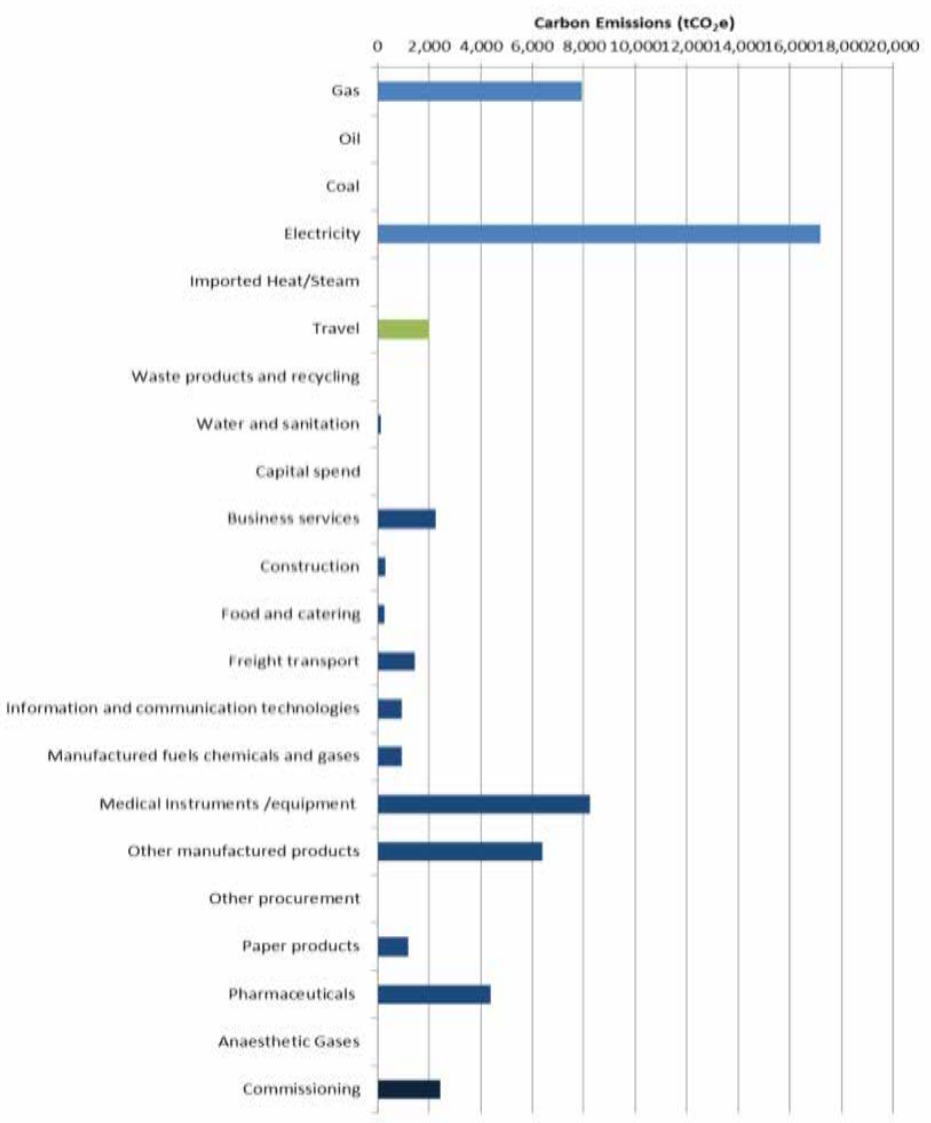
Resulting in an estimated total carbon footprint of 56,225 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 189 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 210 grams per pound.

Category	% CO_2e
Energy	45%
Travel	4%
Procurement	47%
Commissioning	4%

Proportions of Carbon Footprint



Organisation of Carbon Emissions Profile



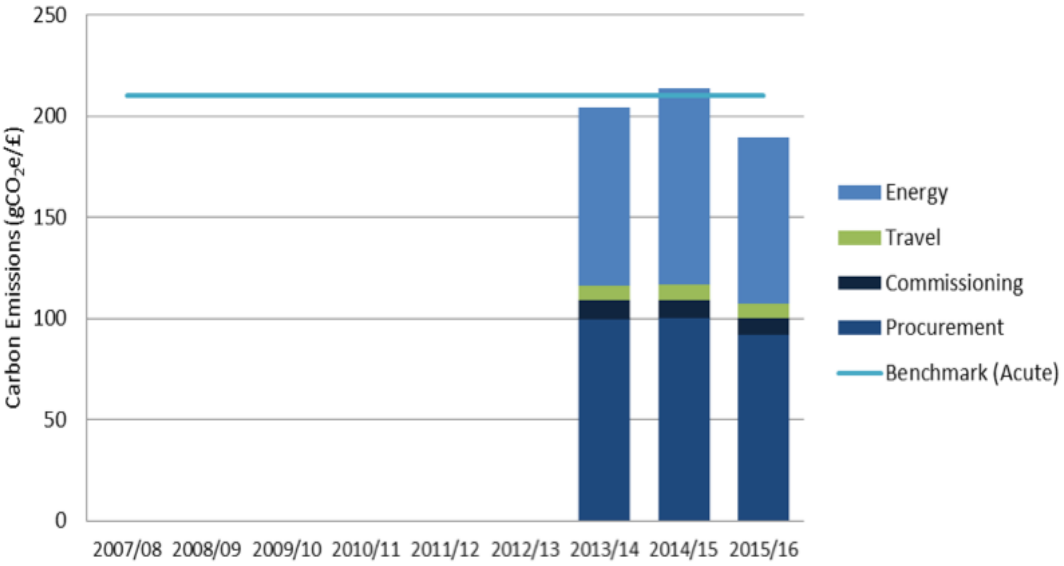
The procurement data shows medical instruments and equipment as being hotspots items, along with energy consumption for acute hospitals, which is entirely in line with SDU guidelines.

Modelled trajectory

The 10% target from 2007 highlighted within this chart is not applicable to King's Mill Hospital as the site did not open until 2011 with the full site load being realised much later. As the SDU model prediction based on our historical emissions based on known carbon emissions and our current energy profile shows, we would have made our 10% target based on our performance over the last three years. However, the modelled forecast for 2020 shows that it will require an extra effort to follow the roadmap to the 28% emission reduction on 2013 levels by 2020. As previously discussed, carbon emissions factors can have a significant impact on the Trusts performance. Therefore, despite consist energy reduction our carbon emissions reduction may be slower due to year-on-year increases in grid electricity carbon factors. Power and gas consumption is down on 2013 and we have seen a 79% decrease in waste carbon emissions from waste management practises.

Despite a difficult year in 2014/15, mainly due to carbon emission factors outside of the Trust's control, the overall performance has been one of continuous improvement in terms of carbon emission reduction

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



Part 3
Accountability Report

3.1 Directors Report

The Trust was placed in special measures in 2013 as a result of the rapid response review undertaken by Sir Bruce Keogh, NHS Medical Director for England. We were inspected by the CQC in June 2014, received a 'requires improvement' rating and judged to remain in 'special measures'. We were re-inspected by the CQC in June 2015 and received an 'inadequate' rating overall and remained in 'special measures'.

In response we have developed a Quality Improvement Plan (QIP) to address all the areas identified in the CQC report and incorporate any outstanding actions from previous action plans. The development of just one plan will ensure focus on the actions to be delivered.

The plan has been divided into 10 workstreams, each with an executive director lead:

- Leadership
- Governance
- Recruitment and Retention
- Personalised Care
- Safety Culture
- Timely Access
- Mandatory Training
- Staff Engagement
- Maternity
- Newark

There are robust governance processes in place to ensure actions are implemented and embedded and then monitored to safeguard sustainability.

We are also engaged in Long Term Partnership arrangements with NUH in order to further improve and sustain quality service provision through the recruitment and retention of high calibre permanent staff as well as improving governance and leadership across the Trust. It is expected the merger will be completed within the next financial year.

We have continued to receive a significant amount of external scrutiny and regulatory intervention during the year and we continue to embrace the opportunity for clear challenge and clarity regarding the improvements that need to be made. We are pleased with the progress in addressing concerns regarding our Board, quality and financial governance and particularly with the improvements to the quality of healthcare received by our patients.

We welcome greater openness and transparency on Board deliberations through our meetings in public, which in turn challenge us to plan our agendas and look to maximise our impact, and reflect on the decisions we have made. We strive to continue our improvement agenda, in 2016/17 and beyond, to ensure we deliver the best quality of care that we can to patients and at the same time satisfy our regulatory conditions.

Much work was undertaken during the year with regard to quality governance, which was seen as vital for us to satisfy ourselves and patients that we have effective arrangements to continuously monitor and improve the quality of the care provided, and tackle areas in need of improvement. Having the right systems in place to measure quality of care and providing staff with a way of showing that the right level of quality is in place and being met, such that they themselves have full confidence in what they are doing, is ultimately what quality governance is all about.

We have worked to improve our quality governance during the year, through the appointment of a Director of Governance to ensure we have robust systems in place to deliver Duty of Candour, ensure quality standards are achieved sustainably and learn from incidents and complaints. Monitor defines quality governance as the combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

Ensuring required standards are achieved
Investigating and taking action on sub-standard performance
Planning and driving continuous improvement
Identifying, sharing and ensuring delivery of best practice
Identifying and managing risks to quality of care

In response to Monitor's revised Risk Assessment Framework, the Trust submits a self-assessment to Monitor quarterly with regard to its financial sustainability risk rating and governance rating, more detail is provided later in this report.

Disclosure of information to the auditor

In exercising reasonable care, skill and diligence, each director confirms that so far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware and that each director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information. Relevant audit information is information needed by the auditor in connection with preparing their report.

Meet the Board of Directors

The primary responsibility of the Board of Directors is to promote the long term success of the Trust by creating and delivering high quality services within the funding streams available. The Board seeks to achieve this through setting strategy, monitoring strategic objectives and providing oversight of implementation by the management team. In establishing and monitoring its strategy, the Board considers, where relevant, the impact of its decisions on wider stakeholders including employees, suppliers and the environment.

The individuals who served at any time during the financial year as directors were as follows: Sean Lyons (Chairman), Gerry McSorley,(vice Chairman and Senior Independent Director) Peter Marks (Vice Chairman), Claire Ward, Mark Chivers, Tim Reddish (Senior Independent Director), Ray Dawson, Neal Gossage, Graham Ward, Ruby Beech, Karen Fisher (Acting Chief Executive), Paul Robinson, Andrew Haynes, Susan Bowler, Susan Barnett, Kerry Rogers (Company Secretary), Peter Wozencroft, Peter Herring (Interim Chief Executive), Jon Scott, Graham Briggs, Julie Bacon and Shirley Clarke (company secretary). Full biographies of our directors and non-executive directors, together with their terms of office can be found on our website.

The balance, completeness and appropriateness of the membership of the Board is reviewed periodically and upon any vacancies arising amongst either the executive or non-executive directors. This balance of skills is appropriate to the requirements of the Trust. Board directors are required to declare any interests that are relevant and material on appointment, or should a conflict arise during the course of their term. A register of Board members interests is maintained by the company secretary and is updated and published annually as covered later in the annual report. Board directors are also required to meet the Fit and Proper persons test and this is evidenced in their individual personal files, which have been independently audited. The Chairman had no other significant commitments during the year.

Register of Interests

The Register of Interests for all members of the board is reviewed regularly and is maintained by the Head of Corporate Affairs/Company Secretary. Any enquires should be made to the Head of Corporate Affairs/ Company Secretary, Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters , Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, NG17 4JL.

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

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

	Public		Private	
NAME	Actual	Possible	Actual	Possible
Peter Herring	5	5	5	5
Jon Scott	5	5	5	5
Karen Fisher	10	10	10	10
Dr Andrew Haynes	9	11	9	11
Susan Bowler	4	6	4	6
Shirley Clarke	6	7	6	7
Sean Lyons	11	11	11	11
Gerry McSorley	2	2	2	2
Dr Peter Marks	9	11	9	11
Ray Dawson	11	11	11	11
Clare Ward	9	11	9	11
Tim Reddish	9	11	9	11
Mark Chivers	5	6	5	6
Graham Ward	6	6	6	6
Ruby Beech	6	6	6	6
Kerry Rogers	4	4	4	4
Peter Wozencroft	9	11	9	11
Susan Barnett	6	6	6	6
Paul Robinson	11	11	11	11
Neal Gossage	8	10	8	10
Graham Briggs	7	9	7	9
Susanne Banks	5	6	5	6
Julie Bacon	3	3	3	3
Paul Moore	3	3	3	3

Cost allocation

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information Guidance.

Trust performance against Better Payment Practice Code – measure of compliance

The Better Payment Practice Code is a non-mandatory target to pay 95% of all undisputed invoices by the due date or within 30 days of the receipt of goods or a valid invoice. Our performance has been challenged in year as a result of the deteriorating financial position and the time scales to accessing loans from the Department of Health to support the revised planned deficit

	2015/16		2014/15	
	Number	£000s	Number	£000s
Total non NHS trade invoices paid in year	65,084	154,432	69,380	135,556
Total non NHS trade invoices paid within the target	31,858	118,037	52,678	118,368
Percentage of non NHS trade invoices paid within the target	49%	76%	76%	87%
Total NHS invoices paid in year	2,418	16,889	2,263	12,343
Total NHS invoices paid within the target	771	10,541	1,403	8,590
Percentage of NHS invoices paid within the target	32%	62%	62%	70%

Late payments of commercial debts (interest) act 1998

No amounts have been included in finance costs (2014/15 nil) and no compensation has been paid to cover debt recovery costs under this legislation

Stakeholder relations

Long Term Partnership

We are facing unique challenges following the recent Care Quality Commission (CQC) inspection which rated the Trust as 'Inadequate' overall, whilst recognising the caring nature of its services. The inspection outcome, combined with a worse than planned financial position, led the CQC and sector regulator, Monitor, to conclude that we should remain in 'special measures', whilst seeking a long term partnership with another acute Trust. Nottingham University Hospitals (NUH) has been identified and announced as the partner organisation. This will lead to the creation of a new organisation that will be responsible for the delivery of safe and sustainable clinical services for mid-Nottinghamshire, and the other communities currently served by SFH.

Ahead of a formal partnership transaction being agreed in the coming financial year, the team at NUH continues to provide SFH with support, helping us to continue to make clinical improvements. During 2016/17, the partnership will bring a stable leadership team, improvements in governance and a particular focus on the areas in which the CQC identified serious concerns.

Over the longer term, the new organisation will provide further opportunities to ensure we have clinically and financially sustainable services for our local communities. The partnership will help with the recruitment and retention of staff, giving greater career development prospects for our workforce.

Better Together Alliance

We have continued to fully participate in the mid-Nottinghamshire Better Together programme, which is fundamental to locally delivering the vision set out in the Five Year Forward View. As one of the nine 'Vanguard' sites for Integrated Primary and Acute Care Systems (IPACS), our collective commitment to securing a sustainable future for health and social care in mid-Nottinghamshire remains resolute.

In 2015/16, the Better Together programme has seen the development of a Commissioner / Provider Alliance, which will move into a new phase in 2016/17. However, the core priorities remain: to prevent avoidable admissions, support self-care and deliver care closer to patients' homes, facilitated through closer integration between partners across health and social care.

The Alliance consists of mid-Nottinghamshire Clinical Commissioning Groups (CCGs), local healthcare providers (including SFH), social care and the third sector. We have a collective commitment to work together and demonstrate our ability to improve outcomes, reduce costs and provide care in appropriate settings. The Alliance will share and rationalise key assets, including clinical expertise, managerial functions and estates, delivering improved access and outcomes for citizens through removing traditional organisational boundaries. The Alliance partners have agreed the Alliance Agreement, which sets out the aims and objectives for 2016 onwards.

During 2016/17, the Better Together Alliance will develop the model for a capitated outcome based contract. As the lead Vanguard site for the development of this future payment mechanism, the Alliance will benefit from the groundwork already done in this area and support others through shared learning. Part of the development of the future payment model will see the introduction of a series of agreed outcomes and a 'live' outcome based payment mechanism. This will enable the Alliance members to test the principles and behaviours of the new Alliance Agreement and to start delivering improved patient outcomes as soon as possible.

Building on recent progress in 2016/17

The transformational initiatives that are fundamental to the Better Together programme will continue to be implemented in 2016/17, building on progress made in 2015/16. In the last year, we have created a 'single front door' at King's Mill Hospital (KMH), which enables an integrated service to be jointly run across the Emergency Department (ED) and 24 hour primary care service (PC24). Patients are triaged and streamed to the most appropriate point of care, with direct access to GPs for primary care conditions and ED access for patients requiring emergency care. Building on this success, preparations for a single front door at Newark Hospital will be completed in 2016/17, to facilitate the co-location of a GP service with the Minor Injuries Unit (MIU), leading to improved integration and patient experience.

We will continue to fully participate in the 'Transfer to Assess' initiative in 2016/17, which supports patients to be discharged to their own homes (where possible) and to other community settings. We will continue to be actively involved in the PRISM service, working collaboratively with partners across health and social care to deliver an integrated hospital, community, primary and social care model, that will:

- improve outcomes for the frail elderly and patients with Long Term Conditions
- deliver better access to more integrated care outside hospital
- reduce unnecessary hospital admissions
- facilitate more effective cross boundary working – including Social Care, Mental Health and the Third Sector
- provide support to increase citizens' independence & involvement in their own care

Additional community based services, such as Specialist Intermediate Care Teams, will be introduced in 2016/17. The combined impact of these services will be reductions in demand for acute hospital-based care, as more people are supported in other settings. This will enable the Trust to focus on those people who really need to be in hospital.

Furthermore, 2016/17 will see the increased use of the 'Call for Care' service, which was introduced in November 2015, following the development of the new model by SFH, the East Midlands Ambulance Service (EMAS), Nottinghamshire Healthcare (NHCFT) and Central Nottinghamshire Clinical Services (CNCS). 'Call for Care' provides a telephone streaming service to clinicians, providing them with direct access to:

- clinically trained assessors providing access to physical and mental health support, and who have the ability to deploy assessors to the patient's home where needed
- a comprehensive directory of services that can provide support or care packages enabling patients to remain at home

The aim of the service (which is currently in a 'proof of concept phase') is to provide the right care package to patients not requiring emergency care, ensuring that they are treated closer to home, thereby reducing attendances at ED. Initially the service was only accessible to EMAS but a full roll out to all GP practices is currently being undertaken. During 2016/17, improvements will be made to enhance the service, based on experience to date and planned developments.

Patient involvement

Implementation of our Patient Experience and Involvement Strategy (developed during 2014) continues, with the intention of creating a culture that actively seeks, listens and learns from patient and visitor feedback. In building upon progress made in year two of the strategy (i.e. 2015/16), the following initiatives will be implemented during 2016/17:

- 'experience based design' – asking patients about their experiences and feelings at agreed 'touch points' within a patient journey
- patient stories – capturing patient stories on film and providing versions to the Board and as training resources for divisional staff
- patient forums – establishing a supporting patient forums, based within divisions and specialties
- listening events – further events focused on specific areas for improvement, shaped by the intelligence gathered from complaints, concerns and the Friends and Family Test
- Feedback received through these mechanisms will be shared with staff to help improve services and systems, as well as to shape the development of further strategies for improvement and engagement in the future.

3.2 Remuneration Report

Scope of the Report

The Remuneration Report summarises the Trust's 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 Section 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 the NHS Foundation Trust Code of Governance.

Annual Statement on Remuneration

The Remuneration Committee met eight times during the year and key decisions made include the remuneration for the interim Chief Executive and interim Chief Operating Officer, who was also nominated by the committee as Deputy Chief Executive. These posts were crucial to address the issues raised in the CQC report published in October 2015 and the requirement to progress a Long Term Partnership with Nottingham University Hospitals to address the concerns in the report.

Remuneration Policy

We are committed to the governing objective of maximising value over time. To achieve its goals, the Trust must attract and retain a high calibre senior management team and staff and ensure it is positioned to deliver its business plans.

During the year the Trust adhered to the principles of the agreed pay framework that remunerated the performance of the executive directors and corporate directors based on the delivery of objectives as defined within the Annual Plan. There are no contractual provisions for performance related pay for executive and corporate directors and, as such, no payments were made relating to 2015/16. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility necessary to adapt to the dynamics of an ever changing NHS. It is fundamental to business success and is modelled upon the guidance in The NHS Foundation Trust: Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health).

The key principles of the approach are that pay and reward are firstly assessed relative to the financial performance of the whole Trust and secondly in line with available benchmarks. In light of the Trust's financial situation, the Remuneration Policy for the next financial year will not include any performance related pay elements, but all directors' performance will be assessed against delivery of the Annual Plan and associated corporate objectives and kept in line with recognised benchmarks (Capita and NHS Providers and the wider pay policies of the NHS).

Executive appointments to the Board of Directors continue under permanent contracts and during 2015/16, no substantive director held a fixed term employment contract. The Chief Executive and all other executive and corporate directors hold office under notice periods of six months except when related to conduct or capability. There were a number of interim members of the Board of Directors during 2015/16.

During the year the non-executive directors successfully appointed:

- Interim Chief Executive
- Interim Chief Operating Officer
- Interim Director of Governance
- Interim Director of HR
- Substantive new Chief Nurse

Where payment of senior managers is greater than £142,500, the Trust assures itself that pay for its senior managers is reasonable. Associated governance is in place through the Remuneration Committee which considers pay on an individual basis attributed to scope and remit of role. The Trust 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 be assured that salary is reflective of responsibility.

Non-executive directors' remuneration

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 Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs. They 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 and are currently required to participate in a competitive process.

Their remuneration framework as agreed previously by the Council of Governors is consistent with best practice and external benchmarking, and remuneration during 2015/16 has been consistent with that framework. There were no cost of living increases applied for non-executive directors during 2015/16. None of the non-executive directors are employees of the Trust; they receive no benefits or entitlements other than fees, and are not entitled to any termination payments. The Council of Governors as a whole determines the terms and conditions of the non-executive directors.

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

During the year the governors successfully appointed a replacement non-executive in order to succession plan the departure of Gerry McSorley who left the Trust in May 2015. The process accords with the rules governing appointments of non-executive directors as laid out in the Trust's Constitution. Subsequently Neal Gossage was recruited as a replacement. The Trust also received the resignation of Mark Chivers who came to the end of his tenure in 2015. The committee approved the recruitment of two NEDs, Graham Ward and Ruby Beech, to enhance the knowledge and capacity of the board.

Termination Payments

There were no termination payments made to Board members during 2015/16.

Annual Report on Remuneration

Major decisions on senior managers' remuneration

There were no major decisions on senior managers' remuneration during 2015/16, save for the approval of the remuneration for interim directors, detailed earlier in this report.

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

There were no substantial changes to senior managers' remuneration during 2015/16.

Remuneration and Nominations Committee

The Board appoints the Remuneration and Nominations Committee and its membership comprises only non-executive directors. The committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation including the framework of executive and senior manager remuneration. Its remit currently includes determining the remuneration and terms and conditions of the executive and corporate directors, and approving severance payments and Employer Based Clinical Excellence Awards.

During the year, the following non-executive directors have served on the committee as core members:

	Attendance:
Sean Lyons (Chairman)	(7/8)
Tim Reddish (SID)	(5/8)
Peter Marks(Vice Chairman)	(8/8)
Ray Dawson	(7/8)

The committee also invited the assistance of the Acting Chief Executive (Karen Fisher), the interim Chief Executive (Peter Herring), the Interim Executive Director of Human Resources (Graham Briggs) the Director of Corporate Services/Company Secretary (Kerry Rogers) and the Head of Corporate Affairs and Company Secretary (Shirley A Clarke). None of these individuals nor any other executive or senior manager participated in any decision relating to their own remuneration.

The Committee has met on eight occasions during 2015/16.


NHS
Nottinghamshire County
Teaching Primary Care Trust
Mansfield Community Hospital

Governor and director expenses

During the year the Trust reimbursed expenses incurred in respect of Trust business as follows:

Directors		TOTAL PAID 2015/16 £	TOTAL PAID 2014/15 £
Sean Lyons	Chairman	3,550.32	3,642.95
Peter Marks	Non-executive director	627.79	446.22
Gerry McSorley	Non-executive director	600.04	3,548.25
Ray Dawson	Non-executive director	1,628.40	1,631.45
Claire Ward	Non-executive director	1,121.07	1,421.60
Mark Chivers	Non-executive director		741.26
Tim Reddish	Non-executive director	472.02	1,309.92
Neal Gossage	Non-executive director	1,537.48	
Paul O'Connor	Chief Executive	488.22	3,175.70
Peter Herring	Interim Chief Executive	1,692.63	
Fran Steele (left Aug14)	Chief Financial Officer		158.25
Karen Fisher	Acting Chief Executive	133.68	80.42
Susan Bowler	Executive Director of Nursing and Quality	100.17	327.04
Graham Briggs	Interim Director of Human Resources	5,663.74	
Peter Wozencroft	Director of Strategic Planning and Commercial Development	448.56	1,342.27
Kerry Rogers	Director of Corporate Services	0.00	0.00
Jacqui Tuffnell	Director of Operations		184.61
Susan Barnett	(Commenced Jan 15) Interim Director of Operations	24,000.00	0
Paul Robinson	Chief Financial Officer	845.74	0.00
TOTAL		42,909.86	18,009.94

Governors		TOTAL PAID 2015/16	TOTAL PAID 2014/15
Samantha Annis	Staff Governor, Newark Hospital	No Claim	No Claim
Colin Barnard	Public Governor, Ashfield	No Claim	No Claim
Jim Barrie	Public Governor	No Claim	£239.75
Alison Beal	Staff Governor, Kings Mill Hospital	No Claim	No Claim
Wesley Burton	Staff Governor, Kings Mill Hospital	No Claim	£21.56
Angie Emmott	Staff Governor, Newark Hospital	£64.59	£21.54
Craig Gunton-Day	Public Governor, Ashfield (Resigned)	No Claim	No Claim
Richard Hallam	Public Governor, Mansfield (Resigned)	No Claim	No Claim
Louise Knott	Appointed Governor, Vision West Notts (appointed March 2015)	No Claim	No Claim
Nicola Juden	Volunteer Governor, Newark Hospital	No Claim	No Claim
Andy March	Public Governor, Mansfield	No Claim	No Claim
Nigel Nice	Public Governor, Newark & Sherwood	£526.79	£486.30
Roz Norman	Staff Governor, Kings Mill Hospital	No Claim	No Claim
Annie Palmer	Public Governor, Rest of the East Midlands	No Claim	No Claim
David Payne	Appointed Governor, Newark & Sherwood District Council	No Claim	No Claim
Beryl Perrin	Public Governor, Ashfield	No Claim	£25.00
Martin Stott	Public Governor, Newark & Sherwood	£136.40	£341.41
Amanda Sullivan	Appointed Governor, NHS Nottinghamshire	No Claim	No Claim
John Swanwick	Public Governor, Mansfield	No Claim	No Claim
John Barsby	Public Governor, Mansfield	No Claim	No Claim
Kevin Stewart	Public Governor, Ashfield	No Claim	No Claim
Susan Holmes	Public Governor, Ashfield	£52.92	No Claim
Susan Moss	Public Governor, Newark & Sherwood (resigned January 2016)	£85.25	No Claim
Ron Tansley	Volunteer Governor, Kings Mill Hospital	No Claim	No Claim
Diane Wright	Public Governor, Mansfield	No Claim	No Claim
Valarie Bacon	Public Governor, Derbyshire	£274.79	£232.53
Nicola Waller	Public Governor, Derbyshire	No Claim	£215.97
Jim Aspinall	Appointed Governor, Ashfield District Council	No Claim	No Claim
Yvonne Woodhead	Appointed Governor, Nottinghamshire County Council	No Claim	No Claim
Sonia Ward	Appointed Governor, Mansfield District Council (Resigned)	No Claim	No Claim
Sharron Adey	Appointed Governor, Mansfield District Council	No Claim	No Claim

Senior Managers Disclosure

	2015/16						2014/15					
Name and title	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (nearest £100)	Employer pension contributions (nearest £1,000)	Pensions related benefit (bands of £2,500)	Total	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (nearest £100)	Employer pension contributions (nearest £1,000)	Pensions related benefit (bands of £2,500)	Total
Executive Directors												
Mr P O'Connor [1] (Chief Executive Officer) Left 9 April 2015	0 - 5	0	0	15	40 - 42.5	60 - 65	195 - 200	100 - 105	0	29	90 - 92.5	414 - 427
Ms K Fisher [2] (Acting Chief Executive Officer) Left post 18 November 2015	100 - 105	0	4,800	15	467.5 - 470	585 - 590	100 - 105	0	4,600	14	5 - 7.5	123 - 131
Mr P Herring (Interim Chief Executive Officer) Appointed 19 November 2015	170 - 175	0	0	0	0	170 - 175	N/A	N/A	N/A	N/A	N/A	0
Mr P Robinson (Chief Financial Officer) Appointed 23 March 2015	145 - 150	0	0	0	0	145 - 150	0 - 5	0	0	0	0	0 - 5
Mrs M Ashworth (Interim Chief Financial Officer) Appointed 1 August 2014	N/A	N/A	N/A	N/A	N/A	0	210 - 215	0	0	0	0	210 - 215
Ms F Steele (Chief Financial Officer) Left 31 July 2014	N/A	N/A	N/A	N/A	N/A	0	45 - 50	0	0	7	32.5 - 35	84 - 92
Mrs S Bowler (Executive Director of Nursing and Quality) Left post 30 October 2015	55 - 60	0	6,800	9	15 - 17.5	90 - 95	100 - 105	0	6,700	14	5 - 7.5	125 - 133
Ms S Banks (Interim Chief Nurse) Appointed 18 January 2016	30 - 35	0	0	0	0	30 - 35	N/A	N/A	N/A	N/A	N/A	0
Dr A Haynes [3] (Executive Medical Director) Interim from 1 October 2013, substantive from 1 July 2014	175 - 180	0	0	26	205 - 207.5	410 - 415	160 - 165	0	0	19	500 - 505	679 - 689
Ms K Rogers (Non-voting Director of Corporate Services / Company Secretary) Left 30 August 2015	40 - 45	0	0	6	50 - 52.5	100 - 105	95 - 100	0	0	15	12.5 - 15	122 - 130
Ms S Clarke (Non-voting Director of Corporate Affairs / Company Secretary) Appointed 1 September 2015	45 - 50	0	0	7	35 - 37.5	85 - 90	N/A	N/A	N/A	N/A	N/A	0
Mr P Moore (Interim non-voting Director of Governance) Appointed 18 January 2016	45 - 50	0	0	0	0	45 - 50	N/A	N/A	N/A	N/A	N/A	0
Mr P Wozencroft (Non-voting Director of Strategic Planning and Commercial Development) Appointed 2 December 2013	100 - 105	0	1,600	15	0	115 - 120	100 - 105	0	0	15	17.5 - 20	132 - 140
Ms J Bacon [4] (Interim Director of Human Resources) Appointed 16 February 2016	15 - 20	0	0	0	0	15 - 20	N/A	N/A	N/A	N/A	N/A	0
Mr G Briggs [3] (Interim Director of Human Resources) Appointed 27 May 2015 - left 31 March 2016	120 - 125	0	0	0	0	120 - 125	N/A	N/A	N/A	N/A	N/A	0
Mr J Scott (Interim Chief Operating Officer) Appointed 23 November 2015	165 - 170	0	0	0	0	165 - 170	N/A	N/A	N/A	N/A	N/A	0
Ms S Barnett (Interim non-voting Director of Operations) Appointed 5 January 2015 - left 17 December 2015	225 - 230	0	0	0	0	225 - 230	90 - 95	0	0	0	0	90 - 95
Ms J Tuffnell (Non-voting Director of Operations) Left 31 December 2014	N/A	N/A	N/A	N/A	N/A	0	75 - 80	50-55	4,700	11	27.5 - 30	168 - 180
Non-Executive Directors												
Mr S Lyons	50 - 55	0	0	0		50 - 55	50 - 55	0	0	0		50 - 55
Mr MJ Chivers (Left 31 October 2015)	5 - 10	0	0	0		5 - 10	10 - 15	0	0	0		10 - 15
Mr R Dawson	10 - 15	0	0	0		10 - 15	10 - 15	0	0	0		10 - 15
Mr P Marks	10 - 15	0	0	0		10 - 15	10 - 15	0	0	0		10 - 15
Dr J McSorley (Left 31 May 2015)	0 - 5	0	0	0		0 - 5	10 - 15	0	0	0		10 - 15
Mr T Reddish	10 - 15	0	0	0		10 - 15	10 - 15	0	0	0		10 - 15
Ms C Ward	10 - 15	0	0	0		10 - 15	10 - 15	0	0	0		10 - 15
Mr G Ward (Appointed 1 December 2015)	0 - 5	0	0	0		0 - 5	N/A	N/A	N/A	N/A		0
Ms R Beech (Appointed 1 November 2015)	5 - 10	0	0	0		5 - 10	N/A	N/A	N/A	N/A		0
Mr N Gossage (Appointed 10 May 2015)	10 - 15	0	0	0		10 - 15	N/A	N/A	N/A	N/A		0

Benefit in kind relates to lease car P11D taxable charge

[1] 2014/15 other remuneration relates to pay in lieu of notice accrued in 2014/15. Left the Trust 9 April 2015

[2] The high value of the 2015/16 pensions related benefit figure is due to the effect of an increase in salary - 2015/16 salary shown for part year only
Ms K Fisher acted as Chief Executive Officer from 1 April to 18 November 2015, then continued to work for the Trust in a non-Board member capacity until the end of the financial year - the pensions figures reflect the full year values

[3] 2014/15 pension increase is due to effect of part year appointment in 2013/14

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

Hutton disclosure

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 Foundation Trust in the financial year 2015-16 was £175,000 - 180,000 (2014-15, £200,000-205,000). This was 7.98–times (2014-15, 9.20-times) the median remuneration of the workforce, which was £22,236 (2014-15, £22,016). In 2015-16, 1 (2014-15, 0) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £6,452 to £190,973. 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.

	2015/16	2014/15
Band of highest paid directors' remuneration (£000's)	175-180	200-205
Median total remuneration (£)	22,236	22,016
Ratio of median to highest paid Director	7.98	9.20
No. of employees paid more than highest paid director	1	0

The median is the mid-point, based on the full time equivalent of the lowest and highest staff salaries of staff on payroll during the year. This has been calculated excluding any enhancements or overtime payments, and relates to staff employed by the Trust at the reporting period end.

The ratio to highest paid director has been calculated based on the mid-point of the salary banding of the highest paid (substantive / on payroll) director. Off-payroll staff, including interim directors, have been omitted from the calculation as we are unable to determine their full time equivalent annualised salary for this calculation.

Pension Disclosure

2015/16

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2016	Employer's contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr P. O'Connor	0 - 2.5	5 - 7.5	55 - 60	175 - 180	1,197	52	1,264	26
Mrs S. Bowler	0 - 2.5	2.5 - 5	40 - 45	120 - 125	738	22	770	9
Mrs K Rogers	2.5 - 5	0 - 2.5	15 - 20	35 - 40	203	28	234	18
Mr P. Wozencroft	0	0	25 - 30	85 - 90	494	0	492	N/A
Ms K. Fisher *	20 - 22.5	80 - 82.5	60 - 65	190 - 195	785	387	1,183	265
Mr A. Haynes	7.5 - 10	35 - 37.5	70 - 75	215 - 220	1,316	198	1,531	128
Mrs S. Clarke	0 - 2.5	0 - 2.5	5 - 10	0	85	43	129	29

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

2014/15

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2014	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2015	Employer's contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr P. O'Connor	2.5 - 5	15 - 17.5	50-55	165 - 170	1,054	117	1,197	82
Mrs S. Bowler	0 - 2.5	0 - 2.5	40 - 45	120 - 125	695	26	738	18
Mrs K Rogers	0 - 2.5	0 - 2.5	10 - 15	35 - 40	183	15	203	11
Ms F. Steele	0 - 2.5	0 - 2.5	5-10	0 - 5	84	22	107	15
Mr P. Wozencroft	0 - 2.5	2.5 - 5	35 - 40	85 - 90	456	26	494	18
Ms K. Fisher	0 - 2.5	0 - 2.5	40 - 45	125 - 130	740	26	785	18
Mr A. Haynes	20 - 22.5	85 - 87.5	60 - 65	185 - 190	816	480	1,316	336
Mrs J. Tuffnell	0 - 2.5	2.5 - 5	30 - 35	100 - 105	475	33	520	23

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

The Trust has 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.

Peter Herring
Interim Chief Executive
26 May 2016

Compliance Statement

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

Peter Herring
Interim Chief Executive
26 May 2016


PRO 300 V2
DINAMAP
Tympanic Probe Covers
Sherwood Forest Hospitals
NHS Foundation Trust
W4-05

3.3 Staff Report

Staffing profile

The largest staff group at the Trust are employed in nursing, midwifery and health visiting staff with the next highest groups of staff in administration and estates, healthcare assistants and other support staff and medical & dental roles. The fewest number of staff are employed as healthcare scientists. The highest numbers of permanent staff are in nursing, administrative and estates, and healthcare assistants and other supporting staff.

The Trust's average workforce numbers, as at 31 March 2016, are:

Average number of persons employed

	Year ended 31 March 2016 Number	Permanently employed Number	Other Number	Year ended 31 March 2015 Number
Medical and dental	555	417	138	501
Administration and estates	975	855	120	969
Healthcare assistants and other support staff	813	813		525
Nursing, midwifery and health visiting staff	1,300	1,118	182	1,347
Nursing, midwifery and health visiting learners	4	4	0	0
Scientific, therapeutic and technical staff	344	329	15	515
Healthcare science staff	109	109	0	0
Other	40	40	0	0
TOTAL	4,140	3,685	455	3,966

Breakdown of Staff (Headcount as at 31 March 2016)

	Male	Female
Director	12	5
Employees	826	3,544

The Trust follows a clear governance structure for the approval and ratifications of policies and procedures for matters relating to current and prospective staff members. Each policy document has a completed Equality Impact Assessment covering all the relevant equality strands that enables possible areas of direct or indirect discrimination through the ratification to be reduced and mitigated.

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

As at 31 March 2016 we had 49 live policy documents relating to support and developing current and prospective staff members, during 2015/16 11 were reviewed as part of the bi-annual cycle of development and reviewing, aligned any legislative changes and matters of best practice to existing policy document.

Expenditure on consultancy

The Trust incurred costs of £2,822,000 (£3,173,000 in 2014/15). These costs were predominantly related to support in turnaround, development of financial improvements and understanding the causes of the deficit.

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.

Off-payroll engagements as of 31 March 2016 for more than £220 per day and more than 6 months

Number of engagements	1
Of which:	
Number that have existed less than 12 months	1
Number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	1
Left during the period	1
Of which	
Number for whom assurance has been requested and received	1

Off-payroll engagements that reached six months duration between 1 April 2015 and 31 March 2016 for more than £220 per day

Number of engagements	1
Of which:	
Number that have existed less than 12 months	1
Number. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	1
Left during the period	1
Of which	
Number for whom assurance has been requested and received	1

Off-payroll engagements of board members with significant financial responsibility, between 1 April 2015 and 31 March 2016

Number of engagements	5
Of which:	
Number that have existed less than 12 months	4
Number. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	5
Left during the period	2
Of which	
Number for whom assurance has been requested and received	5

There were two executive directors who left during the year. While active recruitment was undertaken, it was not possible to appoint to these posts in the short-term. Due to the nature of the posts, interim appointments were therefore made. The duration of appointments was:

- Director of Human Resources, 27 May 2015 – 31 March 2016
- Director of Operations, 5 January 2015 – 17 December 2015
- Director of Operations, 23 November 2015 – on-going

A contractual clause giving the Trust the right to request assurance in relation to income tax and National Insurance obligations is in place for all new contracts.

Policy for off-payroll arrangements

The Trust's policy is to avoid the use of off-payroll arrangements for engaging highly paid staff. The only event in which they are used, exceptionally, is where there is a business need to execute skilled expertise the Trust does 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 kept for a minimum time until the requirement for the work is concluded or a permanent recruitment has been achieved. Any off-payroll engagement is subject to approval by a Board member on the basis of a clear case of need, and is followed up to ensure that the arrangement has been concluded within the expected timescale.

Exit packages

We confirm that there have been no redundancy and termination payments made to serving senior officers within 2015/16.

Listening to our Workforce

Our commitment to engaging with staff is evidenced throughout this section which highlights the mechanisms which are in place to ensure this happened effectively, including:

- Team brief
- Chief executive's blog
- National NHS annual staff survey
- Quarterly staff survey
- Joint staff partnership forum
- Medical local negotiating committee

National NHS Staff Survey – 2015

The Trust participates in the national NHS Staff Survey on an annual basis. We elect to survey 850 randomly selected staff from all staff groups. The survey is undertaken from the beginning of September until early December each year.

The response rate was 45% which was above average for acute trusts in England and compares to a 44% response rate in 2014.

Summary of all key findings for 2014 and 2015

	2013 (28)	2014 (29)	2015 (32)
Best 20%	1 Area	1 Area	2 Areas
Better than average	7 Areas	4 Areas	3 Areas
Average	8 Areas	4 Areas	9 Areas
Worse than Average	7 Areas	11 Areas	6 Areas
Worst 20%	5 Areas	8 Areas	12 Areas

Overall indicator of staff engagement

The overall indicator of staff engagement for the Trust was 3.68 which is in the lowest (worst) 20% when compared to trusts of a similar type. This compares to 3.66 last year when the Trust was below average.

NHS Staff Survey Comparison for Overall Staff Engagement - 2014 and 2015		
Overall Staff Engagement 2015	3.68	Average for acute trusts in England 3.79
Overall Staff Engagement 2014	3.67	Average for acute trusts in England 3.74

Overall staff engagement is an important indicator which incorporates the following key findings:

- KF1. Staff recommendation of the trust as a place to work or receive treatment
- KF4. Staff motivation at work
- KF7. Staff ability to contribute towards improvements at work

The Trust's Quality Improvement Plan will seek to secure improvements in these and other areas identified as concerning in the staff survey.

Where staff experience has improved

KF24. % of staff/colleagues reporting most recent experience of violence
KF22. % of staff experiencing physical violence from patients, relatives or the public in the last 12 months

Where the staff experience has deteriorated

KF32. Effective use of patient/service user feedback

Top 5 ranking scores

KF24. % of staff/colleagues reporting most recent experience of violence. This has improved since 2014 and the Trust is in the highest (best) 20% of acute trusts in England.
KF 16. % of staff working extra hours. No change. The Trust is in the lowest (best) 20% of acute trusts in England.
KF28. % of staff witnessing potentially harmful error, near misses or incidents in the last month. No change. The Trust is below (better) than average.
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver. The Trust is above (better) than average.
KF3. % of staff agreeing that their role makes a difference to patients/service users. The Trust is above (better) than average.

Bottom 5 ranking scores

KF6. % of staff reporting good communication between senior management and staff. No change. The Trust is in the lowest (worst) 20% of acute trusts.
KF10. Support from immediate managers. No change. The Trust is in the lowest (worst) 20% of acute trusts.
KF18. % of staff feeling pressure in the last 3 months to attend work when feeling unwell. No change. The Trust is in the highest (worst) 20% of acute trusts.
KF32. Effective use of patient/service user feedback. Decrease (worse than 2014). The Trust is in the lowest (worst) 20% of acute trusts.
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents. The Trust is in the lowest (worst) 20% of acute trusts.

It should be noted that at the time of the 2015 staff survey the Trust was facing significant challenges, including receiving the outcome of the CQC inspection, continuing to be in 'special measures' and a focus for media attention, significant financial pressures and continued high demand on services. Despite these pressures the Trust's results showed no significant change in 19 key findings and improvements in two.

Areas identified for action following the 2014 staff survey

In response to the 2014 NHS Staff Survey findings we developed a detailed action plan to address priority areas, each fronted by an identified project lead. Delivery of the actions was overseen by the Organisational Development and Workforce Committee. Areas of development included:

- Ensuring senior and line managers within divisions/departments engage with staff using innovative and creative communication methods
- Developing an open and transparent culture where staff have the confidence to raise concerns via appropriate mechanisms and have confidence these will be appropriately considered by adopting an open door policy and no blame culture. Where staff have raised concerns the Trust will develop mechanisms to ensure feedback is provided
- Improving appraisal rates and achieve the Trust target of 98% compliance and ensure all staff have a personal development plan aligned to appraisals and organisational objectives
- Ensuring all staff attend mandatory training
- Embedding Quality for All values and behaviours;
- Roll out of Mentally Healthy Workplace training
- Supporting staff with their on health and wellbeing by promoting health and wellbeing initiatives
- Ensuring all staff are consistently and fairly managed in accordance with Trust HR policies and procedures, providing support, guidance and coaching via HR business partnering, occupational health, training and development

Staff Engagement

A key workstream of the Quality Improvement Plan has focused on staff engagement. A range of activities has been undertaken over the last 12 months such as the development of a new staff engagement strategy, a revised team brief system and the design and delivery of new managers Toolbox Talk master class designed to equip managers to effectively engage with their teams.

The Trust has also appointed two Speak Up Guardians who have been trained to listen to staff and raise concerns on their behalf. We have also delivered a series of mentally healthy workplace events.

Executive director 'drop in' events have also continued over the last 12 months which allow all staff to raise concerns or celebrate successes with senior leaders across the organisation.

The purpose of the SFH approach to successful employee engagement is 'to enable our staff to deliver great patient care, affect positive cultural change and drive improvement'. It is based on what our staff have told us, what best practice and research evidence says about successful employee engagement and includes measures that will inform the evaluation of impact on key performance indicators around patient safety, patient care and the quality of service delivery.

Research tells us that successful employee engagement is a necessary pre-requisite for high levels of patient safety, patient care and quality of service. Our main focus is on behaviour and in particular the behaviour of staff in positions of management and leadership who can influence the behaviours of others. Research tells us that the four main barriers to successful and sustainable employee engagement lie with managers and their behaviours;

1. Managers' awareness and understanding of their role and responsibility in employee engagement
2. Managers' interest and know how in engaging staff
3. Managers' confidence in their skills and capabilities to engage their staff
4. Managers' level of commitment to engaging their staff

Our delivery focus is based on the following;

1. **Development:** support for managers and leaders across the Trust to learn about the case for engagement, be interested in how to apply it in their work area, develop the confidence in their capability and skills to apply and commit to trying to better engage their staff. We have made provision for over 200 Trust managers and leaders to attend development sessions between April and July 2016. Early results are encouraging with improvements reported by those who have attended in levels of understanding (+12%), interest (+7%), confidence (+14%) and commitment (+9%).

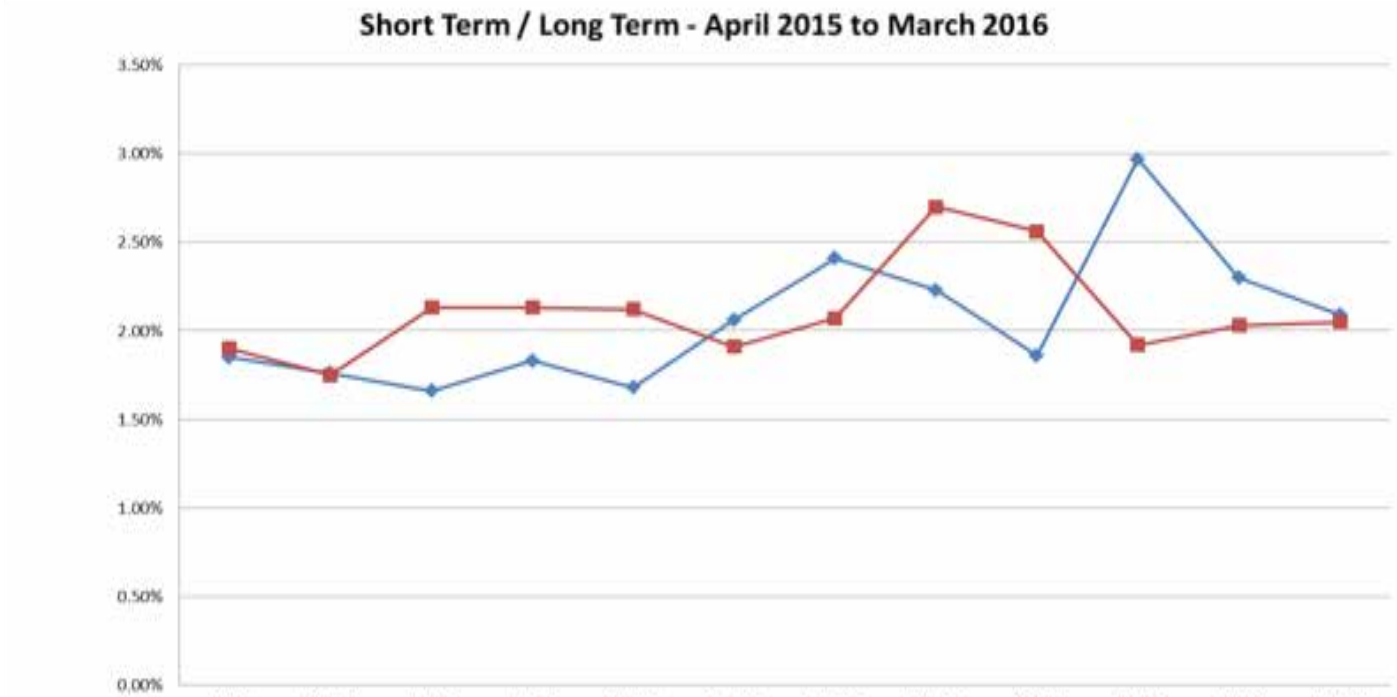
2. **Communications:** Ensuring that we have effective communication systems and arrangements in place is important to build successful and sustainable employee engagement. We are realigning our communications in response to what our staff are telling us is important for them; we have reviewed and realigned our Team Briefing system and are exploring ways to enable staff suggestions on improvements to patient care, safety and quality of service to be more easily and readily achievable.

3. **Service Improvement:** Successful employee engagement is a necessary pre-requisite for sustainable service improvement. We are therefore embedding our approach on engagement into our service improvement work. For example we are currently exploring a major Patient Safety culture change programme that will affect all ward based staff at King's Mill, Mansfield Community Hospital and Newark Hospital along with other staff. The programme will include a major employee engagement element. This reflects a new way of approaching service improvement; one that is based on proven evidence of how to achieve sustainable changes and improvement in the safety of patients in healthcare systems.

4. **Long Term Partnership:** our work on employee engagement is seen as an important part of the work that is necessary to ensure that the transition to the new merged organisation works well. We have set an ambitious timescale and have identified employee engagement as one of the key issues that needs to be addressed.

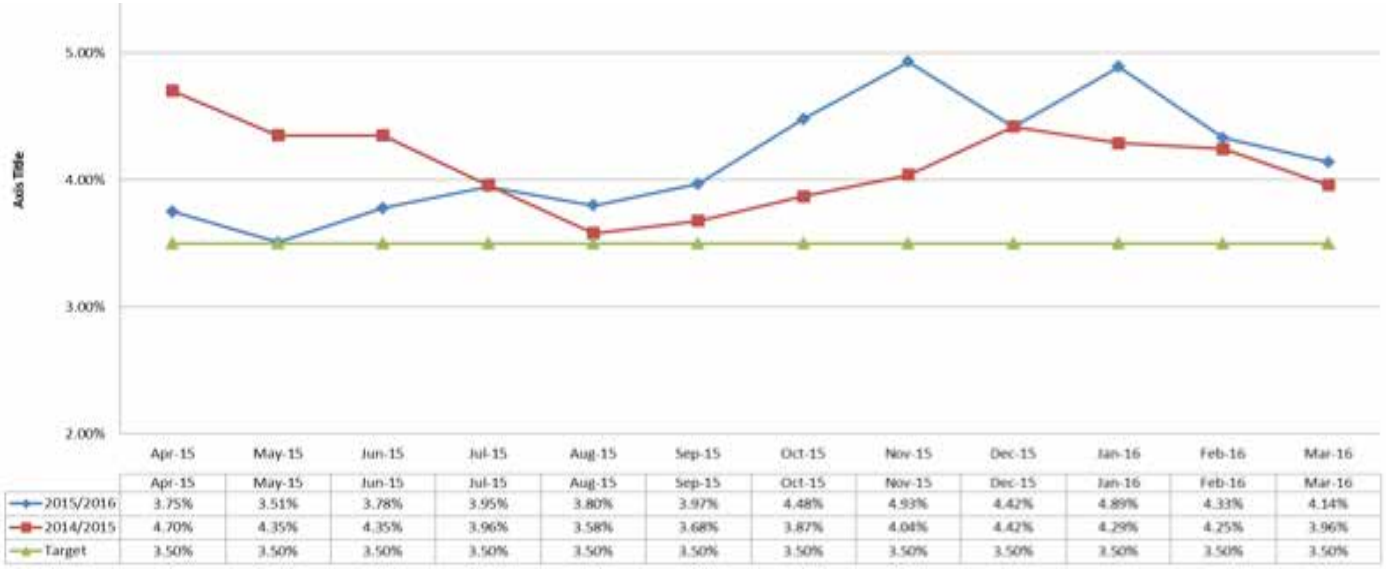
Sickness Absence

The target sickness absence for the Trust for 2015/16 remained at 3.50%. The total sickness absence rate for 2015/16 was 4.17%, compared to 4.12% in 2014/15. The cost of paying absent staff stood at £4.66m compared to £4.57m in 2014/15.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
ST - 2015/2016	1.85%	1.76%	1.66%	1.83%	1.68%	2.06%	2.41%	2.23%	1.86%	2.97%	2.30%	2.09%
LT - 2015/2016	1.90%	1.75%	2.13%	2.13%	2.12%	1.91%	2.07%	2.70%	2.56%	1.92%	2.03%	2.05%

The graph below shows a comparison of sickness absence rates in terms of short and long term rates against target for 2015/16 against 2014/15:



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2015/2016	3.75%	3.51%	3.78%	3.95%	3.80%	3.97%	4.48%	4.93%	4.42%	4.89%	4.33%	4.14%
2014/2015	4.70%	4.35%	4.35%	3.96%	3.58%	3.68%	3.87%	4.04%	4.42%	4.29%	4.25%	3.96%
Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

The Trust is maintaining its focus on managing short term sickness absence with HR business partners supporting divisional managers to monitor trends and carry out absence reviews when required.

There is continued focus on managing long-term sickness with cases being proactively managed according to Trust policy and linking with Occupational Health to ensure staff receive support and intervention to improve attendance and facilitate staff positively back to work.

Further sickness absence information is outlined below:

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

Key priorities

- To continue to support managers to manage sickness absence effectively, especially targeting new managers with key training
- To continue developing health and wellbeing initiatives to support staff to maintain healthy lifestyles and prevent future absences
- Timely and effective return to work interviews by managers is a key priority area for improvement
- A renewed focus and range of initiatives are being implemented or are planned for 2016/17 which are designed to reduce sickness absence and ensure practice within the Trust is consistent with recognised best practice

Valuing our Members

The Trust plays a key role in the community through its work with its local commissioners to improve the health and wellbeing of our local populations and will continue to develop this role through the development of its membership activities.
The Council of Governors is required to promote the aims and priorities of the Trust through links into the local community and seek further opportunities for community engagement.
Governors have an important role to play in member recruitment and engagement; governors are the link between the members, the wider public and the Board of Directors.
The Trust's Membership Strategy states the aim and primary objectives of the Trust with regards to its members

Aim

The Trust's membership aim is to ensure that the public is at the heart of everything we do by creating representative membership and engaging them in the transformation of their health services.

Primary Objectives

- To create an engaged and supportive membership, representative of the public and stakeholders in our area
- To develop the infrastructure and processes to enable efficient and effective dialogue between the Board of Directors and its members
- To inform members of the health landscape and provide them with the information to access services and make the best health choices
- To enable members to influence the services the Trust offers them and hold the Board to account for the delivery of those services

The key challenge for the Trust as a membership organisation is to secure sustainable membership interest and involvement whilst ensuring membership encompasses all the communities served by the Trust.

Over 18,000 people from the local population have chosen to support Sherwood Forest Hospitals by becoming a member of our Foundation Trust. We are extremely grateful to all our members for their continuing support.

Our public membership was 18,619 at the end of March 2016.

Overview

The Trust has two membership constituencies:

- Staff constituency
- Public constituency

Staff Constituency

Trust employees continue to be registered as members under an opt-out scheme and the number of employees who choose to opt out remains extremely low. The staff membership ensures that a large majority of staff are able, through a number of additional channels to participate in and offer their views on developments at the Trust. The Trust has around 5,000 employees and volunteers who are classed as staff members.

The staff constituency is divided into four classes:

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

Public Constituencies

As well as residing within the geographic boundaries described below, public members must be aged 16 or over and meet other eligibility criteria as described in the Trust's Constitution.

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

There are five public constituencies:

- Ashfield – includes the geographic boundaries of Ashfield District Council and the wards of Ravenshead and Newstead from Gedling District Council
- Mansfield – includes the geographic boundaries of Mansfield District Council and the ward of Welbeck from Bassetlaw District Council
- Newark and Sherwood – includes the geographic boundaries of Newark and Sherwood District Council plus wards from Bassetlaw, South Kesteven and Rushcliffe District Councils
- Derbyshire – includes wards from Bolsover and North East Derbyshire District Councils
- Rest of the East Midlands – includes the remainder of the East Midlands region which is not covered in the other constituencies

Public membership breakdown at 31 March 2016

	Number of Members	Membership Profile	Population Profile	Trend
Age (years)				
0 – 16	1	0.01%	19.62%	▼
17 – 21	241	1.39%	6.46%	▼
22+	17010	98.5%	73.9%	▼
Ethnicity				
White	16758	89.96%	98.7%	▼
Mixed	31	0.18%	1.85%	▲
Asian	95	0.56%	6.29%	▲
Black	38	0.22%	1.74%	▼
Other	10	0.05%	0.34%	▼
Ethnicity				
Male	6877	37. 3%	49.3%	▼
Female	11529	62.6%	50.6%	▼

Membership activity throughout the year

As part of the Trust's commitment to having an active membership, we have worked with the governors' Membership and Engagement Committee during 2015/16 to build more 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 are, in order to utilise our loyal membership to support us in understanding how the Trust is perceived externally and where we need to focus our improvement efforts.

The Membership and Engagement Committee continues to be active in developing communication and engagement activities for all our members and we are grateful to Beryl Perrin, public governor for the Ashfield Constituency and committee chairman for her tireless commitment to improving membership engagement.

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

Member Events

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

- **Health living members' events**
  These sessions offer tips and advice to members on the everyday lifestyle changes that can be made to promote healthy living. Including Stoptober events supported by New Leaf who offered smoking cessation advice, New Year New You campaign for members, signposting members to services to help support them in achieving their New Year's resolutions.

- **Meet the governor events**
  These events, across all three hospital sites, enable governors to directly engage with members with regard to feedback the quality of the services provided at each location. The comments received both positive and negative and fed back to the services area's in order to support learning and improvement initiatives.

- **Annual general meeting/Annual members meeting**
  This event, on Wednesday 23 September 2015 at King's Mill Hospital, was attended by more than 60 members who visited the interactive display stands as well as attending the dementia members' event and the Annual General Meeting presentation.

We continue to work closely with our members to help us be truly accountable for the quality of the services we provides. Although 2016/17 will be another challenging year for us with many changes particularly with regard to the Long Term Partnership arrangements with Nottingham University Hospitals, we will continue to ensure members have the opportunity to be involved in future service developments and initiatives.

Details of how members can contact Board Members and Governors are detailed on the Trust website.

Valuing our Governors

The Board of Directors sets our strategic direction with participation from the Council of Governors. The statutory general 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 and
- to represent the interests of the members of the trust as a whole and the interests of the public

In addition the Council of Governors, amongst other matters, is responsible for making decisions regarding the appointment or removal of the chairman, the non-executive directors and the Trust's auditors.

As an NHS Foundation Trust we are accountable to the Council of Governors, which represents the views of members.

The Trusts constitution makes clear the process to appoint or remove the Chairman and the other non-executive directors including their role in deciding the remuneration and allowances and other terms and conditions of office of the non-executive directors.

The Council met a number of times during the year (see table). The meetings were well attended, with wide ranging debate across a number of areas of interest. Reports were received from each of the governor working groups, with distinct terms of reference:

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

Governors Annual Report 2015/16

The past year has been one of the most difficult in our history. The Governors were very disappointed with the CQC report and it has proved to be a challenge for the staff and Governors to bring about the required changes. Since the departure of our former Chief Executive Officer (CEO), we have had an acting CEO, Karen Fisher, who worked tirelessly during her brief term to help the Trust to move things forward during its time of crisis. The governors would like to thank her for her hard work and efforts whilst in this role. Peter Herring our new interim CEO joined the Trust in autumn 2015 and continues to develop the Trust and to help find a long term partner. With regard to the governing body, there was sad news as one of its most active governors, John Swanwick, public governor for Mansfield, passed away after a brief illness. It is fair to say that governors respected John immensely and he will be sorely missed. Also, Susan Moss resigned her position from the governing body. We have also welcomed a new governor – Councillor Sharron Adey, Mansfield District Council.

The governing body has had to work under the shadow of the CQC report for most of the year. There have been lots of positive changes and initiatives brought about by the report which have been strongly supported by the governors such as:

- The Maternity Improvement Board – this is looking into improving maternity services
- The Sherwood Forest Hospital Trust Oversight Group – is looking at delivering the quality improvement plan produced from the outcomes of the CQC report.
- The Out-patients Improvement Board - which looks at improving the outpatients service

The governors continue to seek assurance through the Safety and Experience, Performance and Strategy and Membership committees. Meetings of these are held quarterly and continue to be a valuable way to assess the Trust. The governor development training programme is an on-going initiative and constantly delivers the required information to enable governors to further understand the Trust and to hold the non-executives to account. There have been several governor membership engagement sessions which have proved to be an excellent way of gauging public response. These will now become an integral part of the on-going governor programme.

The governors appreciate that the next 12 months will also prove hard in trying to form a Long Term Partnership with Nottingham University Hospitals and are sure that working together the long term quality care for patients will be delivered.

Colin Barnard, Lead Governor

Governor elections 2016

Public and staff governors are elected to serve a period of up to three years. During 2016 the majority of public governors and all staff and volunteer governors will have reached the end of their three year tenure. Therefore, during April 2016, governor elections took place with all staff governors and 10 public governors being elected from 1 May 2016 with the two public governors from Derbyshire taking up their posts from 1 August 2016. We look forward to working with the new Council of Governors as it progresses the Long Term Partnership arrangements with Nottingham University Hospitals.

Membership Recruitment and Engagement

The governors are in a unique position to be able to determine the needs and views on the delivery of services from their members and the public and feed this information back to the Board of Directors who hold responsibility for delivering services to the community. Governors are therefore required to convey information from the Board of Directors to members and the local community with regards to service plans and/or change, health improvement initiatives and overall affordability of services.

Governors are vital in ensuring that the trust responds to the community needs, having a broad and representative membership and a Council of Governors elected from and by our members, is key to working together to better meet the needs of the communities we serve.

Throughout the year a number of recruitment and engagement events were held for Trust members and prospective Trust members. Representatives from the Council of Governors have been present at these events and have been able to answer questions and receive feedback from our members and the public.

The Membership and Engagement Committee has met throughout the year and reviews membership recruitment and engagement ambitions at each of its quarterly meetings. After robust analysis of the Trust's membership figures, the committee recommended to the Council of Governors that, while still aiming to boost recruitment in our under-represented areas, the focus should be on delivering high quality engagement events for our current members.

We will continue to use targeted recruitment methods with the aim of ensuring that our public membership is representative of those eligible to join.

Attendance at Council of Governor meetings

Governors	Constituency	Elected/ Appointed	Meetings Attended
Samantha Annis	Staff Governor, Newark Hospital	Elected	3/6
Colin Barnard (Lead Governor)	Public Governor, Ashfield	Elected	5/6
Jim Barrie	Public Governor	Elected	4/6
Alison Beal	Staff Governor, Kings Mill Hospital	Elected	6/6
Wesley Burton	Staff Governor, Kings Mill Hospital	Elected	6/6
Angie Emmott	Staff Governor, Newark Hospital	Elected	6/6
Louise Knott	Appointed Governor, Vision West Notts (appointed March 2015)	Appointed	3/6
Nicola Juden	Volunteer Governor, Newark Hospital	Elected	0/6
Andy March	Public Governor, Mansfield	Elected	2/6
Nigel Nice	Public Governor, Newark & Sherwood	Elected	5/6
Roz Norman	Staff Governor, Kings Mill Hospital	Elected	6/6
Annie Palmer	Public Governor, Rest of the East Midlands	Elected	4/6
David Payne	Appointed Governor, Newark & Sherwood District Council	Appointed	5/6
Beryl Perrin	Public Governor, Ashfield	Elected	6/6
Martin Stott	Public Governor, Newark & Sherwood	Elected	5/6
Amanda Sullivan	Appointed Governor, NHS Nottinghamshire	Appointed	1/6
John Barsby	Public Governor, Mansfield	Elected	6/6
Kevin Stewart	Public Governor, Ashfield	Elected	4/6
Susan Holmes	Public Governor, Ashfield	Elected	5/6
Susan Moss	Public Governor, Newark & Sherwood (resigned January 2016)	Elected	3/5
Ron Tansley	Volunteer Governor, Kings Mill Hospital	Elected	4/6
Diane Wright	Public Governor, Mansfield	Elected	3/6
Valarie Bacon	Public Governor, Derbyshire	Elected	6/6
Nicola Waller	Public Governor, Derbyshire	Elected	3/6
Jim Aspinall	Appointed Governor, Ashfield District Council	Appointed	2/6
Yvonne Woodhead	Appointed Governor, Nottinghamshire County Council	Appointed	6/6
Sharron Adey	Appointed Governor, Mansfield District Council	Appointed	3/6

It has been a busy year for our governors who have attended Council of Governor meetings including two extraordinary Council of Governor meetings, numerous governor training and development sessions and various committees including Trust Board committees where they act as observers and report back to the main Council of Governors and its sub committees.

This reflects an excellent year of working together, with governors and Board members involving themselves in walkabouts within our healthcare settings to support the Trust in continually improving healthcare delivery as well as being out and about in their constituencies and within the Trust in order to get closer to members.

The Council of Governors has played a key role in ensuring the Board of Directors is following a robust and transparent process as we move forward with the Long Term Partnership arrangements with Nottingham University Hospitals and will continue to challenge and support the Board of Directors in achieving the best outcome for the patients and service users of the Trust.

The Trust acknowledges and respects the unique contribution that individual governors and the Council of Governors as a whole are contributing to the future development of the Trust and we are also grateful for the support of the Lead Governor, Colin Barnard, who has supported the Chairman and Company Secretary to enhance the relationship between the Board of Directors and the Council of Governors.

3.4 Disclosures set out in the FT Code of Governance

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

The Board of Directors is focused on achieving long term success for the Trust through the pursuit of sound business strategies, whilst maintaining high standards of 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 the community and its members.

The Board of Directors brings a wide range of experience and expertise to its stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive. In the past year, the Trust welcomed a number of new members to the Board each bringing excellent skills and expertise to the organisation at a crucial time.

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

Chairman, Sean Lyons is responsible for the effective working of the Board, for the balance of its membership subject to Board and governor approval, and for ensuring that all directors are able to play their full part in the strategic direction of the Trust and in its performance. The Chairman conducts annual appraisals of the non-executive directors and presents the outcomes of such to the Governor Remuneration and Nomination Committee. Furthermore the Chairman carries out the appraisal of the Chief Executive.

Peter Herring, interim Chief Executive from November 2015, is responsible for all aspects of the management of the Trust. This includes developing appropriate business strategies agreed by the Board, ensuring appropriate objectives and policies are adopted throughout the Trust, that appropriate budgets are set and that their performance is effectively monitored.

The Chairman, with the support of the Company Secretary (Shirley Clarke) ensures that the directors and governors receive accurate, timely and clear information, making complex information easier to digest and understand. Directors are encouraged to update their skills, knowledge and familiarity with the Trust's business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with governors. The Board is regularly updated on governance and regulatory matters. There is an understanding whereby any non-executive director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Head of Corporate Affairs/Company Secretary at the Trust's expense. The non-executive directors provide a wide range of skills and experience. They bring an independent judgement 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 was independent in character and judgement and met the independence criteria set out in Monitor's Code of Governance. The non-executive directors have ensured that they have sufficient time to carry out their duties. Annually the non-executive directors, through the Remuneration and Nominations

Committee, review the performance appraisal conducted by the Chief Executive of executive directors. During the year time has been spent with the governors to understand views of the Trust and its strategies, and all Board members attend the Council of Governors, and governors are invited to attend the Board and its committees as observers.

A number of key decisions and matters are reserved for the Board's approval and are not delegated to management. The Board delegates certain responsibilities to its committees, to assist it in carrying out its functions of ensuring independent oversight. The Board of Directors has a formal schedule of matters reserved for its decision which has been reviewed in 2015/16, and has in date and relevant terms of reference for the Board's key committees. The Board receives monthly updates on performance, and delegates management, through the Chief Executive, for the overall performance of the organisation which is conducted principally through the setting of clear objectives and ensuring that the organisation is managed efficiently, to the highest standards and in keeping with its values.

The engagement policy, developed with the Council of Governors in recognition of the recommendations contained in the Code of Governance to address engagement between the Board of Directors and the Council of Governors, was refreshed in June 2015. This policy outlines the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support on-going interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council of Governors has concerns about the performance of the Board of Directions, compliance with the Trust's Provider Licence, or other matters related to the overall wellbeing of the Trust.

Committees of the Board

The Audit & Assurance Committee was chaired by Ray Dawson, who is a fellow of the Chartered Institute of Management Accountants and holds extensive financial expertise. The committee terms of reference makes clear membership comprises wholly non-executive directors with executives and others in attendance. Attendance of non-executive members at meetings is detailed below:

Ray Dawson	6/6
Mark Chivers	1/6
Peter Marks	4/6
Neal Gossage	1/3
Graham Ward	1/2
Tim Reddish	1/1

During the year the membership of the committee was realigned after the departure of Mark Chivers who left the Trust at the end of his tenure. Peter Marks stepped down and Graham Ward and Tim Reddish joined the committee. Neal Gossage was briefly a member of the committee and now chairs the Finance Committee.

The committee assists the Board in fulfilling its oversight responsibilities and its primary functions as stated in its approved terms of reference are to:

- Monitor the integrity of the financial statements
- Review the systems of internal control and risk management and the quality of patient care
- Maintain an appropriate relationship with the Trust's external auditors ensuring the objectivity of the audit process
- Ensure auditor independence is safeguarded when non-audit work is conducted by our auditors

In assessing the quality of the Trust's control environment, the committee received reports during the year from the external auditors KPMG and the internal auditors 360 Assurance on the work they had undertaken in reviewing and auditing the control environment. The Trust's internal auditors, 360 Assurance are an external service.

The committee works with Counter Fraud Service and Trust colleagues to actively promote and raise awareness and encourage people to raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Counter Fraud Service has a standing invitation to all meetings, with relevant policies readily available on the Trust's intranet.
The Audit Committee routinely receives financial information, including cash and liquidity and the going concern status of the Trust, as well as operational information. This includes assurance from Finance Committee regarding risks to the financial position of the PFI liabilities and the associated impact on cash and liquidity.

As part of the year-end process and approval of the accounts to the Board for ratification, the committee reviews and takes into account:

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

Standards of business conduct

The Board of Directors supports the importance of adoption of the Trust's Standards of Business Conduct. These standards provide information, education, and resources to help staff make good, informed business decisions and to act on them with integrity. In addition, managers should use this resource to foster, manage, and reward a culture of accountability within their departments. The Trust believes that working together it can continuously enhance culture in ways that benefit patients and partners, and that strengthen interactions with one another.
Internal audit (360 Assurance)

The Audit Plan for 2015/16 was developed in line with the mandatory requirements of the NHS Internal Audit Standards. 360 Assurance, an external service, has worked with the Trust to ensure the plan was aligned to our risk environment. In line with the internal audit work plan full scope audits of the adequacy and effectiveness of the control framework in place are complete or underway. Recommendations made from the audits are followed up by internal audit to ensure that all recommendations are sustainably implemented within the organisation.

External Audit Service (KPMG)

KPMG were appointed as the Trust's external auditors from 1 November 2012 for a period of three years. The Audit & Assurance Committee approved a 12 month extension to the contract (thus taking the contract expiry date to 31 October 2016) in November 2015 to enable the Trust to conduct a competitive exercise in light of revised framework agreements.

We incurred £69,000 in audit service fees in relation to the statutory audit of our accounts for the 12 month period to 31 March 2016 (£67,000 for period to 31 March 2015). Non-audit services amounted to £34,000 (£29,000 for the period to 31 March 15). To ensure the independence of the external auditors, non-audit services required during the year are not carried out by a member of the team conducting the external audit but by team members with separate lines of accountability.

Remuneration and Nomination Committee

As at 31 March 2016, and on-going, the membership comprises Sean Lyons as Chairman and all non-executive directors. The attendance of non-executive directors is detailed within the Remuneration Report.

Its primary role is to recommend, to the Board, the remuneration strategy and framework, giving due regard to the financial health of the Trust and to ensure the executives are fairly rewarded for their individual contributions to the Trust's overall performance. The Remuneration Report is set out in its own section of the Annual Report. The remuneration of the non-executive directors is determined by the Council of Governors via recommendations from their own Remuneration and Nomination Committee.

Committee of the Council of Governors

The Council of Governors' Remuneration and Nomination Committee comprises Sean Lyons as Chairman, and representatives from the public, staff and partner governor classes, membership of which is detailed within the Council of Governor section of the Annual Report. Its role is to ensure that appropriate procedures are in place for the nomination, selection, training and evaluation of non-executive directors and for succession plans and it sets their remuneration. 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. See Remuneration Report for further information regarding the work of the committee.

Committees of the Board of Directors

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

- Quality Committee, which enables the Board to obtain assurance regarding standards of care provided by the Trust and that adequate and appropriate clinical governance structures, processes and controls were in place
- Finance Committee, which oversees the development and implementation of the Trust's strategic financial plan and oversees management of the principle risks to the achievement of that plan
- OD and Workforce Committee, which enables the Board to obtain assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff
- Risk Committee, which provides assurance to the Board of directors with regard to compliance with the Trusts risk management system and processes and identifies those risks (and risk mitigation action plans) which need to be brought to the attention of the Board of Directors.

The terms of reference of the Board committees reflect the required focus on integrated risk, performance and quality management.

Counter fraud

The Board of Directors attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by our local counter fraud specialists in liaison with the NHS Counter Fraud and Security Management Service (CFSMS).

We continue to work to maintain an anti-fraud culture and have a range of policies and procedures to minimise risk in this area. A number of events were held over the year to highlight how staff should raise concerns and suspicions. Staff also have access to counter fraud awareness training which changed in year to become predominantly eLearning rather than face to face training and forms part of their induction training on joining the Trust.

We are committed to providing and maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the Trust, and ensure rigorous investigation and disciplinary or other actions as appropriate. We use best practice, as recommended by the NHS Counter Fraud and Security Management Service. Over the year we have published our policies and procedures for staff to report any concern about potential fraud. This is reinforced by awareness training. Any concerns are investigated by our Local Counter Fraud Specialist or CFSMS as appropriate. All investigations are reported to the Audit and Assurance Committee.

NHS Litigation Authority

Our CNST premium has increased by £2.67m in 2015/16 (£4.86m to £7.53m) – this is a 55% increase. The previous risk management discount scheme has now ceased, in 2014/15 this reduced the Trust's premium by £0.74m. Nationally CNST premiums have risen by 35%. The excess for SFH relates to our historic claim profile.

Compliance with the Code of Governance

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

The Board of Directors is committed to high standards of corporate governance. For the year ended 31 March 2016, the Board considers that it was, throughout the, year fully compliant with the provisions of the NHS Foundation Trust Code of Governance with the following exceptions where we have alternative arrangements in place.

The Code of Governance requires that a Board be supplied with information in a timely manner in a form and quantity appropriate to enable it to discharge its duties. Describing in part how we apply this principle demonstrates the value of performance evaluation in helping to develop directors' information needs. The Board continued its programme of Board development which included looking at a deeper understanding of the compliance and performance information the Board receives. This included on-going improvements in the corporate governance arrangements for the Trust, many of which were borne out of the work emanating from Foresight Partnership's Board review of the Board and the Quality Committee and reviews into financial governance in year.

There will be additional and on-going development sessions for the full Board of Directors in 2016 and the governance structure, which has evolved to keep pace with an ever changing organisation, will stand the Trust in good stead and allow the Board to continue to learn and develop through the new skills and experiences of those on the Board. The Trust will continue to look to current and evolving best practice as a guide in meeting the governance expectations of its patients, members and wider stakeholder community and will continue to assess the effectiveness of the Board following an external assessment The outcome of the external assessment has led to an action plan being formulated in order to continually improve the effectiveness of the Board. These have been incorporated into the Trust's Quality Improvement Plan.

The Trust, in common with the health service and public sector as a whole, is operating in a fast changing and demanding external environment, particularly as it understands and responds to the changes through the Health and Social Care Act 2012. The Trust recognises the need to significantly increase efficiency whilst maintaining high quality care at a time when budgets will be tight, and it will continue to build on improvements through its exceptional staff to respond to these challenges.
The Trust ensured due regard was taken to its legal obligations and implemented a governor development programme that accorded with, and ensured a detailed understanding of the new requirements of the Act to include equipping the Governors with the requisite knowledge and skills.
The roles and responsibilities of the Council of Governors are described in the Constitution, together with detail of how disagreements between the Board and Council of Governors will be resolved. The types of decisions taken by the Council of Governors and the Board, including those delegated to sub-committees, are described in the approved terms of reference.

The Board determines which of its committees may have governors in attendance. There is a detailed scheme of delegation and reservation of powers which was comprehensively reviewed during 2015/16. This sets out, explicitly, those decisions which are reserved to the Board, those which may be determined by standing committees and those which are delegated to managers.

Members of the Board are invited to attend all meetings of the Council of Governors. Governors and non-executive directors take part in internal assurance visits to clinical areas of the Trust and were heavily involved in out-patient and staff engagement events.

Governors have been involved in a number of membership events during the year which seek to improve engagement with the membership. Governors also attend public events with the Membership and Communications Officer and help to recruit new members to join the Trust.

The executive team consulted with the Council of Governors during the year on matters such as the Annual Plan, quality account, the Long Term Partnership proposals and other relevant strategies and reports.

In an NHS Foundation Trust, the authority for appointing and dismissing the Chairman rests with the Council of Governors. The appraisal of the Chairman is therefore carried out for, and on behalf of, the Council of Governors. This is undertaken by the senior independent director, supported by the Lead Governor. They review the Chairman'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. The committee in turn reports to the Council of Governors.

The directors of the Board are appraised by the Chief Executive who is, in turn, appraised by the Chairman. The Council of Governors does not routinely consult external professional advisors to market test the remuneration levels of the chairman and other non-executive directors. The recommendations made to the Council of Governors are based on independent advice and guidance as issued from time to time by appropriate bodies such as NHS Appointments Commission in relation to NHS Trusts or the NHS Confederation, together with benchmark data from NHS Providers and Capita.

In April 2016 the Board of Directors and Council of Governors approved an amendment to the constitution. To remove section 8.7.1.8, which refers to disqualification

8.7.1 An individual may not become or continue as a Director of the Trust if:

8.7.1.8 he is an executive or non-executive director or governor of another NHS Foundation Trust, or an executive director, non-executive director, chairman, chief executive officer of another Health Service Body.

This section has been removed to ensure the Constitution complied with current legislation to support a merger with Nottingham University Hospitals.

Regulatory Ratings

The Risk Assessment Framework, updated in August 2015, sets out the approach which Monitor takes to assess the compliance of NHS Foundation Trusts with their terms of authorisation, with a particular

focus on the continuity of services and governance licence conditions.

The aim of a Monitor assessment, under the risk assessment framework, is to show when there is:

- significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services
- poor governance at an NHS foundation trust, including poor financial governance and inefficiency

The financial sustainability risk rating states Monitor's view of the level of financial risk facing a provider of key NHS services and its overall financial efficiency.
There are four ratings ranging from 1, the most serious to 4, the lowest risk. A rating indicating a serious risk does not necessarily represent a breach of the provider's license but reflects the degree of concern of Monitor and therefore the frequency of monitoring.

There are three categories to the governance ratings applicable to all Foundation Trusts, green - where there are no grounds for concern, under review – where Monitor has identified a concern but not yet taken action, red – where Monitor is already taking enforcement action.

The Trusts annual plan for 2015/16 forecast a Continuity of service rating of 1 (Where one is poor and five is excellent) with a forecast governance risk rating of 'red'. The table below is the outcome for each quarter of the year and a comparison of the previous year

2015/16	Annual Plan 2015/16	Q1	Q2	Q3	Q4
Continuity of service rating (Q1)	1	1			
Financial Sustainability risk rating (from Q2)*			2	2	2
Governance rating	Red	Red	Red	Red	Red

2014/15	Annual Plan 2014/15	Q1	Q2	Q3	Q4
Continuity of service rating	1	1	1	1	1
Governance rating	Red	Red	Red	Red	Red

*Risk Assessment framework updated August 2015

The Trust has updated Monitor regularly through the performance review meeting (PRM) process, providing updates on progress with the improvement agenda.

The Board, in its annual plan 2015/16, highlighted performance risks in respect of RTT admitted patients, RTT non-admitted patients, RTT incomplete pathways, A & E 4 hour wait and Cancer 62 day wait for first treatment (all cancers). The updated Risk Assessment Framework in August 2015 removed the requirement to report on the admitted and non-admitted referral to treatment targets.
Details of full-year performance can be found in the performance report section of this Annual Report. These outcomes have been reported to Monitor through the PRM process and monthly monitoring are made available on the Trusts website through the Board meeting papers.

In April 2015 Monitor accepted the Trusts section 106 undertakings with regard to:

- Financial Breaches
- Target Breaches
- Governance Breaches

The Trust developed and submitted the required action plans to Monitor in order to monitor progress against the identified breaches.

Monitor imposed an additional licence condition under section 111 of the Health and Social Care Act 2012 on 1 April 2015.

3.5 Statement of the Chief Executive's responsibilities as the Accounting Officer of Sherwood Forest Hospital 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 Account Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Sherwood Forest Hospitals NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statement 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 him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Peter Herring
Interim Chief Executive
Date 26 May 2016

3.6 Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Significant breach of the Trust's terms of authorisation

In September 2012, the Trust was declared as being in significant breach of its terms of authorisation by Monitor, the former independent regulator of foundation Trusts, owing to its failure to meet, consistently, the required standards of governance and also due to concerns about the underlying financial deficit, the pace of delivery of a sustainable cost improvement programme (CIP) and the PFI funding gap closure necessary to address part of this deficit.

The Board's capacity to address these issues was also influenced by significant changes to the Board members, changes which have continued during 2015/16 in order to address Monitor's concerns. The Trust has remained in significant breach until the end of the financial year and has entered 2016/17 with discretionary requirements and an enforcement notice remaining on its licence with NHS Improvement.

Monitor issued a compliance certificate with regard to the explicit terms of the section 106 undertakings as referenced in this annual report and redefined other section 106 requirements and section 111 requirements in April 2015.
A CQC inspection of the Trust in June 2015 rated the Trust as overall 'inadequate' and recommended the Trust remain in 'special measures'.

The Trust takes the Regulators' concerns very seriously. As Accounting Officer, I recognise that these failures indicate that the Trust's systems of internal control were not sufficiently effective in managing risk to an acceptable level in these areas. As a result, the Trust has taken action to further develop the governance arrangements, including risk management, to address the concerns identified.
The rest of this statement explains how the Trust has achieved this to date and gives an indication of the work in progress.

With respect to performance against specific targets, the Annual Report describes what the Trust has achieved and explains areas of breach and compliance with national targets, namely A&E, referral to treatment and cancer targets.

A significant amount of work has been undertaken through a recovery programme to respond to key issues identified both in operational capacity and pathway management as well as issues arising from the migration to a new patient access system (PAS).This recovery programme reflects the efforts to improve data quality and enhance the management of administrative functions on the RTT pathway. These have made producing accurate and robust trajectories challenging.

The Trust also identified, and is addressing, concerns within its outpatient services and associated administration of appointments. As a consequence an outpatients working group was established to plan and deliver sustainable improvements in patient experience for those accessing outpatient services. The group includes staff, governor representation and external stakeholders.

By the end of the year, the performance of our teams has resulted in the Trust meeting most national targets and we have plans in place to improve that position further in 2016/17. The Trust is very proud of its staff in ensuring delivery against these targets during another challenging year.

Capacity to manage risk

The Board of Directors provides leadership on the overall governance agenda. The Board provide high level of commitment for establishing effective risk management systems across the Trust. The Chief Executive has overall responsibility for the management of risk and chairs the Board Risk Committee. Responsibility for specific risk management areas has been delegated to the Trust Executive.

The Risk Management Policy continues to be developed to strengthen and mature the organisation's approach to risk management, and clarify roles and responsibilities.

Policies, procedures and guidelines are in place to help mitigate risk. These control documents set out specific roles and responsibilities in relation to the risk. There is strong evidence of improvement in relation to serious incident management and complaints, and this shall continue in order to be responsive to safety management and service user concerns. Lessons for learning are shared with staff. Learning is communicated using a range of modalities including, but not limited to, dissemination of iCARE newsletters, team meetings, management briefings, individual support and feedback where necessary, and senior leadership visits.

The Trust learns from good practice through a range of processes, including clinical supervision, individual and peer reviews, professional development through formal methods such as clinical audit, application of evidence based practice and root cause analysis. The establishment of the Governance Support Unit has commenced and will better support quality governance.

The risk and control framework

The Risk Management Policy sets out in detail the Board's appetite for taking risk, the risk management process, scoring methodology and escalation criteria.

A Risk Committee, which is a committee reporting to the Board of Directors, which I chair as Chief Executive, was established during the year to lead risk management improvement and monitor progress with Divisional Risk Registers and ensuring alignment with the Board Assurance Framework (BAF). The Board's Risk Committee seeks to ensure that risk is kept under prudent control at all times.

Amongst the most significant of the Trust's risks are financial recovery and the sustainability of quality improvements following the CQC inspection in June 2015. The Board of Directors has taken steps throughout the year to continue to monitor and prepare prudent, risk assessed responses to financial risks, such as liquidity. This has included work to develop an accurate forecast and financing via working capital facility and loans for both capital and revenue.

All staff are responsible for identifying, reporting and acting upon incidents, hazards, complaints and near misses in accordance with Trust policies. Divisional clinical management teams have refreshed risk profiles. They maintain and oversee divisional risk registers which shall, from June 2016, be formally reviewed as part of a rolling programme by the Board Risk Committee.

Risk management arrangements are also underpinned by:

- Clear lines of accountability within the BAF;
- Risk scoring matrix to ensure a consistent approach;
- Policy for the reporting, investigation, management and analysis of incidents, complaints, concerns and claims including the Management of Serious Incidents;
- Induction programme and mandatory update training programme;
- Regular patient safety and patient experience reports including the reporting of serious incidents.

The Trust has developed a Service Level Agreement with Nottingham University Hospitals NHS Trust during the year to review its emergency preparedness and civil contingency requirements. This has led to a revision of the Trust's Business Continuity, CBRNe policy and a refreshed Resilience Assurance Committee. In light of the terrorist attacks in Paris a paper was submitted to public Board in March 2016 to provide assurance of the plans in place for the Trust to deal with any similar event, as per NHS England requirements. The Emergency Preparedness Resilience Response (EPRR) was submitted to NHS England in September 2016 and the Trust was rated as amber.

Board Assurance Framework

The BAF was in place during 2015/16 and was improved to ensure a more concentrated focus on the key strategic risk areas. The Trusts enhanced governance arrangements are founded on the operation of the BAF and include the presentation and scrutiny of information to evidence assurance of control effectiveness at all committees of the board which increases the assurance processes.

The Board Risk Committee reviews the BAF monthly to ensure progress, risk is kept under prudent control, and the Board's assurance needs are being met. The majority of the risks identified on the BAF are addressed through the specific workstreams of the quality improvement plan, to ensure focus and sustainability and the reduction of duplication.

The risks identified on the BAF are:

BAF Ref	Risk Description
AF1.0	If we do not deliver safe care than patients may suffer avoidable harm and poor clinical outcomes.
AF2.0	If we do not improve patient flow in order to create bed capacity in line with emergency demand we will fail national quality and performance standards and also fail to ensure that our clinical teams have manageable workloads
AF3.0	If we fail to create an accurate patient tracking list and validate the data on the list, or do not manage our elective capacity or have processes in place to appropriately communicate with patients we will fail national quality and performance standards in relation to access
AF4.0	Failure to achieve and maintain financial sustainability
AF5.0	Not establishing a clinical or organisational vision which will safeguard the sustainability of local services for the Trust and its hospitals
AF6.0	If we do not get good levels of staff engagement then staff morale and patient outcomes may not improve
AF7.0	Inability to source staff to meet the requirements of the service
AF8.0	The inability to develop and maintain a stable leadership team will result in shifting priorities and confusion for staff, patients and stakeholders

The Internal Audit plan and Counter Fraud plan were approved by Board members at the beginning of the year and aligned where appropriate with the BAF. The Audit & Assurance Committee has considered and determined the level of assurance required by the Board in order to meet the Board's assurance needs for the year ahead.

Internal Audit opinion

Internal Audit has reviewed the BAF process utilised by the Trust during the year and although the process was revised, as a result of a development session to refocus the risks in relation to the updated strategic priorities and include the scrutiny of the BAF in the Risk Committee, which is chaired by the Chief Executive, a limited assurance opinion was given as the process although much improved was not fully embedded at the time of report.

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

The Trust is compliant with NHS Foundation Trust Condition 4, the Trust's governance committee structure has been revised during the year to reduce the number of committees serving the assurance committees and refocus the assurance committees of the board of directors and the management committees. The Trust undertook a Board Review in December 2014 and actions from this were incorporated into the Quality Improvement Plan.

Quality Governance

The key elements of the Trusts quality governance arrangements are:

- The Trust's Quality Account (reported through the Board Quality reports) and Integrated Performance reports which enable the regular tracing of progress against quality goals by the Board of Directors. These include all national, regional and local indicators as well as national priorities
- Significant work to improve risk registers, through the development and enhancement of divisional risk registers which are regularly reviewed by committees at the appropriate level.
- Appropriately skilled members of the Board of Directors provide rigorous challenge to the quality governance processes through receipt of reports relating to quality governance many of which are standing items on the agendas of the Board of Directors meetings and its committees
- Quarterly reports from the Chief Nurse and Medical Director, which include patient safety and patient experience issues e.g. incidents, complaints and themes and learning, in addition to results of local and national patient surveys
- Internal and External Audit reports
- An appropriate lead executive director for each risk contained within the BAF
- Board members have played an active role in the delivery of quality improvement objectives. Directors have undertaken leadership visits, shadowed consultants and overseen implementation of the Quality Improvement Plan and supported associated engagement events
- The Raising Concerns (Whistleblowing) Policy is embedded throughout the organisation and is supported by whistleblowing guardians who have received focussed training in order to support staff through the process. The Senior Independent Director is the Board lead for Whistleblowing
- Staff members continued to lead on quality improvement initiatives such as sepsis management, falls and pressure ulcer prevention schemes, and nursing and quality metric performance and the reporting of these successes through the Trust's internal communication mechanisms such as Team Brief and iCARE newsletters

- The quality of performance information has had internal and external audit focus to assure elements of the information on which the Board relies. Going forward, we intend to further develop arrangements to include:
    - A Data Quality and Business Intelligence strategy
    - Work to develop a Data Assurance methodology which quality assures the data used to underpin all indictors contained within the Trust's Quality Account and Monitor Submissions

Reviews of data quality and completeness for all Trust performance information falls within the purview of the Audit and Assurance Committee. The Audit & Assurance Committee has sought and reviewed assurances in respect of data quality and completeness

Information Governance

Information Governance (IG) is the responsibility of the Head of Corporate Affairs and also of the Chief Finance Officer, who is the Trust Senior Information Risk Owner (SIRO) supported by a network of Information Asset Owners who ensure the integrity of and access to the systems for which they are responsible. The Medical Director as Caldicott Guardian and the SIRO co-chair the IG Group. The reporting and management of both data and security risks are supported by ensuring that all employees of the Trust are reminded of their data security responsibilities, through education (over 4,000 staff members received mandatory IG training in 2015/16), and regular reminders are shared via staff communications. Near misses and lessons learned are used as supporting tools for the whole Trust education process.

For the 2015/16 submission the Trust has fully implemented all IG Toolkit requirements at level 3, for the Caldicott Recommendations Report. The Trust maintained its satisfactory 'green' rating, with 86% compliance, for the 2015/16 submission for version 13 of the IG toolkit and relevant IG and ICT policies have been reviewed for this submission.

There were nine reportable incidents with regard to information governance during 2015/16. Of the nine reported incidents, four relate to information disclosed in error, three letters sent to the wrong address and two lost paperwork. Two have been closed from the ICO these require no further action but to ensure that the related policies and guidelines are updated, seven remain with the ICO and we are awaiting the outcome.

Learning from the IG incidents is disseminated through a variety of methods these include, additional training and support offered to staff members, IG bulletins circulated to staff on a weekly basis regarding pertinent IG issues, reports are shared at departmental meetings, learning boards are developed and shared for organisational learning and for use at patient safety events, updates to policies and guidelines are circulated to staff via the weekly bulletin and available on the staff intranet.

Care Quality Commission

As described earlier in this report the Trust received an overall 'inadequate' rating from the Care Quality Commission inspection in June 2015, reported in October 2015. The Trust has implemented a Quality Improvement Plan and is progressing a merger with Nottingham University Hospitals to address the concerns raised in the report.

The Trust is not fully compliant with the registration requirements of the CQC but hopes, given the improvement made through the implementation of the Quality Improvement Plan, this position will be

significantly improved. Further details of the Trust's quality priorities and targets are contained within the quality report.

Board Statements

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

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

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

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

The work of the Board and its committees have facilitated the organisation's effective and efficient operation, albeit in very challenging times, by enabling it to respond appropriately to significant business, operational, financial, compliance and other risks to achieving the Trust's objectives. This has included the continued safeguarding of assets from inappropriate use or from loss and fraud and ensuring the liabilities are identified and managed. Internal Audit plans, agreed by the Audit and Assurance Committee, are focused on key risk areas and audits have been undertaken during the year in line with those priorities. Assurance is reported to the Audit and Assurance Committee, together with improvement action plans where appropriate agreed by the accountable manager. Follow up audits are included in the plan to ensure actions are implemented and improvements sustained.

The use of the BAF has developed the Board's understanding of the strategic risks facing the organisation, and set out more directly the mitigations required to keep risk under prudent control and address the challenges that lie ahead. Going forward, the magnitude of the savings required to meet the financial challenges faced by the Trust will continue to require tight control of all expenditure. Continuance of quality impact assessment will be key to safeguarding the quality of the service delivered to our patients during periods of significant cost reduction.

The Trust has ended the year with a deficit of £55.0m before reversal of an impairment which is included in more detail in other section of the Annual Report. The Trust remains in a financially challenged position with a remaining and significant underlying deficit. The Trust has worked closely with commissioners and Monitor to manage contractual risks and its liquidity position. The Trust has engaged with commissioners regarding proposed service changes as part of the Better Together programme for future service provision and the forecast 2016/17 plan is in line with previous submissions to Monitor.

Liquidity support has been agreed with Monitor /DoH in the form of loans and working capital facility. A total of £12.3m of working capital facility, £47.8m of revenue loans and £5.6m of capital loans has been drawn down as forecast in 2015/16. Liquidity is a significant factor in assessing an organisations ability to continue as a going concern and at the date of this statement there is no reason to conclude that liquidity support will not be available for 2016/17 as the Trust is planning to deliver the deficit control total of (£41.1m) as set by Monitor. It is therefore the Trust's intention to prepare its accounts on a Going Concern basis. A detailed 'Going Concern' paper was reviewed and approved by the Audit Committee in support of this assessment and is subject to External Audit review.

The Trust is likely to remain in breach of its terms of Authorisation/License throughout 2016/17 due to its underlying deficit and the need for financial support in connection with capital and revenue cash support throughout the year ahead. At the date of publication of the accounts, the Trust traded at a loss for 2015/16 and is forecasting trading a loss for 2016/17 and as such the financial elements of licence conditions are likely to remain in place.

An enhanced approach to performance management and the supporting Programme Management Office will take place in 2016/17 to safeguard delivery of the challenging cost improvement programme and planned performance outcomes. In order to deliver cost improvements of the magnitude required, transformational change is necessary and the executives and divisional teams are driving focus around improvements that address admission, length of stay and clinical efficiencies each being fundamental to realising cost effectiveness and allowing for the inevitable reduction required in bed stock and associated expenditure, particularly around variable pay (bank, agency and locum staff).

The Board has considered the risks to its strategic objectives during the year and ensured appropriate actions to mitigate these as far as possible. Amongst those risks is the maintenance of a stable leadership to deliver the Quality Improvement Plan which was implemented following the CQC inspection in June 2015, additionally the BAF include risks concerning financial sustainability, the ability to recruit and retain skilled and experienced staff and the focus on providing safe, high quality, effective care for all patients.

The Trust's control environment mitigated the impact of those risks during the year and in order to transform the way the business delivery healthcare, some of which was externally assured and positively reflected upon through external assessments, e.g. Dr Foster review of the Trusts Sepsis process and procedures. The Trust will continue to progress its improvements through the implementation of the QIP to ensure the benefits of improvement activity are realised in order to monitor and measure the intended success of the transformational programme.

In view of the improvements required, the current pace of change and the economic challenge faced by the organisation, it has been agreed with Monitor the Trust's aims to merge with Nottingham University Hospitals NHS Trust during 2016/17. This should support the Trust in achieving its strategic objectives and improve the quality and sustainability of services provided in a cost effective and efficient manner thereby providing enhanced service provision to patients, carers and visitors.

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. Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual Quality Report which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The Quality Report presents a balanced picture of Sherwood Forest Hospitals NHS Foundation Trust's performance over the period covered from April 2015 to 31 March 2016 and indicates that there are appropriate controls in place to ensure the accuracy of data.

These controls include:

- Corporate level leadership for the quality account is aligned to the Chief Nurse and operationally led by her deputy and associate directors and clinical leaders
- Quality governance and quality and performance reports are include in the Trusts Performance Management Framework
- Internal audits of some of our indicators have tested how the indicators included in the quality report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities

All indicators included within the Quality Report are reported on a regular basis within the monthly and quarterly quality reports. Reports are shared with the divisions and the Board. Specific indicators within the report are also monitored and reported via the monthly performance management meetings with divisions and The Board of Directors.

The Quality Report is included within the Annual Report and Accounts and describes how a wide range of stakeholders have been engaged in the Trust's Quality for All activity. The same assurance processes are used as are utilised for other aspects of the Trust's performance. Work will continue in 2016 to ensure the robustness of the Trust's policy framework in supporting effective risk management across clinical and non-clinical areas and also in areas that will give greater certainty that what is reported is an accurate reflection of what has actually happened in terms of the quality data on which the Board relies. Key elements of the CQUIN programme and Quality report are reported monthly to the Board of Directors and divisional management teams. A qualified assurance opinion on 18 Week Incomplete Pathways and A&E 4 Hour Wait indicators in the Quality Report has been provided by the Trust's external auditors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation Trust 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 committee, Quality committee and risk committee and a plan to address weaknesses and ensure continuous improvement of the systems is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of performance and quality as indicators of effective control.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit has provided me with a limited assurance opinion for 2015/16, although it acknowledges progress made in the latter part of the year. This opinion is related to the BAF not being embedded throughout the year. This has been addressed through specific training being run for the Board that has developed strategic risks being faced by the Trust and has led to the BAF being rewritten and a Risk Committee being established that meets monthly. Significant process has been made on the developing the governance arrangements, including a new Director of Governance in place from January 2016 and a new performance management framework in place from April 2016.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance via regular Board and management reports which support the dynamic nature of the Board's assurance framework. The BAF itself and the work of the Audit and Assurance and Risk Committees in particular, provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic priorities have been reviewed. My review for 2015/16 is also informed by:

- Regular executive reporting to Board and escalation processes through the Board Committees
- Assessment of financial reports submitted to Monitor, the Independent Regulator
- Health and Safety Executive assessments
- External validations and peer reviews
- Results of National Patient and Staff Surveys
- the Care Quality Commission's visits and feedback
- Investigation reports and action plans following Serious Incidents and near misses and learning events
- Reponses to all formal written complaints
- Monitor governance declarations

The Board is continually reviewing its assurance processes to ensure continuous improvement of the systems and infrastructure in place. The governance structure and assurance reporting framework has ensured a regular review of systems and action plans to assure Board of the effectiveness of the system of internal control.

The Audit & Assurance Committee, supported by the detailed work undertaken by the Finance and Quality Committee has provide the Board of Directors with an impartial and objective review of financial and corporate governance and internal financial control, receiving reports from external and internal auditors. Internal Audit has reviewed and reported upon control, governance and risk management processes, driven by an audit plan approved by the Audit & Assurance Committee. Their work included identifying and evaluating controls and testing their effectiveness. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management and progress monitored.

Conclusion

There are no other significant internal control issues that I wish to report. I am satisfied that all internal control issues raised have been, or are being, addressed by the Trust through appropriate action plans and that the implement of these action plans is monitored.

Significant improvement in pace and sustainability of quality developments and in performance management and financial controls are paramount given performance outcomes in 2015/16. Actions have been taken in year where weaknesses have been identified quality governance, patient experience, incident investigations and budget control and are identified within this Statement as relevant and the Board is clear on the additional improvements that need to be progressed in 2016/17.

The Board is however being monitored closely by Monitor and the CQC which will continue whilst the Trust remains in 'special measures' and in significant breach of its Authorisation/Licence conditions. The Board will continue to progress cost reduction strategies and the close performance and project management of cost and quality improvement plans and further enhance performance management and assurance arrangements in order to ensure continued financial and quality recovery in significantly challenging times for the Trust to ensure the protection of high quality services for all.

Peter Herring
Interim Chief Executive
Date 26 May 2016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Introduction to the Quality Account

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

The Quality Report incorporates a review of the activities and achievements in improving the quality of our care during 2015/16, and goes on to state and explain our quality priorities for 2016/17.

The retrospective elements of this report pertain to the activities undertaken by the Trust during the financial year of 2015/16 and incorporate all of the mandatory reporting requirements set out by Monitor, referenced within the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2015/16
- Data Dictionary

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

I am pleased to introduce the Quality Report and Accounts for 2015/16, which details the steps we have taken to improve delivery of quality care to our patients.

We have also set out our principles and quality priorities, which always place the patient at the heart of everything we do, ensuring we achieve our 'Quality for all' values.

Improving quality of care has been at the very forefront of our minds throughout the year and was particularly brought home by the Care Quality Commission (CQC) report, published in October 2015, following an inspection in June. The report gave the Trust an overall rating of 'inadequate' and recommended that it stay in 'special measures'.

We have accepted the CQC findings and are making progress to address all the concerns identified including:

- Improving the management of sepsis (an infection which spreads into the bloodstream
- Ensuring incidents are reported across the Trust and their learning is shared
- Implementing the Newark Hospital vision and strategy with renewed focus and pace
- Making sure there is a better line of sight from 'Board to ward' and 'ward to Board', specifically on governance, quality and risk management
- Ensuring patients over 75 receive a cognitive assessment when they arrive in the emergency department at King's Mill Hospital
- Ensuring lifesaving equipment is in place and properly maintained in Newark Hospital's Minor Injury Unit resuscitation area and King's Mill Hospital's maternity unit
- Ensuring staff at Newark Hospital have appropriate qualifications, skills and experience to care for and treat children safely in the minor injuries unit
- Ensuring medication for children and young people is monitored, in date, and fit for purpose
- Providing care plans that are personalised to individual patient needs
- Ensuring appropriate systems and policies are in place to prevent the spread of infection

In August 2015, the Trust was served with section 31 and section 29a warning notices (under the Health and Social Care Act 2008).
These specifically related to and need to improve:

- The effectiveness of assistance to assess, monitor and mitigate risks to people receiving care as inpatients and outpatients
- The effectiveness of assistance to assess, monitor and improve the quality and safety of the services provided to both inpatients and outpatients in our hospitals
- The processes in place to enable us to make the rapid assessments required by the Fit and Proper Person's Requirement

We have acted to address the enforcement undertakings; we have made steady progress under the watchful eye of the Care Quality Commission, Clinical Commissioning Group, NHS England and NHS Improvement.
Following a review by the CQC, the warning notice on section 29a relating to the Fit and Proper Person's Requirement was lifted in April 2016.
In January 2016, the Trust was issued with a section 10 breach notice regarding our registration with the CQC in relation to 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'. We have submitted an application for this registration and are now awaiting confirmation from the CQC.

We were pleased that the CQC inspectors acknowledged the Trust as a caring organisation rating across all hospitals as 'good'. Staff were found to be hard-working, passionate and caring and to provide care that is kind and respectful with good interactions between staff and patients.
There were also several areas of outstanding and innovative practice, for example, 'staff went out of their way to meet patients in the critical care unit'. Patients and visitors said they were generally happy with the service they received and felt that they were involved in their care.

The Trust has developed and is currently delivering a detailed Quality Improvement Plan (QIP) and, supported by Monitor, the national regulator, started to deliver positive changes in the way care is planned and delivered at each of our hospitals. The QIP identified 10 work streams for change:

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

On 12 February 2016 the Board of Directors selected Nottingham University Hospitals as a preferred Long Term Partner to deliver clinically safe and sustainable services.
We continue to plan, implement and monitor all actions in the QIP in accordance with the timelines agreed by the Board and we are also taking steps to assure that the actions form part of everyday practices across the organisation. The QIP is dynamic and we recognise it will continue to evolve over time.

During 2015/16 we continued to achieve our quality priorities, including:

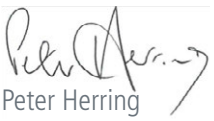
- The number of in-patients falling in hospital with harm reduced and we delivered a safety improvement programme, developed through learning from the best practice in local and national organisations. We also introduced a seven-day falls service and appointed a Falls Lead Nurse
- We reduced our average length of stay for patients, specifically focusing on older, frail patients and ensuring, where possible, that they are on discharge safely cared for in the community without having to be re-admitted to hospital
- We met our targets for improving discharge information for acute kidney injury, diagnosis and treatment in hospital. GPs are now more informed about patient care in hospital, enabling them to monitor kidney function appropriately
- We have met all national targets for sepsis, having achieved 99% compliance. The screening for sepsis for patients who are emergency admissions is 100% as is administr t colleagues for patients who have communication difficulties, and started a Dementia Café at Newark Hospital which will be replicated at King's Mill Hospital and Mansfield Community Hospital. We also increased and improved dementia awareness training for health and care staff

The Trust recognises, and is proud of, our loyal and dedicated staff and volunteers. Whether

through Trust-based recognition schemes, such as 'Star of the Month', Staff Excellence Awards, or national awards; we are proud of their achievements and determination to ensure that we continue to improve the quality of our care and services.

We continue to develop strong relationships with our strategic health and social care partners and look forward to the opportunities to further improve patient care and innovate future services that we will, hopefully, have by working within a larger merged organisation.

We have much to do over the next year, to improve our CQC rating and continue to build the trust of our patients. We do not take these tasks lightly but are determined to be in a far better position over the next few months. I am confident that the information in this report accurately reflects our performance and provides an honest and consistent reflection of where we have succeeded and exceeded in delivering on our plans and where we will need to do more to achieve them.



Peter Herring
Interim Chief Executive Officer

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

2.1 Providing High Quality Care Through our Patient Safety and Quality Strategy

Sherwood Forest Hospitals (SFH) is committed to providing high quality care to every patient who accesses our services. Our Patient Safety and Quality Strategy (2014-17) is modelled on the principles that underpin Lord Darzi's vision contained within 'High Quality Care for All', namely that the provision of high quality care can be achieved if it is:

- Safe
- Effective
- Delivers a positive patient experience

Our quality priorities for 2016/17 have been discussed and agreed by our Board and encompass our guiding principles in relation to quality and safety, which are:

Principle 1:
We will build on our strengths and previous successes of quality initiatives already in place, and on our clinical governance infrastructure

Principle 2:
We will aim to eliminate all avoidable patient deaths and avoidable harm events

Principle 3:
We recognise the benefits of community integration, and will ensure our safety and experience systems follow the patient's journey

Principle 4:
We will ensure every member of staff is aware of their individual role and contribution in achieving our quality objectives, aligning to our 'Quality for all' values and behaviours

Principle 5:
We will implement a proactive safety and learning culture, integrating risk management into our day-to-day practice

Principle 6:
We will listen and involve patients to ensure the care we provide reflects our vision for patient experience: "I want to go there because I know it's the best place to be cared for" because we:

- Deliver the best possible outcomes
- Provide safe, efficient, timely care – in a caring, respectful way
- Deliver care as close to home as possible
- Have professional staff who listen and involve patients, carers and colleagues as part of the team
- Anticipate and understand patient and carer needs and tailor services to best meet them
- Involve patients and internal customers in continuous improvement and innovation.

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

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient and outpatient surveys
- Feedback from our Board of Directors and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Analysis of ward assurance framework and nursing metrics
- Quality and safety reports
- Internal and external reviews
- National policy
- Organisational strategies, namely: Patient Safety and Quality Strategy, Patient Experience and Involvement Strategy and our organisational development strategy.
- Feedback and observations from Healthwatch through joint partnership working
- Feedback from Stakeholders, partners, regulators, patients and staff in the development of our Quality Improvement Plan
- Governor feedback and reviews on what the focus of our 2016/17 quality priorities should be.

2.2 Key Quality Priorities for 2016/17

From our longer list of priorities we have identified three improvement areas which we would like to give particular focus to in 2016/17, shown in the table below:

	Priority description	Outcome
Key Priority 1	Reduce mortality as measured by hospital standardised mortality ratio. (HSMR) (QIP)	• To ensure that global and specific HSMR results fall within the expected range • To have an embedded mortality reporting system visible from service to Board • To eliminate the difference in weekend and weekday mortality as measured by HSMR
Key Priority 2	Recognise and respond effectively to deteriorating patients.	• To embed a recognised sepsis local protocol/screening tool within all areas of the Trust • To administer intravenous antibiotics to patients presenting with sepsis within one hour of presentation • Implement 2016 NICE guidelines for sepsis when released • To monitor improvement in recognising and responding to deteriorating patients
Key Priority 2	To improve the safe use of medicines.	• Zero medication-related Never Events • Increase the reporting rate for medication-related incidents and near-misses reported on Datix® and improve learning from incidents • Reduce the number of medication-related incidents resulting in moderate/severe harm by 25% (compared to 2015/16 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation

2.3 Key Priority 1 (this was also a priority in 2015/16) Reduce Mortality as Measured by Hospital Standardised Mortality Ratio (Key Priority 1 for 2016/17)

Introduction

Mortality rates are one of the indicators of quality of care. They help us understand the risks of hospital treatments for individual patients, changes in the patterns of disease over time and can point to improvements needed to reduce mortality. Changes in mortality rates over time in a given hospital may highlight changes in clinical practice and differences between hospitals may indicate areas to review. Whilst our mortality measured through HSMR has improved, the Trust has chosen to keep this as a key area of focus for 2016/17 so this remains a key priority.

The crude mortality rate looks at the absolute number of deaths that occur in a hospital in any given year and then compares that against the number of people admitted for care in that hospital for the same time period. It is not a sensitive measure because it is affected directly by the number of admissions and gives no indication of the type of patient and their risk of death. The total number of deaths varies from year to year and is influenced by factors such as extremes of climate and the severity of seasonal flu outbreaks.

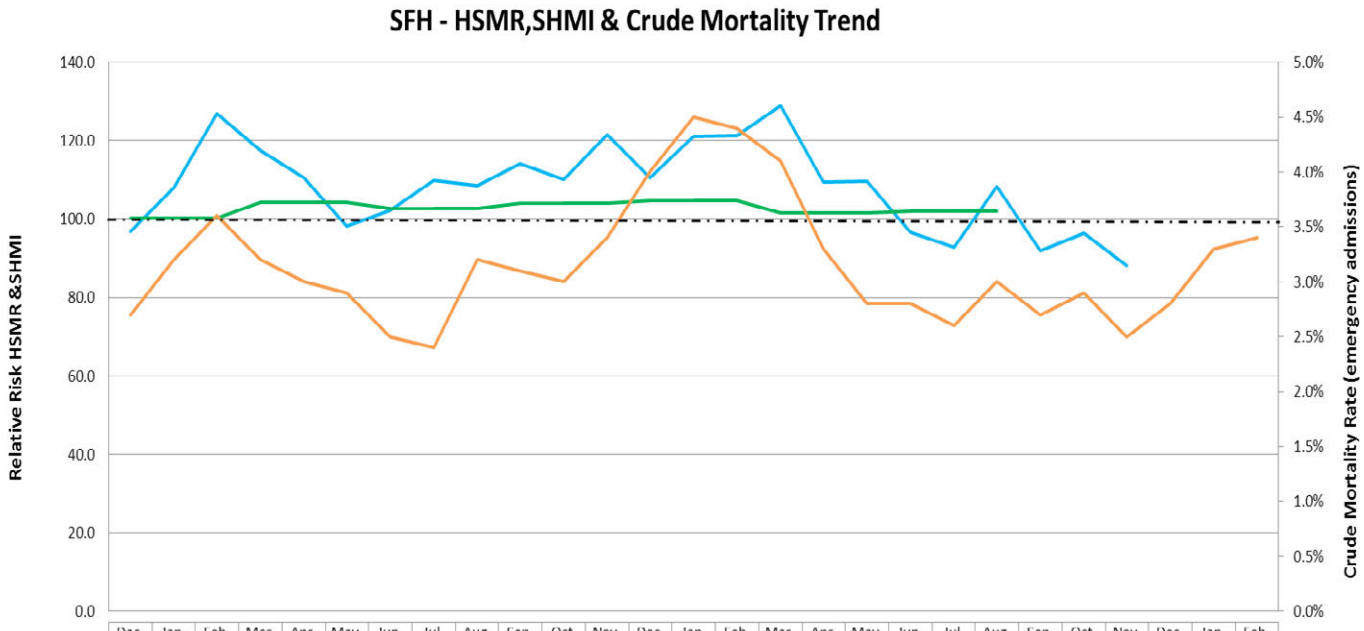
Standardised mortality rates are a way of allowing comparison between hospitals. By comparing risk factors (e.g. age, number of co-morbidities) in the local population against those for the whole of England, an expected number of deaths can be calculated. Comparison of the observed and expected deaths gives a ratio so that any number above 100 indicates more deaths than expected. The ratio will vary from one month to the next hence a normal range is described and values within this range indicate no excess of unexpected deaths. If the local population differs significantly from the average across England or the accuracy with which activity is coded differs significantly from average, the standardised mortality ratio can be falsely elevated. For these reasons, elevated ratios above 100 may indicate avoidable deaths related to clinical issues and require an understanding of local data.

The hospital standardised mortality ratio (HSMR) considers deaths in a 'basket' of conditions which cover 80% of deaths in hospital. The summary hospital mortality index (SHMI) covers all hospital deaths and those outside of hospital within 30 days of discharge.

What did we aim to achieve in 2015/16?

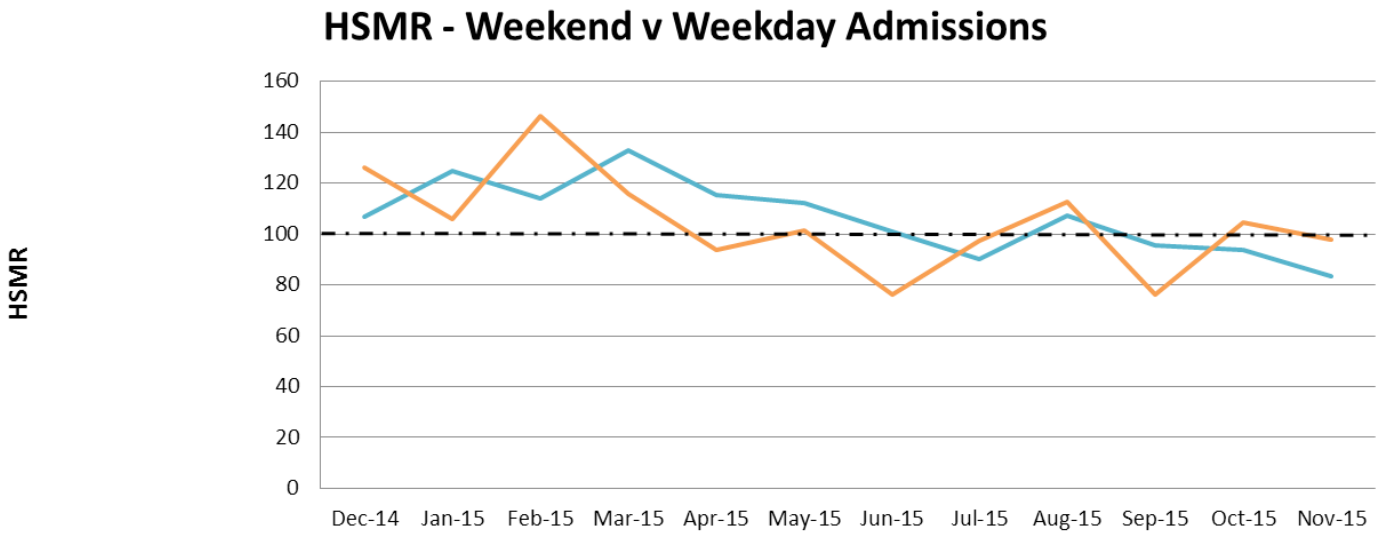
- Reducing HSMR and having an accurate expected mortality rate remained a high priority and required continuous audit and monitoring. Given that the results of the mortality review would suggest that the deaths are not avoidable, we planned to focus on coding, working with coders and clinicians to improve the recording of co-morbidities in particular
- Work to continue around weekday and weekend mortality as we continue our advances towards seven day services
- Widespread use of the mortality review format across all divisions and introduction of an electronic entry form and centralised database
- Use of alerts and reviews to continue developing new work streams to look at patient care
- Make use of the learning from reviews to share across the Trust and publish some of the successes to share learning externally

How are we performing against these targets?



	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
HSMR	96.9	108.1	126.9	117.6	110.5	98.2	102.3	109.9	108.5	114.1	110.0	121.6	110.5	121.1	121.3	129.0	109.4	109.7	96.6	92.8	108.4	91.9	96.3	88.1			
SHMI	100.2	100.2	100.2	104.3	104.3	104.3	102.6	102.6	102.6	104.1	104.1	104.1	104.6	104.6	104.6	101.5	101.5	101.5	102.1	102.1	102.1						
Crude Mortality SFH	2.7%	3.2%	3.6%	3.2%	3.0%	2.9%	2.5%	2.4%	3.2%	3.1%	3.0%	3.4%	4.0%	4.5%	4.4%	4.1%	3.3%	2.8%	2.8%	2.6%	3.0%	2.7%	2.9%	2.5%	2.8%	3.3%	3.4%

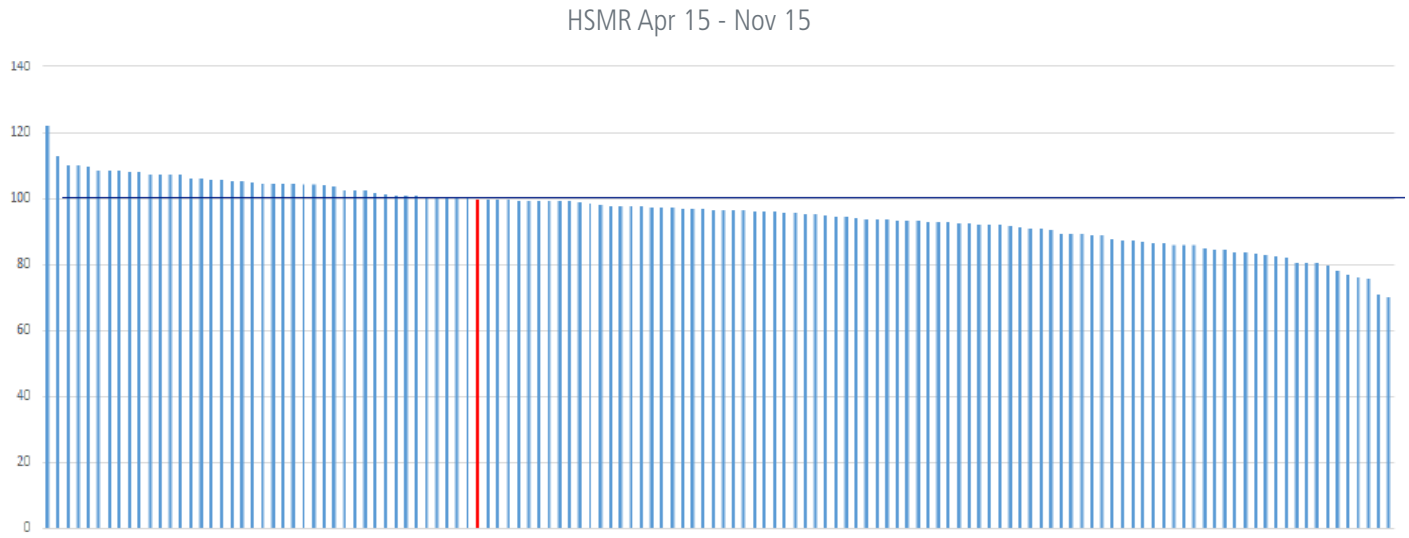
HSMR reduced to below 100 in June 2015 and has remained below or only just above since. There is always a lag of a few months in the availability of data nationally, but the indications are that we will continue to keep an HSMR close to 100.



	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Weekday Admission HSMR	106.89	124.61	114.11	132.67	115.17	112.09	101.05	90.09	107.06	95.52	93.82	83.29
Weeend Admission HSMR	126.01	106.10	146.18	115.83	93.74	101.48	76.25	97.15	112.57	76.19	104.61	97.80

The variation of HSMR between patients admitted at weekends and those admitted on weekdays has evened out and remains close to 100.

National HSMR



The red line represents Sherwood Forest Hospitals against all the other Trusts in the UK for the period from April 2015. In 2014 the HSMR was the worst in the country. In 2015, the position was sixth. The position is now much stronger.

How did we achieve this?

2015/16 has seen an intensive programme of work around mortality and HSMR. We have strengthened our care pathways in conjunction with our specialist physicians and increased front door availability of our specialist physicians, meaning that patients get the right treatment plans very early on in their admission, including at weekends. This results in shorter inpatients stays, improving the patient's experience.

There has also been a liaison between the clinical and coding teams to share an understanding of the HSMR and where we could improve. In March 2015, we introduced a new medical admissions booklet that included a document that identifies co-morbidities for that patient. The co-morbidities of a patient are one of the most significant things that affect their risk of dying (i.e. the 'expected' mortality that was referred to in the introduction). Work from both the clinicians (in terms of improved recording of co-morbidities), and the coders (in identifying them and their importance) has led to an increase in our figure for expected deaths, meaning that the ratio of crude to expected has come down. This can be seen in our decreasing HSMR since March.

At the same time, we have continued regular mortality reviews to ensure that we are monitoring for avoidable deaths. Any deaths where there is concern over care received have been investigated within the Trust's Serious Incident Investigation process. We have also responded to two Dr Foster HSMR Outlier alerts, one for a higher than expected HSMR in patients who received an endoscopy during their stay and one for a higher than expected HSMR in patients who had a primary diagnosis of electrolyte imbalance at the start of their admission. All cases were reviewed for both alerts (22 for the first and 13 for the second). The reviews showed that there were no avoidable deaths, but we were able to further reinforce the importance of recording correctly for the coders to code appropriately.

The mortality review form is now available in electronic format across the Trust, which will bring valuable data about the deaths in our hospital.

Monitoring and Reporting for Sustained Improvement

HSMR has improved greatly as a result of the work that has been done over the last few years. We need to ensure that this continues. Even areas where HSMR is no longer above expected, such as pneumonia and stroke, are regularly monitored and review will be on-going.

We have recently terminated the Trust Mortality Group (TMG) and introduced a Mortality Surveillance Group (MSG), with a membership drawn from senior personnel across the Trust divisions and including informatics. This group will be reporting directly to the Quality Committee to provide assurance regarding mortality in the Trust. The Quality Committee will then be able to report this to the Board of Directors.

The MSG is supporting the use of the electronic mortality review tool by all specialities to provide the information that they need in their local mortality and morbidity groups. This learning is then to be reported and shared at divisional level and Trust level through the MSG. Specialities will be required to present regularly to the group. Use of the electronic tool will mean that most deaths in the Trust will be reviewed before even the data is available from Dr Foster. The MSG will be able to take that data and analyse it, looking for themes and trends that need to be reviewed.

Any areas of concern, whether from this internal analysis or from external alerts, will be assigned to the appropriate division/speciality to investigate and report back to the MSG, so that learning and improvements can be shared. This will result in a continuous improvement cycle aimed a sustaining the optimal care for our patients and an HSMR that reflects our patients and that care.

2.4 Key Priority 2 (amended priority for 2016/17) Recognise and Respond Effectively to Deteriorating Patients (Key Priority 2 for 2016/17)

Introduction

In 2015/16 the Trust had a key priority to reduce mortality from sepsis. This work, undertaken during the year and as discussed below, identifies the Trust's improved position. Sepsis remains an important area of focus for the Trust; however we recognise that the same improvement focus needs to be in place for all patients whose clinical condition deteriorates. For this reason we have chosen to extend our focus from sepsis to recognise and respond effectively to deteriorating patients.

The first part of this section describes work undertaken in 2015/16 during which the focus was on improving the management of sepsis and thereby reducing sepsis-related mortality. Sepsis is a medical emergency; it arises when the body's response to an infection injures its own tissues and organs and can rapidly lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly. Sepsis claims 44,000 lives annually in the U.K and those who survive sepsis can be left with long-term problems requiring substantial support during rehabilitation.

Patients with severe sepsis or septic shock have a mortality (death) rate of about 40-60%, with the elderly and very young most at risk. Similar to patients who have multiple traumatic injuries as a result of an accident, acute myocardial infarction or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence outcome. In hospital, sepsis is one of the most common causes of patient deterioration; it is thought problems in achieving consistent recognition and rapid treatment of sepsis contribute to the numbers of preventable deaths from sepsis seen nationally.

Critical to improving survival rates is screening patients for suspected sepsis. This enables early identification and timely delivery of the sepsis care bundle. This is a collection of clinical interventions that when delivered promptly within the first hour of diagnosis, can significantly improve chances of recovery. The most crucial element of the bundle is administration of intravenous antibiotics. The importance of screening for sepsis and administration of antibiotics is recognised in their selection as a quality indicator during 2015/16 (national CQUIN) in order to drive and performance manage the improvements required regarding sepsis care.

What did we achieve during 2015/16?

Our performance for screening emergency admissions for suspected sepsis exceeded the required target.
2014/15

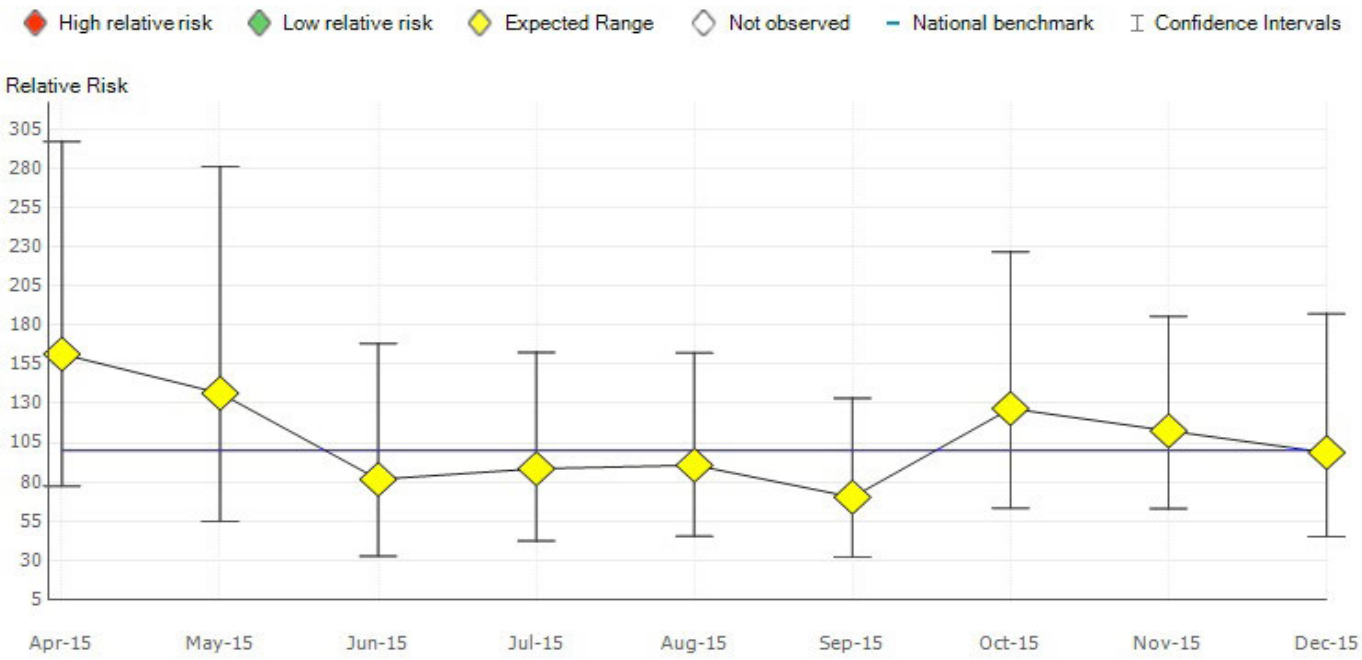
Quarter	Target Set	Results Achieved
Q1	None	57.1%
Q2	90%	94.1%
Q3	90%	99.3%
Q4	90%	99.3%

Our performance for administering intravenous antibiotics, within 60 minutes of arrival at hospital, in cases of severe sepsis exceeded the required target. Measurement commenced in Q2.

Quarter	Target Set	Results Achieved
Q2	None	75%
Q3	82.5%	88.8%
Q4	90%	100%

During 2015/16 sepsis-related mortality (HSMR) has fallen within the expected range and significantly reduced from 2014/15.

Graph 1. Sepsis related HSMR from April – December 2015



How did we achieve this?

Improving sepsis care has been a top safety priority for us in 2015/16. A Sepsis Steering Group monitors performance on a weekly basis and has multi-disciplinary involvement. The audit and improvement program has been supported by a drive to engage staff at all levels, shared learning through governance and training and education packages.

Why has this indicator been chosen for 2016/17?

2016/17 is the third year that sepsis forms part of a quality priority for the Trust. Nationally and locally the importance of early identification of sepsis and delivering all elements of the sepsis care bundle has been recognised, with sepsis being a national CQUIN for 2016/17. We have realised improvements in sepsis care and in reducing sepsis mortality through focussed work and in 2016/17 are extending the focus of our improvement work using our existing methodology and engaging with other partners to recognise and respond effectively to all deteriorating patients, thereby reducing morbidity and mortality from deteriorating patients.

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

Monitoring and reporting for sustained improvement

Sepsis improvement will remain a Trust priority for us during 2016/17. NHS England has published a cross-system action plan for improving outcomes for patients with sepsis, which will also guide our work this year. The Sepsis Lead Nurse is now a substantive post and will continue to work at both a local and national level to continue the improvement made thus far.
The newly formed Patient Safety and Quality Board (PQSB) chaired by the Medical Director will receive assurance reports which focus on monitoring and improve care delivered to deteriorating patients.

2.5 Key Priority 3 (new priority for 2016/17) To Improve the Safe Use of Medicines (Key Priority 3 for 2016/17)

Introduction

Improving the safe use of medicines has been a quality priority for the Trust in previous years, however recognising the national drive to improve medicines incident reporting and ensure safer care, we have chosen, in 2016/17, to make this a key priority.

As an organisation we are striving for the safest possible use of medicines. Medicines are the most commonly used intervention in the NHS, account for the second greatest spend after staff and are inherently one of the highest risks to patient safety. There is a continual stream of national guidance relating to safe use of medicines and a heightened requirement for improvement nationally – NHS England required all Trusts to introduce Medication Safety Officers to oversee, advise and assist Chief Pharmacists in setting the strategy for improving safety of medicines usage. Medication usage is so commonplace in hospitals that healthcare professionals can become blasé and hence underestimate the potential implications of poor practice and lack of attention when prescribing, administering or dispensing medicines. We are aiming to ensure that all healthcare staff that handle medicines do so in a manner that optimises their usage and protects patients from harm.

Why is medicines safety a priority?

Nationally medication safety is high profile and within SFH we have identified that there is scope for considerable improvements in how we handle medicines. Previous targets to make safety improvements have achieved variable levels of success. Moving medicines safety to a Trust priority will help to engage all staff in this agenda and drive safer practice.

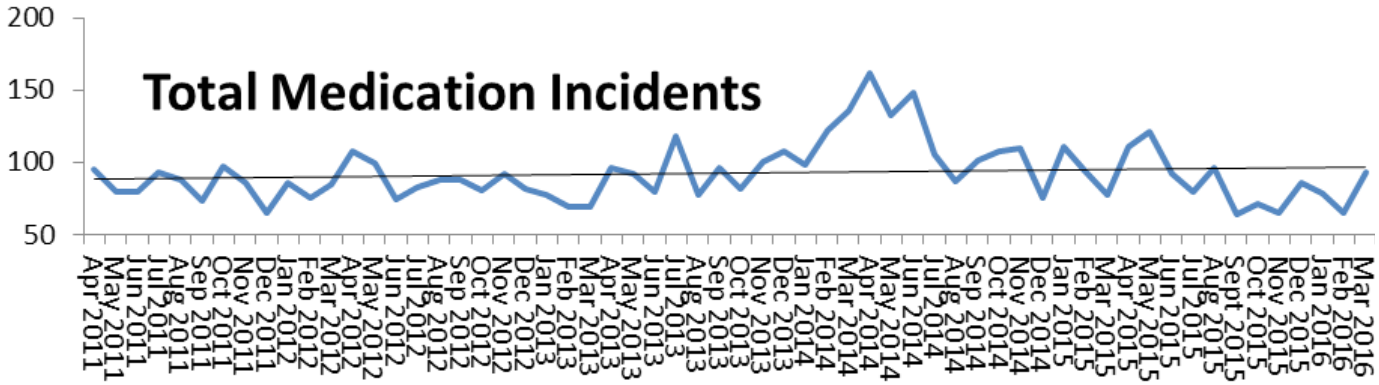
What did we aim to achieve during 2015/16

- To achieve zero medication-related Never Events

This objective was achieved, no medication-related Never Events occurred within any of our hospitals. Neighbouring Trusts have reported Never Events around incorrect route of administration of medicines, namely oral medicines being given intravenously. We have taken on board the shared learning from these events.

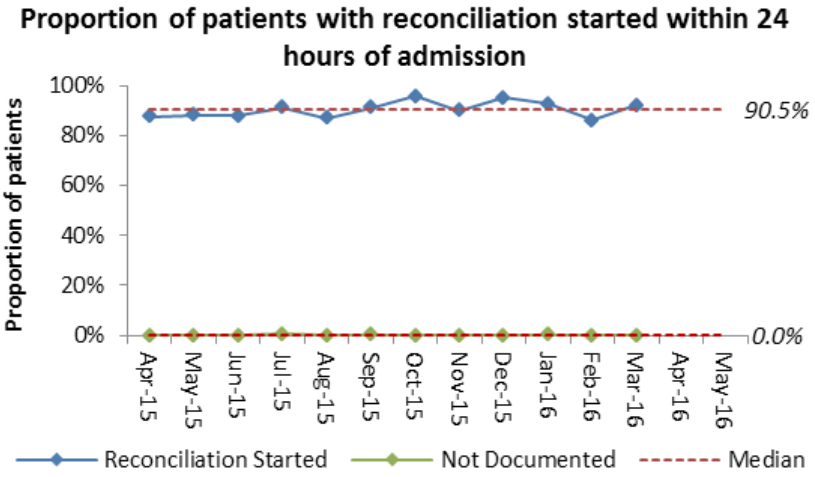
- To increase the number of medication-related incidents and near misses reported on Datix®

This objective was not achieved. NHS England issued a directive to organisations requiring the appointment of Medicines Safety Officers and introduction of processes to encourage recording of medication incidents. Incident reporting has been high profile and encouraged for example via newsletters and directives to report all missed doses of critical medicines via Datix® ; however this is clearly not having the desired impact.
Our ability to achieve this objective will be strengthened and we aim to achieve this within 2016/17.



- To increase the number of patients whose medicines are reconciled by pharmacy staff within 24 hours of admission to hospital

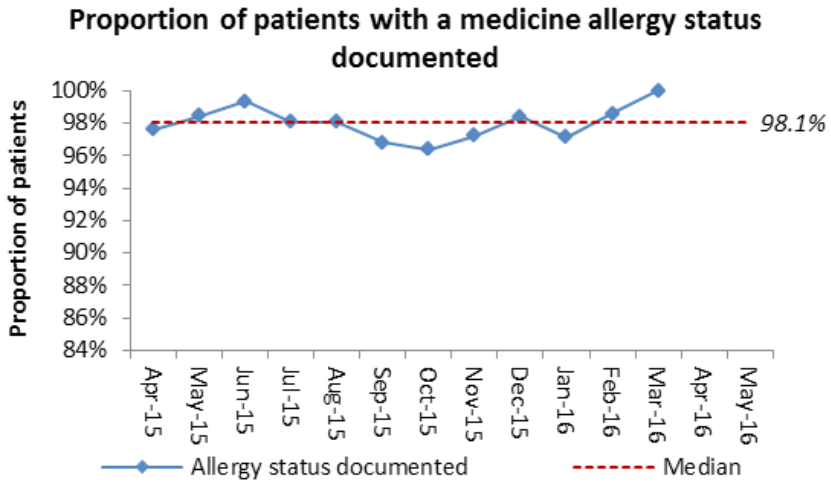
It is recognised that one of the highest rates of errors with prescribing of medicines occurs when patients are moved between care settings. Medicines reconciliation helps ensure that patients are taking the medicines as intended. Nationally a target of 95% reconciliation within 24 hours has been set, but few organisations are able to achieve this level.



When the Trust agreed this target it had been anticipated that seven-day services would be extended within pharmacy and that this would assist increasing our reconciliation rate. Due to financial pressures, funding was not available to allow this and our reconciliation rates have remained steady. Audits of reconciliation across the East Midlands have demonstrated that SFH is the second highest performer in reconciling patients' medication within 24 hours of admission.

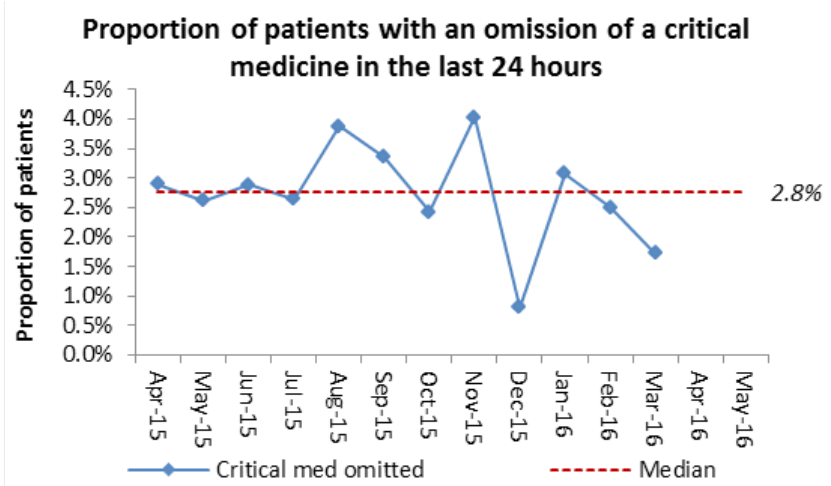
- To ensure all patients have a documented allergy status on prescriptions

Patients are at risk of serious harm if they receive a medicine to which they are allergic. We have a policy in place that stipulates the requirement for completion of allergy status for all patients before medicines are supplied or administered. The National Medication Safety Thermometer tool allows us to monitor our performance against allergy documentation, which lies at around 98%. There will be a focus on medication allergy recording and preventing administration of medicines to which patients are allergic in 2016/17.

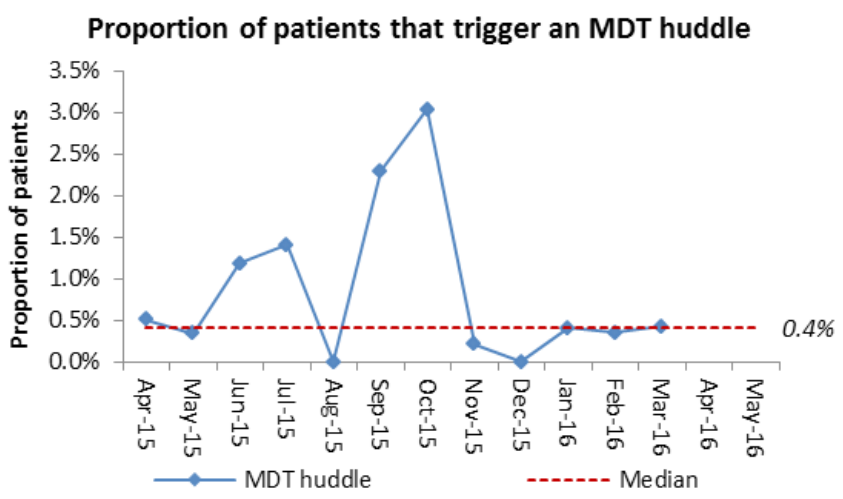


- To reduce the number of patients with omitted doses of critical medicines (e.g. antibiotics, insulin etc.)

Over that last 18 months the organisation has undertaken a significant amount of improvement work on reducing the number of missed doses of medicines. There has been a particular focus on critical medicines (this was a requirement of the National Patient Safety Agency) and we have demonstrated improvements in our omission rates. The Medication Safety Thermometer shows our Trust to be one of the high performing Trusts for missed critical medicines and we wish to build on these strong foundations moving forward into 2016/17 and further reduce the risk to our patients.



- To reduce the number of medication-related incidents resulting in 'harm'. Such incidents involving 'high-risk' medicines (e.g. insulin, anticoagulants etc.) to be specifically highlighted



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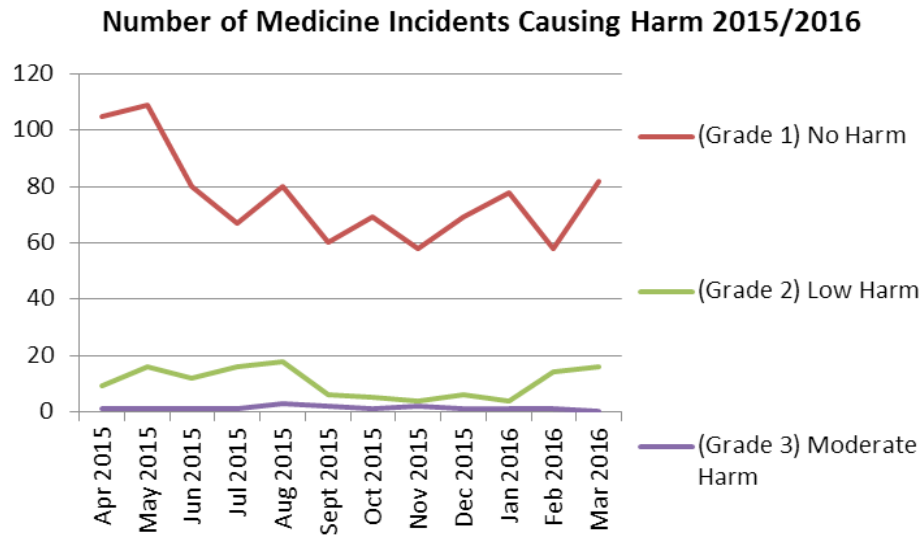


Diagram 1 – Summary of strategic plan

Following the introduction of our Medication Safety Officer we now have strong systems in place to focus on medicines safety. One of the areas that the Medicines Safety Group(MSG) particularly concentrates on is the analysis of reported incidents relating to medicines and highlighting to healthcare staff where there are particular safety concerns with use of particular medicines or where there is a high potential, for example confusion between products, mistakes with administration or inherent risk of harm from certain medicines. For most high-risk medicines, we have seen a stable reporting rate, an increase in warfarin-related reporting but for actual harm there has not been a discernible change. For the year there were 12 medicine errors (of moderate harm or above), which resulted in harm.

What do we aim to achieve in 2016/17?

We have focussed on a number of achievable goals to help protect our patients these are:

- Zero medication-related Never Events
- Increase the reporting rate for medication-related incidents and near-misses reported on Datix® and improve learning from incidents
- Reduce the number of medication-related incidents resulting in moderate/severe harm by 25% (compared to 2015/16 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc

We will achieve this by undertaking the following work:

- To achieve zero medication-related Never Events

The Trust continues this as a priority from 2015/16.

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

The Trust currently uses CareFusion pumps as standard in all areas. These pumps have the capacity to use dose error reduction systems (DERS) to assist with medication management and safety when using infusion pumps. The pumps may be pre-set with infusion 'limits' which will minimise, if not remove the risk of an incorrect dose being administered to a patient via this route. There is currently no safety mechanism from the infusion pump to highlight or stop any errors in the ml/hr rate inputted. The correct rate relies on correct prescribing, correct rate calculation and correct inputting of the rate. The DERS allows 'soft limits' (can be overridden) to be established to prevent under/overdosing and allows the setting of 'hard limits' (no override). The user is alerted via the device when a limit is reached or breached.

The DERS system would record all events in its memory which can be downloaded and analysed to assist users to learn from infusion practice problems.

- Revitalisation of self-administration of medicines across the Trust

Self-administration of medicines was introduced to SFH in 2004 and we have had an extant self-administration policy since this date. The uptake of self-administration has not been great and hence a working group has been tasked to revisit the policy and work with specific wards to reintroduce a process that should ensure we are providing self-administration for those patients who will benefit or who specifically wish to self-administer their medicines during their stay.

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

During 2015 there were 18 documented instances recorded on Datix® of patients having received medicines to which they had a documented allergy. Each case has the potential to cause fatality. Improvement work will be undertaken to:

- Ensure all patients have a documented allergy status on their prescription
- Reintroduce the 'zero tolerance' policy for allergy documentation
- Ensure no patients receive medication to which they are allergic

Data from the Medicines Safety Thermometer can be used to track progress against the target of 100% documentation. Historically, the organisation resisted the introduction of red wrist bands to alert staff of patient allergy status and SFH is now an outlier in this respect, hence we will now be introducing this system to help protect our patients from harm from inadvertent administration of medicines to which they are allergic.

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

Medication is currently the second highest reported incident category within the Trust, but this is not a true reflection of the number of medication incidents and it remains under-reported. In reality we know that medication incidents should be the highest reported incident group in acute hospitals: in November 2015, the pharmacy department carried out a continuous data collection where all interventions made by the Pharmacy Team are recorded for seven days. Although not all of these would be entered into

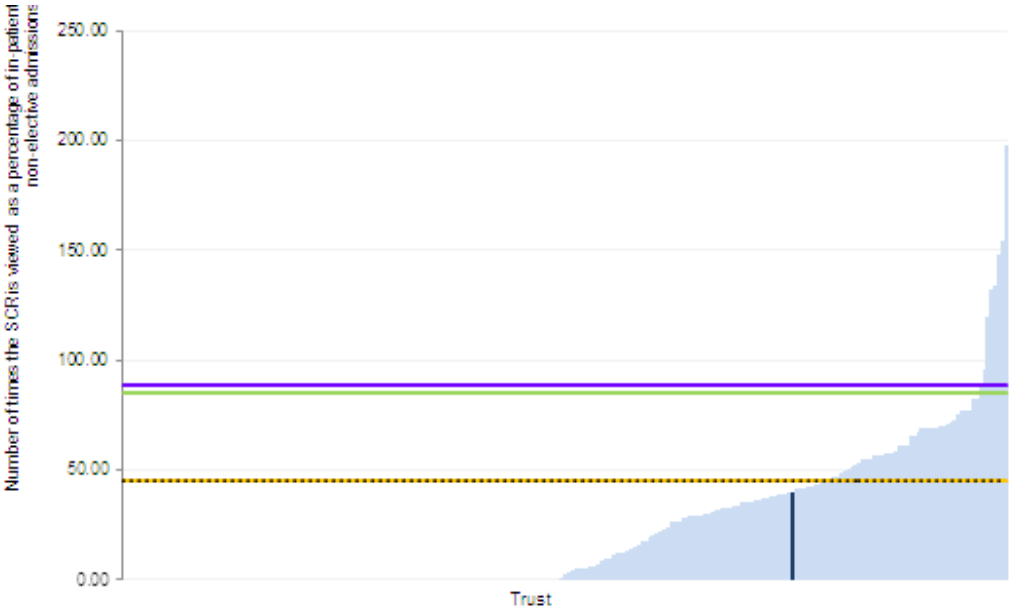
Datix®, 1649 contributions were made in a seven-day period. Of this total, 113 were considered to be 'major' issues that could have caused patient harm, but only two were recorded onto Datix®. There is significant work to be done with regard to medication incident reporting for all disciplines. Clinical areas will be set targets for reporting of medication incidents based on the volume of usage of medicines. This should drive an improvement in the reporting culture for medicines.

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

Although SFH is a high performing Trust within the East Midlands, in terms of reconciliation of medicines, we are still aiming to improve our performance. The original national target was set at 95% within 24 hours and the ideal would be to reconcile 100% of patients' medicines. We will be aiming to build on our current performance with the ideal of reaching the 95% target.

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

Not all medical staff currently have access to the Summary Care Record which is a national database containing details of patients' medication prescribed via GP practices. Allowing medical staff access to this database may assist in achieving a higher rate of medicines reconciliation. Work is being completed by the Trust in early 2016/17 to ensure all appropriate staff have access to the summary care record.



Key:

East Midland average

Derbyshire/Nottingham area average

Non-specialist Trust average

England average

The above graph shows the level of access at SFH (dark blue line) compared to other Trusts in the country. Over 100% access represents access to the SCR more than once for a particular patient.

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

Considerable work has already been undertaken across all wards within the Trust to minimise the number of patients who miss or have a delayed dose of medicine. For critical medicines the potential for patient harm is greater and hence robust processes should be in place to help minimise missed/delayed doses of this group of medicines.

- To reduce the number of medication-related incidents resulting in moderate / severe harm by 25% (compared to 2015/16 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

Although we wish to increase the overall reporting rate of incidents and near misses, the underlying goal is to reduce harm from medicines and hence the target to reduce moderate and severe harm.
There is gross under-reporting of medication incidents and tackling this is one of the key factors in preventing patient harm.

Monitoring, measurement and reporting

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

The Medicines Management Committee reports to the Patient Safety and Quality Board and progress reports will be taken via this route.

2.6 Additional Quality Priorities for 2016/2017

We have identified a number of supplementary quality priorities in line with Quality Account requirements that will be implemented during 2016/17. A summary of our quality priorities is included in the table below:

	2016/17 priority	Target/outputs
IMPROVING THE SAFETY OF OUR PATIENTS	To reduce the number of Clostridium difficile cases reported (Contract/CQUIN)	• To reduce the number of Clostridium difficile cases reported during 2015/16 to less than 48 cases • Reduce antibiotic consumption and encourage prescribing reviews within 72 hours of commencing antibiotics (CQUIN)
	Reduce harm from falls	• To reduce the number of inpatients falling in hospital against an agreed trajectory to less than the national average per 1000 occupied bed days • To deliver a safety improvement programme utilising best practice both from a local and national perspective • Work in collaboration with Alliance partners to reduce harms from falls • To review the impact of the redeveloped enhanced patient care tool
	To reduce the number of urinary tract infections (UTIs)	• To reduce the total number of hospital acquired urethral catheter associated bacteraemia cases to less than five cases per year
	Underpinning these objectives will be the continued development of the Trust's safety culture and sign up to the safety campaign	
IMPROVING THE EFFECTIVENESS OF CLINICAL CARE	Hospital length of stay (Contractual)	• To reduce average length of stay for general and acute patients
	Improve the discharge information for acute kidney injury (AKI) diagnosis and treatment in hospital	• The stage of acute kidney injury to be recorded in the medical records and communicated to the patient's General Practitioner (GP) • Evidence of a medication review having been undertaken • The type and frequency of blood tests required on discharge for monitoring to be communicated to the patient's GP
	To improve the experience of patients who are coming to their end of life (QIP)	• Embed the role of End of Life champions ensuring champions have the right skills and knowledge to enhance End of Life care. • Working in collaboration with partners to increase the number of patients who die in their preferred place of care • To ensure that patients are discharged safely and effectively, underpinned by robust communication with care planning principles in place • Evidence of specific end of life training in place
	Underpinning these objectives will be the continued implementation of care and comfort rounding, accountability handover and expansion of the VitalPAC project	
IMPROVING PATIENT EXPEREINCECARE	Improve the experience of care for dementia patients and their carers (QIP/ Alliance Outcome)	• To find, assess, refer and inform (FAIR) all patients over the age of 75 admitted to hospital for emergency, unplanned care • Provision of a dementia training programme • To enhance the provision of support to carers
	Ensure that our complaints system and processes are robust, responsive and support organisational learning	• Ensure that complaint responses are effectively managed within national timescales • Evidence a reduction in the number of unresolved cases • Demonstrate organisational learning from patient feedback and complaints • Demonstrate Duty of Candour in line with national requirements
	Safeguarding	• To ensure that safeguarding training (Level 2 / 3) targets are achieved • To ensure that Mental Capacity Assessment (MCA) and Best Interest systems and processes are embedded within clinical practice • To further embed the recently implemented safeguarding champion model • Evidence an improvement in the identification, management and delivery of safe personalised care of patients with Mental Health conditions
	Underpinning this objective will be the continued delivery of the patient experience and involvement and organisational development strategies.	

Many of our priorities focus on similar aspects to 2015/16 and we would direct the reader to the data quality section of the Quality Account. This section also updates the reader on mandated elements of the Trust Quality Account, including the staff survey.

These priorities were chosen following patient, staff and stakeholder feedback which helped form our Quality Improvement Plan post CQC visit and reflected the focus of quality improvement work for the Trust. Stakeholders, particularly our CCG, were involved in finalising and agreeing the final set of quality priorities.

2.7 How do we Monitor the Progress of 'Key Priorities'

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

The Trust has developed a new comprehensive committee and governance structure which reports from ward to Board (Appendix 1). This ensures effective monitoring systems are in place to track progress against each of our key priorities.

Throughout 2015/16 the Trust Board received monthly and quarterly quality reports, which identified how we were performing against a range of key performance indicators. This will continue and the three key priority areas will be reported monthly to the Board. This reporting process is underpinned by a strengthened assurance process whereby formal monitoring and measurement of our quality priorities during 2016/17 will be undertaken across a range of committees and groups, these in turn report into the Quality Committee and Board of Directors. Please see Appendix 1 for committee structure.

Further scrutiny and assurance will be facilitated via the quality and performance meeting attended by the Clinical Commissioning Group (CCG) and Sherwood Forest Hospitals executive directors.

2.8 Statement of Assurance from Board

Review of Services

During 2015/16 Sherwood Forest Hospitals NHS Foundation Trust provided 59 mandated relevant services.

The Trust has reviewed all the data available to it on the quality of care in 59 of these relevant services.

Each year we look after over 75,000 inpatients, 420,000 outpatients, 146,337 attendances to our emergency department, and over 3,400 women who choose to give birth at King's Mill Hospital. We employ 4,344 staff, including 156 specialist consultants, working in hospital facilities that are some of the best in the country.

The income generated by the relevant health services reviewed in 2015/16 represents 86% of the total income generated from the provision of relevant health services by Sherwood Forest Hospitals NHS Foundation Trust for 2015/16.

Our overriding aim is to ensure that quality is at the heart of everything that we do as we strive for continuous improvement and safe, personalised care. In order to ensure that quality is a high priority we formally report on our progress against our quality priorities to the Board of Directors on a monthly and quarterly basis.

Further assurance and triangulation is sought and received via our established Internal Assurance Team (IAT) framework, quality visits undertaken by our Clinical Commissioning Group colleagues, senior leadership walkrounds, nursing metrics and ward assurance framework.

All of the above is linked to our revised committee structure (Appendix 1).

2.9 Participation in Clinical Audits

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

Participation in Clinical Audit

During 2015/16, 45 national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides During that period we participated in 95.5% of national clinical audits and 100% of national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2015/16 are as follows:

National Clinical Audit & Enquiry Project Name
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Bowel Cancer (NBOCAP)
Cardiac Rhythm Management (CRM)
Case Mix Programme (CMP)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Emergency Use of Oxygen
Falls and Fragility Fractures Audit programme (FFFAP)
Inflammatory Bowel Disease (IBD) programme
Major Trauma Audit
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
National Comparative Audit of Blood Transfusion programme (NCABTP)
National Complicated Diverticulitis Audit (CAD)
National Diabetes Audit - Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Ophthalmology Audit
National Prostate Cancer Audit
Neonatal Intensive and Special Care (NNAP)
Oesophago-gastric Cancer (NAOGC)
Paediatric Asthma
Procedural Sedation in Adults (care in emergency departments)
Rheumatoid and Early Inflammatory Arthritis
Sentinel Stroke National Audit programme (SSNAP)
UK Cystic Fibrosis Registry
UK Parkinson's Audit
Vital signs in children (care in emergency departments)
VTE risk in lower limb immobilisation (care in emergency departments)

National Clinical Audits 2015/16

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Name	Workstream (if more than one)	Included in NHSE Quality Account List (2015/16)	Part of NCAPOP commissioned by HQIP (Y/N)	Submission Rate (%)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	N/A	Y	Y	100%
Bowel Cancer (NBOCAP)	N/A	Y	Y	100%
Cardiac Rhythm Management (CRM)	N/A	Y	Y	100%
Case Mix Programme (CMP)	N/A	Y	N	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	N/A	Y	Y	100%
Diabetes (Paediatric) (NPDA)	N/A	Y	Y	N/A
Elective Surgery (National PROMs Programme)	N/A	Y	N	92.50%
Emergency Use of Oxygen	N/A	Y	N	100%
Falls and Fragility Fractures Audit programme (FFFAP)	N/A	Y	Y	59%
	Inpatient Falls	Y	Y	100%
	National Hip Fracture Database	Y	Y	100%
Inflammatory Bowel Disease (IBD) programme	N/A	Y	Y	59%
Major Trauma Audit	N/A	Y	N	98.90%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Y	Y	100%

National Clinical Audit Name	Workstream (if more than one)	Included in NHSE Quality Account List (2015/16)	Part of NCAPOP commissioned by HQIP (Y/N)	Submission Rate (%)
Clinical Outcome Review Programme	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	Y	100%
	Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Y	Y	100%
	Maternal mortality surveillance	Y	Y	100%
National Cardiac Arrest Audit (NCAA)	N/A	Y	N	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	Y	Y	100%
	Secondary Care	Y	Y	100%
National Comparative Audit of Blood Transfusion programme (NCABTP)	Use of blood in Haematology	Y	N	100%
	Audit of Patient Blood Management in Scheduled Surgery	Y	N	100%
National Complicated Diverticulitis Audit (CAD)	Acute surgical services	Y	N	100%
National Diabetes Audit - Adults	National Footcare Audit	Y	Y	100%
	National Pregnancy in Diabetes Audit (NPID)	Y	Y	100%
National Emergency Laparotomy Audit (NELA)	N/A	Y	Y	100%
National Heart Failure Audit	N/A	Y	Y	100%
National Joint Registry (NJR)	Knee replacement	Y	Y	100%
	Hip replacement	Y	Y	

National Clinical Audit Name	Workstream (if more than one)	Included in NHSE Quality Account List (2015/16)	Part of NCAPOP commissioned by HQIP (Y/N)	Submission Rate (%)
National Lung Cancer Audit (NLCA)	Lung Cancer Consultant Outcomes Publication	Y	Y	100%
National Ophthalmology Audit	Adult Cataract surgery	Y	Y	0%
National Prostate Cancer Audit	N/A	Y	Y	100%
Neonatal Intensive and Special Care (NNAP)	N/A	Y	Y	100%
Oesophago-gastric Cancer (NAOGC)	N/A	Y	Y	100%
Paediatric Asthma	N/A	Y	N	100%
Procedural Sedation in Adults (care in emergency departments)	N/A	Y	N	100%
Rheumatoid and Early Inflammatory Arthritis	Clinician/Patient Follow-up	Y	Y	0%
	Clinician/Patient Baseline	Y	Y	
Sentinel Stroke National Audit programme (SSNAP)	N/A	Y	Y	100%
UK Cystic Fibrosis Registry	Paediatric	Y	N	100%
UK Parkinson's Audit	Occupational Therapy	Y	N	100%
	Speech and Language Therapy	Y	N	
	Physiotherapy	Y	N	
	Patient Management, elderly care and neurology	Y	N	
Vital signs in children (care in emergency departments)	N/A	Y	N	100%
VTE risk in lower limb immobilisation (care in emergency departments)	N/A	Y	N	100%

National Clinical Outcome Review Projects 2015/16

The national clinical audits and national confidential enquiries that we participated in during 2015/16 are as follows:

Study Title	Participation	Project Status	%
Sepsis	Yes	Cases submitted	100%
Gastrointestinal Haemorrhage	Yes	Cases submitted	100%
Mental Health	Yes	Cases submitted – study still open	n/a
Acute Pancreatitis	Yes	Cases submitted	100%
MBRRACE-UK	Yes	Continuous submission	100%

Outcomes and Learning from Clinical Audits Undertaken During 2015/16

The number of clinical audits both national and local which formed part of the 2015/16 Audit Plan were as follows:

Total Number of Audits of the 2015/16 Plan:	**140**
Number of Local Audits:	**96**
Number of National Audits, inc NCEPOD:	**44**
Number of Audits still on-going (as at 31st March 2016):	**118**
Number of Audits completed:	**22**

The reports of eight national and local clinical audits were reviewed by the provider in 2015/16 and we have taken the following actions to improve the quality of healthcare provided. Below are examples of some of the clinical audits undertaken during 2015/16.

Key
Learning around Patient Safety
Learning around Clinical Effectiveness
Learning around Patient Experience

Audit: National Emergency Laparotomy Audit (NELA)

Patient Safety
Clinical Effectiveness
Patient Experience

Following our participation in this audit we have been able to obtain more reliable implementation of evidence-based standards of care, for example: consultant-led decision making and presence in theatre, use of intra-operative cardiac output monitoring, formal assessment of risk and increased involvement from the Healthcare of the Elderly Team for post-operative rehabilitation.

Audit: National Cardiac Arrest Audit (NCAA)

Patient Safety
Clinical Effectiveness
Patient Experience

This audit has evidenced that cardiac arrest rates are declining both in terms of overall numbers and rate per 1000 admissions. Since the audit began in 2010, arrests have dropped from 169 to 95 per 1000 admissions. We have improved our training for clinicians in acute illness management and we have undertaken a similar local audit which has enabled us to further highlight and explore any potential failures in care.

Audit: Audit of our practice against standards set by the National Chlamydia Screening Programme
Patient Safety
Clinical Effectiveness
Following a review of our already excellent work, an audit was undertaken to review our practice in relation to chlamydia screening. As a result of this audit, some proactive action has been taken including:
- All of our client records are now computerised
- All clinical proformas include reminders about sexual health
- We have worked to improve our education around 'partner notification' – potentially affected partners

Audit: National Audit of Inpatient Falls
Patient Safety
Clinical Effectiveness
Patient Experience
Following our participation in the pilot audit and subsequent national audit. The information extracted from this audit has enabled us to put improvement measures in place such as:
- A multidisciplinary group developing a falls strategy
- New screening processes to identify patients at risk
- Nurse call bell systems in all cubicles in ED
- Medication review of medicines that increase the risk of falls
- Better mobility assessment and improved access to walking aids

Audit: Sentinel Stroke National Audit Programme (SSNAP)
Patient Safety
Clinical Effectiveness
It is encouraging that this year we have made, and continue to make, significant progress in this audit. Last year we were rated a D and our last review rated us a B. This demonstrates the hard work and effort demonstrated by the team.

Audit: An audit of the timelines of inpatient referrals to the Orthotics team
Patient Experience
An audit was undertaken to review and improve the access to treatment for patients by identifying key delays in the discharge process. It identified that the majority of significant delays were happening as a result of incorrect or missing documentation. Work has taken place to ensure that documentation is completed correctly, reducing the wait time for patients accessing the Orthotics service.

Audit: Re-audit of haematology patients admitted with suspected neutropenic sepsis
Patient Safety
Clinical Effectiveness
A re-audit was undertaken following discouraging results in a previous 2011 audit. Results indicated a substantial improvement compared to 2011 and full compliance with standards relating to care later than 24 hours from admission. The 'door to antibiotic' time has also improved considerably and this undoubtedly reflects the overall improvement measures put in place over the last 18 months in relation to sepsis.

Audit: Observational Audit of Dementia Patients mealtimes and routines
Patient Safety
This audit was undertaken to review the mealtime arrangements for dementia patients and to explore what improvements could be made. It found that more awareness was needed of 'This is me' booklet. It also found that more promotion around carers and relatives being able to complete the booklet is required. A further improvement which was identified was to ensure that protected mealtimes across all wards happens.

Looking Back in 2015/16

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

- National Emergency Laparotomy Audit (NELA)
- Discharge Jonah Orthotics Audit
- Neonatal Intensive and Special Care Audit (NNAP)
- National Cardiac Arrest Audit (NCAA)
- National Hip Fracture Database
- National Inpatient Falls Audit
- Management of Suspected or Diagnosed Aneurysmal Subarachnoid Haemorrhage
- Paediatric diabetes audit
- Woolley safeguarding audit

In addition to this, work has been on-going in the following areas:

- Work has been undertaken to move away from paper based data collection in audits, to electronic data collection using a newly purchased system called Meridian; this enables real-time reporting and cuts out the need for separate input and analysis. The system has been warmly received and our three priority Trust-wide audits are now available and ready for online completion. These include medical and nursing health record keeping, medical consent and prescribing
- Work has taken place to ensure the clinical audit intranet site is both useful and fit for purpose. It includes useful information e.g. information on conducting clinical audit, clinical audit training and e-registration of audit
- A new clinical audit database has been developed which now enables better reporting for specialties and divisions to keep track on their audit activity
- An electronic audit registration process has been developed to enable Trust teams and individuals to register their audits online; this automatically feeds into the new clinical audit database
- A new Clinical Audit Policy has been developed to reflect the new systems, processes, and current best practice in clinical audit
- Regular clinical audit training sessions have been set up for all levels of staff to attend. The feedback from these training sessions has been positive.
- Key Performance Indicators (KPI's) and standard operating procedures (SOP) have been developed around obtaining patient notes for the purposes of clinical audit in conjunction with Case Notes Store

Looking Forward to 2016/17

- In 2016/17 one of our main objectives in clinical audit will be the engagement of our staff, including clinicians in clinical audit. During the last year we have spent time addressing shortfalls in our systems and processes which we now believe to have significantly improved in their robustness.
- The work of the Clinical Audit Officer will be refocused to ensure their work concentrates on the findings from clinical audits and that the learning and outcomes are disseminated.
- Collaborative work will be undertaken to work with staff undertaking clinical audits, in particular junior doctors. Additionally, efforts will be made to engage the clinical audit leads within the Trust and ensure audit aspirations are realised through specialties and divisions.

2.10 Participation in Clinical Research and Innovation

The Trust is actively involved in clinical research. This helps to provide access to new treatments for local people and also supports the advancement of clinical care. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16, who were recruited to participate in research approved by the Research and Ethics Committee, was 990. This is recruitment to a combination of National Institute for Health Research (NIHR) adopted studies and non-adopted studies (the non-adopted studies are predominantly conducted for educational purposes).

2015/16 has seen SFH open to a total of 105 studies which are actively recruiting, with another 51 studies seeing patients for a period of follow-up appointments. These are a combination of NIHR and non-NIHR studies. Whilst this is a reduction from last year (231 studies open in 2014/15) it is partly due to a piece of work to ensure all studies are appropriately closed and archived upon completion. This work will continue but will be less labour intensive as it becomes part of usual business.

Our aim for 2016/17 is to increase the number of studies we are actively recruiting to by 20% with a focus on attracting the commercial sector. We currently have 13 commercial studies open with an aim of maintaining this over the coming year. With this in mind we are working hard to provide a robust feasibility process whilst supporting clinical teams in identifying appropriate studies to participate in.

The current recruitment total across all study types for 2015/16 is 990, with 823 being recruited for NIHR portfolio studies. This is more than last year's cumulative total of 821. The Research & Innovation department's aim for 2016/17 is to increase by 10% on our end of year total, which would see us achieve almost 1100 patients recruited into research studies. A vital part of continuing this activity is to maintain the engagement with clinical staff, patients and public visiting the Trust. In order to maintain engagement we are present during Trust induction days and facilitate research awareness days throughout the year as well as promoting International Clinical Trials Day in May.

2015/16 has seen the implementation of a new database as supported/provided by the East Midlands Clinical Research Network. As this is a web-based system, staff can input data at the time of the patient visit thus enabling us to capture accurate and timely activity in one place.

There continue to be changes within the wider national research arena and we have been working towards streamlining our governance processes in line with the Health Research Authority's plans. The Research & Innovation Manager has been working with the Health Research Authority, on a secondment basis, as a regional change lead supporting the Trust in achieving maximum potential in this area. During 2016/17 the Research & Innovation Department will continue to work with colleagues and clinicians across the Trust to maximise innovation. The aim is to benefit patients, improve care and capitalise potential commercial opportunities.

2.11 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN), established in 2009/10, is offered by NHS commissioners to providers of healthcare services commissioned under an NHS contract, to reward excellence by linking a proportion of the provider's income to the achievement of local and national improvement goals.

A proportion of our income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.
Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically via the Trust's website.

During 2015/16 we received payment of circa £4m from our commissioners for the CQUIN goals agreed during that reporting period. This represents 2.5% of eligible clinical contract income. This is in comparison to £4.8m received in 2014/15.

The following section provides an overview of the 2015/16 CQUIN predicted year end position.

Summary of Acute Schemes for 2015/16

CQUIN scheme*	Indicator name	Description	Indicator weighting**	Q1	Q2	Q3	Q4
National	Acute Kidney Injury (AKI)	Improving the provision of information to GPs at the time of discharge	£459,000	A	A	A	A
National	Sepsis	Screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics	£229,000	A	A	A	A
National		Administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis	£229,000	A	A	A	A
National	Dementia And Delirium (FAIR)	Improve care for patients with dementia or delirium during episodes of emergency unplanned care	£183,000	A	A	A	A
Local	Reducing The Proportion Of Avoidable Emergency Admissions To Hospital (UEC)	To ensure that appropriate dementia training is available to staff through a locally determined training programme	£46,000	A	A	A	A
Local	Falls Prevention	Ensure carers of people with dementia and delirium feel adequately supported	£138,000	A	PA	A	A
Local	Information Sharing CQUIN 2015/16	Reducing the proportion of avoidable emergency admissions to hospital	£459,000	A	A	Not yet achieved	
Local	Record Sharing Refinement	Reduce the number of inpatients falling in hospital	£92,000	A	A	A	A
Local	Improving care at end of life	Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital	£92,000	A	A	A	A

CQUIN scheme*	Indicator name	Description	Indicator weighting**	Q1	Q2	Q3	Q4
Local	Assessment, Care Planning and Communication with GP - Sharing information and improving cancer care planning and delivery	Delivery of the safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice	£92,000	A	A	A	A
Local	Cancer Pathway Redesign	Avoiding unnecessary admissions and in achieving the Gold Standard of Care for End of Life Patients	£294,000	A	A	A	A
Local	Better Together: Working in partnership to improve outcomes for our population	Information will be collected and fed back on the usefulness of the information contained within the GP record	£73,000	A	A	A	A
Specialised	HIV - Reducing unnecessary CD4 monitoring	Reduce the proportion of deaths that occur in hospital	£642,000	A	A	A	A
Specialised	Eligible patients receiving a NICEG10 compliant test with provision of monitoring data	Systematic assessment, care planning and information sharing to provide proactive care for people with cancer	£459,000	A	A	A	A
Specialised	Better Together: Working in partnership to improve outcomes for our population	Review and plan improvement programme for other tumour pathways delivered at SFHT	£183,000	A	A	A	A
Specialised	HIV - Reducing unnecessary CD4 monitoring	To ensure that the population of Mid-Nottinghamshire receives the best possible care	£917,000	PA	Not Achieved		
Specialised	Eligible patients receiving a NICEG10 compliant test with provision of monitoring data	To embed evidence based approach to monitoring CD4 counts for management of HIV treatment	£130,680	A	A	A	A
Specialised	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified.	To help patients, who cannot be categorised as low or high risk by existing clinical practice, make more informed choices about whether to undergo chemotherapy through greater insight into their likelihood to benefit	£27,000	A	A	A	A
Specialised	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified.	Where data are complete for an individual child and for a whole unit for these four questions, clinical quality will be improved through identification of areas for improvement and reduced clinical variation	£39,689	A	A	A	A

*CQUIN scheme: (Local/national/ specialist)
** (% of CQUIN scheme available) and expected financial value of indicator (£)

2.12 Registration with the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and our current registration status is 'Inadequate'.

Following assurance reviews undertaken as part of the Sir Bruce Keogh reviews into the quality of care and treatment being provided by those Trusts in England which had been persistent outliers on mortality statistics, the Trust is also in 'special measures'.

We are recorded as being in 'significant breach of governance' with our regulator Monitor.

We have the following conditions on registration 'Section 31' notice of decision to impose conditions on the our registration as a service provider in respect of the regulated activities and a 'Section 29a' warning notice.

The Care Quality Commission has taken enforcement action against the Trust during 2015/16.

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

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

Under the new inspection model, the CQC gives individual ratings to each of the care services that the hospital provides, including accident and emergency, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and outpatients.

For SFH the following rating was awarded:

Safe?	**Inadequate**
Effective?	**Requires Improvement**
Caring?	**Good**
Responsive?	**Requires Improvement**
Well-led?	**Inadequate**

The following section provides a ratings overview of each hospital site

King's Mill Hospital:

Safe?	**Inadequate**
Effective?	**Requires Improvement**
Caring?	**Good**
Responsive?	**Requires Improvement**
Well-led?	**Inadequate**

Newark Hospital:

Safe?	**Inadequate**
Effective?	**Requires Improvement**
Caring?	**Good**
Responsive?	**Requires Improvement**
Well-led?	**Inadequate**

Mansfield Community Hospital

Safe?	**Inadequate**
Effective?	**Requires Improvement**
Caring?	**Good**
Responsive?	**Requires Improvement**
Well-led?	**Requires Improvement**

Inspectors found services across the Trust were caring, and rated these as 'Good'. Nursing staff were seen to be compassionate and patients said staff were caring, kind and respected their wishes. The Trust's hospitals were found to be clean, hygienic and well maintained.

Inspectors saw several areas of outstanding practice including:

- There was some innovative work taking place at King's Mill Hospital where the Trust had developed a new changing facility for patients with complex disabilities. The facility offered a large changing area that would meet the needs of patients with profound disabilities.
- Staff went out of their way to meet the needs of their patients on the critical care unit. Some patients could be moved on their beds out of the critical care unit to an outdoor area. Staff told us they tried to do this when possible as patients appreciated being outside and away from the unit. Staff had been able to allow visiting by patients' pet dogs in this way.

However, the Trust has the following conditions and enforcement notices on its registration:

King's Mill

Requirement notices

- Regulation 9 (2014) Person-centred Care
- Regulation 10 (2014) Dignity and Respect
- Regulation 12 (2014) Safe care and Treatment
- Regulation 17 (2014) Good Governance
- Regulation 18 (2014) - Staffing

Enforcement notices

- None

Newark

Requirement notices

- Regulation 9 (2014) Person-centred Care
- Regulation 12 (2014) Safe care and Treatment
- Regulation 17 (2014) Good Governance
- Regulation 18 (2014) Staffing

Enforcement actions

- Regulation 12 (2014) Safe care and Treatment
- Regulation 18 (2014) Staffing

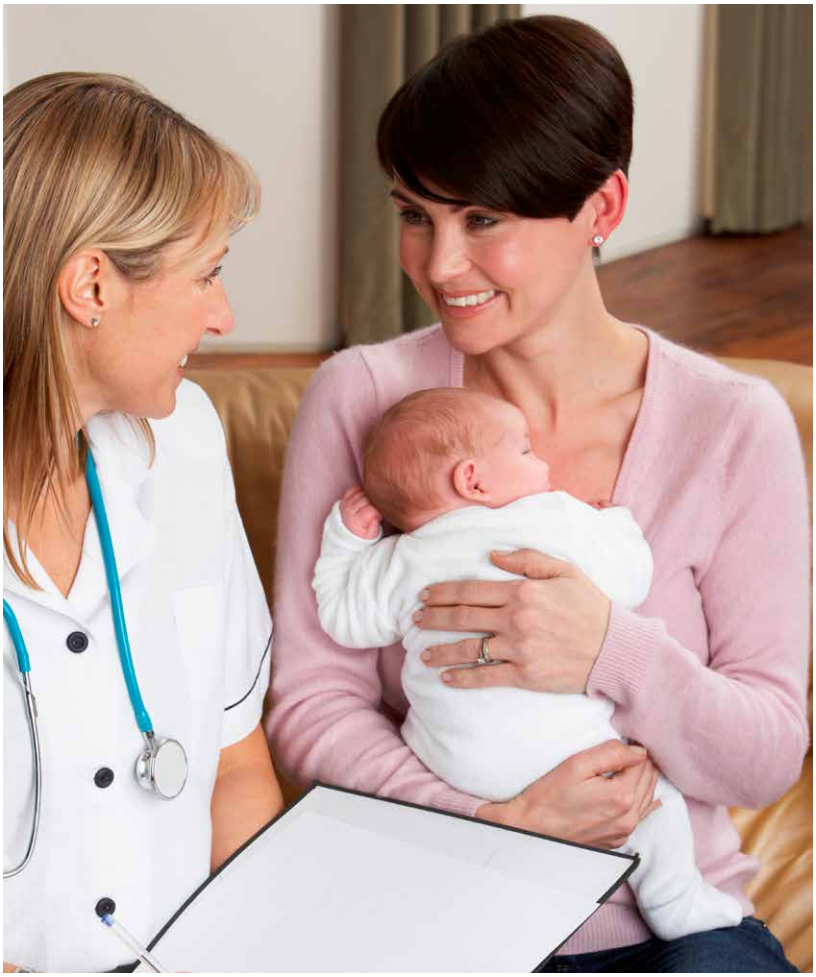
Mansfield Community Hospital

Requirement notices

- Regulation 18 (2014) Staffing

Enforcement action

- None



We have been told that we must make improvements to ensure that:

- An effective system is in place to deliver effective sepsis management, in line with the relevant clinical guidelines
- Systems to assess, monitor, and mitigate risks to people receiving the care as inpatients and outpatients are operated effectively
- Systems to assess, monitor, and improve the quality and safety of the services we provide to people attending our hospitals as inpatients and outpatients are operated effectively
- Proper processes are in place to enable us to make the robust assessments required by the Fit and Proper Persons Requirement

We have not participated in any special reviews or investigations by the CQC during the reporting period.

We intend to take the following action to address the requirements reported by the CQC. In response, following the CQC visit in June 2015 and in conjunction with our Improvement Director, we have developed a Quality Improvement Plan (QIP). This is monitored through an agreed internal assurance process. Oversight and scrutiny is applied through the Sherwood Forest Hospitals NHS Foundation Trust Oversight Group chaired by the Chief Officer of NHS Newark and Sherwood Clinical Commissioning Group and NHS Mansfield and Ashfield Clinical Commissioning Group.

Bespoke lines of enquiry and specific objectives have been developed from QIP; these are delivered with the support of our staff of all grades and backgrounds. Our patients, their carers and families, the public and partners are engaged in aspects of this work providing critical friends with fresh ideas and perspective of what good looks like, where we can improve further and where we are delivering good care.

Further focus on our internal assurance processes including accreditation processes and our senior leadership walk-rounds by executive and non-executive directors support our continuous improvement and give assurance on achievement of goals and when new process have been embedded.

We have made the following progress by 31 March 2016 in taking action against the QIP and, as of the 31 March 2016, the plan had 287 actions of which:

- 187 are rated as green (completed and on track)
- 88 are rated as blue (evidence has been provided to show these actions have been embedded) of which 54 actions relate to the sections 29a and 31.
- 2 are rated as amber (off track but have a plan to recover the position)
- 10 actions are rated as red (have failed to deliver to agreed timescales/are off track and unlikely to deliver to the agreed date).

Further information is available with the monthly Trust Board reports.
We continue to work closely with our regulators and local health community partners to ensure that we become fully compliant with regulations.
The latest update on our QIP can be found via the Trust's website.

2.13 Data Quality 2015/16

Information quality influences all aspects of the delivery of patient care. It crosses internal and external organisational boundaries and is the responsibility of everyone involved in delivering and supporting care. High quality information is crucial to ensure the following:

- Effective delivery of patient-centred services
- Efficient service delivery, performance management and the planning of future services
- Effective management of our reputation with patients, commissioners and regulators for the provision of high quality services and outcomes
- Appropriate income levels are secured

In 2014/15 significant assurance was provided in that there was generally a sound system of governance underpinning data quality; however some areas for further strengthening of processes were identified. Limited Assurance was provided in relation to the 18 weeks RTT target and concern was raised over the quality of underpinning data; therefore a lack of data quality assurance could be provided to the Board to support decision-making.

Improving the completeness, accuracy, validity, timeliness, completeness, relevance and constituency of all patient-based information is a key priority for the Trust Board.

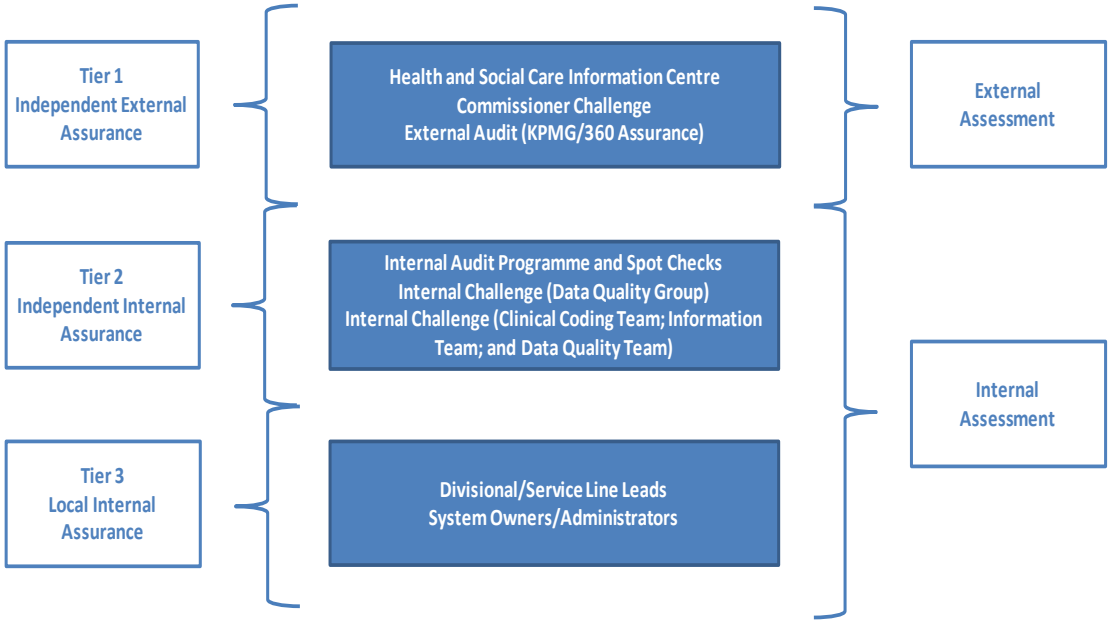
What did we aim to achieve in 2015/16?

- Review and development of Data Quality Strategy

Data quality impacts on the decision-making ability of clinical staff, support services, managers, executives and the Trust Board. It is essential therefore, that we have a clearly defined strategy (in line with our business requirements) that maintains and drives sustainable improvements in data quality. The strategy;

- Defines the organisational governance structures within which data quality is managed, monitored, and reported
- Outlines key organisational roles and responsibilities for ensuring good data quality
- Maps out the Trusts assessment infrastructure (three-tiered approach – see below) for data quality compliance and assurance
- Confirms Trust policies and procedures relating to data quality (e.g. to ensure compliance with all national standards and legal obligations [Freedom of Information]). This includes allocating responsibility for reviewing, updating and amending all relevant documents within an agreed timetable and monitoring system
- Defines how good communication will support improvements in data quality (e.g. raise awareness of data quality issues with clinical and nursing staff)
- Quantifies measures of successes and deliverables (e.g. through the Data Quality Improvement Plan)

Three- tiered approach



The strategy has been tested and audited by KPMG (based on their extensive experience and knowledge of national good practice)
The Trust intends to take the following actions to improve:
Further embed the Data Quality Strategy into the day-to-day functioning of the organisation

What did we aim to achieve in 2015/16?

- Develop the Data Quality Improvement Plan 2015/16 based on the Audit Commission's four standards framework to define the management arrangements to support improvements and secure the quality of our data

The success of the Data Quality Strategy can be measured by the delivery of key actions outlined in the Data Quality Improvement Plan for 2015/16. The plan specifically targets the delivery of a number of improvements in the following key areas:

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

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

What did we aim to achieve in 2015/16?

- Review and update senior accountability/strategic responsibility for data quality at Board level
- Review and update operational and management arrangements for data quality (includes Data Quality meetings and Divisional arrangements)
- Review the work plan of the Data Quality team to ensure that it supports/delivers corporate objectives
- Translate corporate data quality objectives into a measurable set of draft metrics

We intend to take the following actions to improve:

- Develop a measurable set of draft metrics to translate corporate data quality objectives. This requires the production of a monthly dashboard to track progress and inform next steps

What did we aim to achieve in 2015/16?

- Review the risk management arrangements (including use of DATIX system) of the Trust in relation to data quality and the risk associated with unreliable or inaccurate data

We intend to take the following actions to improve:

- Review the Trust's Risk Management Policy to reference explicit risks associated with unreliable or inaccurate data
- Data quality standards that are identified as a risk factor to be reported on the Trust's risk register
- Review current Data Quality risks, outcomes and any lessons learnt from addressing these issues Inform further training requirements

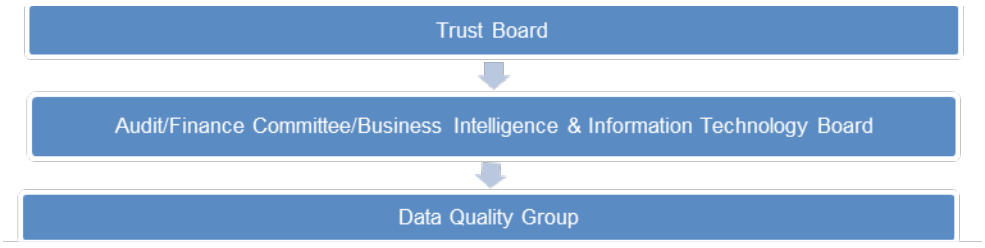
What did we aim to achieve in 2015/16?

- Review, update and re-launched the Data Quality Policy; Data Quality Group Terms of Reference; The Data Quality Improvement Group meetings

We intend to take the following actions to improve:

- Continue to facilitate the Data Quality Group Meetings to inform the revised Data Quality Plan for 2016/17.
- Inform the reporting mechanisms for data quality issues as described below:

What did we aim to achieve in 2015/16?



- Data Quality Training

Review all system based and operational data quality training material (including NHIS), and standard operating procedures to ensure that they are fit for purpose (in terms of data collection, recording, analysis and reporting adherence to Data Dictionary Standard Requirements)
Introduce training plan for 2016/17 for both data quality training and RTT training accessible through the training and development web page, Medway and data quality webpages and mandatory training for all newly appointed administrative staff
Provide divisional reports to assess compliance with training requirements

We intend to take the following actions to improve:

- Further and continuous review of standard operating procedures and provision that documents are accessible from the data quality/Medway web page
- Acknowledgement that this is a continuous process in the light of system upgrades and as a result of potential partnership working with NUH

What did we aim to achieve in 2015/16?

- Development of a Data Quality Internal Audit Programme

The Data Quality Team has developed and agreed a schedule of targeted audits which will be undertaken throughout the year.

We intend to take the following actions to improve:

- The results from these audits will be disseminated and discussed at monthly divisional meetings and the Data Quality Group
- The Data Quality Team will also undertake audit spot checks in response to emerging themes and issues (e.g. in response to monthly commissioner queries)

What did we aim to achieve in 2015/16?

- Development of robust communication channels to inform good data quality practices

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

- Trust articles and bulletins
- Dedicated data quality web page (on the Medway front screen e.g. contains SOPs; Q&A section; policies and procedures [Access Policy] etc.)
- All training sessions (e.g. System specific training [coordinated by NHIS]; Data Quality Team and Information Governance Team)
- E-learning tools
- Awareness sessions
- Progress reports to Audit Committee (e.g. tracking progress on Data Quality Improvement Plan actions)
- Dedicated data quality and clinical coding support provided to all five divisions (and service lines as appropriate)

We intend to take the following actions to improve:

- Further embrace communication technologies to ensure that all staff clinical and administrative have an understanding and responsibility to adhere to data quality standards as described in the six dimensions of data quality (Figures You Can Trust: A Briefing on Data Quality in the NHS, Audit Commission, 2009)

What did we aim to achieve in 2015/16?

- Data Quality Improvement KPIs

To provide assurance that the Trust's data is reliable, we are currently undertaking the deployment of Cymbio Process Analytics software - bespoke data quality dashboards. These will be designed and implemented across the Trust and at all levels (e.g. from Board to ward).
Data quality KPIs can be utilised from a suite of pre-defined metrics. These have been developed by Cymbio based on standard national definitions/requirements and experience of joint working nationally with a number of NHS Trusts.

Alternatively bespoke KPIs can be developed (with or without support from Cymbio) to address specific data quality issues that are unique to the Trust's requirements.

We intend to take the following actions to improve:

- The Data Quality Group will lead the development of this work and corporate ownership will be gained through data quality governance structure
- Ownership is essential for the successful deployment of data quality dashboards (and KPIs) throughout the organisation (and not just the Data Quality Team). Therefore, it is important that end users/service lines/divisions actively participate in the development process for dashboards/KPIs and that they are linked to the governance and reporting structures associated with both data quality and the Trust's performance management framework

What did we aim to achieve in 2015/16?

- PTL Data Quality Validation

In response to the Trust's ability to provide assurance that the RTT waiting time target data is robust work has been completed on updating the current PTL
SQL scripts reviewed (in-conjunction with IST) SQL scripts updated
IST sign off of scripts, logic and reports
PTL DQ Validation; Identify and deploy validation staff (internal and external)

We intend to take the following actions to improve:

- Develop a PTL validation dashboard to monitor progress/resources utilised against agreed improvement trajectory (as agreed with Monitor, NHS England and CQC).
- Routinely audit a random sample of validated pathways (to ensure accuracy of logic application)
- Review and update RTT/PTL training material. Develop, agree and implement a RTT/PTL training plan
- Produce and implement a RTT Strategy

Audit Opinion April 2016

Data Quality Baseline Assessment April 2016

Significant Assurance can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

Summary of Recommendations

	High	Medium	Low	Total
Risk issues identified	-	1	7	8
Proposed actions	-	1	6	7
Agreed	-	1	6	7

2016/17

We intend to take the following actions to improve the quality of our data, and so the quality of services and assurance of that data.

- Data Quality kite mark policy

Scope and test the methodology for introducing a data quality Kite Mark system to support the Board/ executive team's assessment of performance KPI's (e.g. integrated performance report (IPR)).

The data contained within the IPR must be a true reflection of the Trust's performance and therefore must be judged on its reliability and quality as explicitly assessed using a visual indicator.

Work will be undertaken to develop and embed the tool into firstly the IPR and then rolled out to other areas where data assurance is essential.

NHS Number and medical practice code validity

The collection of the patient's NHS number and general medical practice code are vitally important to ensuring accurate information is captured on NHS systems allowing key clinical information to flow throughout the patient's care. The percentages of records in the published data for 2015/16 (part year) and 2014/15 are summarised below:

Apr-15 - Jan 16				
Commissioning Data Set	Valid NHS Number	National average	Valid general medical practice	National average
For admitted patient care	99.8%	99.2%	100.0%	99.9%
For outpatient care	99.9%	99.4%	100.0%	99.8%
For emergency care (A&E)	98.5%	95.3%	100.0%	99.1%

Yr2014/15				
Commissioning Data Set	Valid NHS Number	National average	Valid general medical practice	National average
For admitted patient care	99.8%	99.2%	100.0%	99.9%
For outpatient care	99.9%	99.4%	100.0%	99.9%
For emergency care (A&E)	98.2%	95.2%	99.9%	99.6%

Source: Health & Social Care Information Centre (HSIC)

Analysis of the above table evidences a marginal year-on-year improvement regarding the recording of valid NHS numbers and general practitioners for A&E. Our overall performance regarding the recording of NHS number and GP practice code (2014/15 - 2015/16) is comparable to the national average shown.

2.14 Information Governance (Assessment Report)

The Trust's information governance (IG) toolkit assessment report for 2015/16 is 86% and was graded green satisfactory. This is an increase of 2% on the 2014/15 score and reflects the continual refinement and rigour of the requirements each year.

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade	Reviewed Grade	Reason for Change of Grade
Version 13 (2015-2016)	Published	0	0	18	27	45	86%	Satisfactory	n/a	n/a

All IG-related serious incidents are reported via the IG toolkit, which in turn reports them to the Information Commissioner (ICO). The Trust reported nine IG level 2 serious incidents during the fiscal year 2015/16, all of which have been investigated.

We aim to maintain the standard for 2016/17 by continuing to build on our previous year's actions below:

- Maintain information governance as a mandatory training requirement for all staff
- Continue undertaking a formalised programme of information asset risk assessment, ensuring each division provides assurance for its information assets and that these are reviewed and maintained with responsible officers
- For each information asset the owner will be required to report on progress against the toolkit requirement on an annual basis to the IG Group
- The Trust will further continue to have one lead for each standard responsible for the identification, collation and uploading for the evidence required for the toolkit
- Internal and external information flows for the Trust are being reviewed
- The Trust aims to review its current Publication Scheme and develop an Information Governance strategy

The Trust received 429 Freedom of Information requests for the fiscal year 2015/16; the majority of the requests continue to be from journalists frequently reflecting current news items with many of these requests being sent to all Trusts across the country. Main trends and themes are usually related to Trust spend in particular locum, temporary and agency staffing costs with regular requests reflecting news stories; such as parking costs and figures related to obesity-related illness.

2.15 Clinical Coding Audit

The Trust was subject to the Payment by Results Clinical Coding Audit during the reporting period by the Audit Commission.

The audit was undertaken in April 2015, when 200 finished consultant episodes were audited to assess the accuracy of clinical coding performed across the Trust and any change in HRG and its impact on tariff. Areas audited were – female reproductive system procedure and urological and male reproductive system procedures and disorders.

Audit identified there were only two spells that have impacted on tariff with an over charge of £2586.

We have undertaken, as part of the Information Governance Standard 505, an audit of 200 finished consultant episodes (April – December 2014). The results indicate an error rate of less than five per cent regarding correct primary and secondary diagnoses/primary and secondary procedures and provide assurance that we have a consistently high accuracy rate within this area.

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
IGT level 3 requirement	>=95%	>=90%	>=95%	>=90%
IGT level 2 requirement	>=90%	>=80%	>=90%	>=80%
Sherwood Forest Hospitals NHS Foundation Trust	98%	96.2%	97.8%	96.5%

Recommendations

- Feedback all areas of error found during the audit to the coders
- Reiterate the importance of assigning all mandatory and relevant comorbidities
- Reiterate the importance of following the four step coding process to ensure accurate three and fourth character code assignment
- Ensure the coders are extracting all relevant procedures from the colposcopy documentation

We will be taking the following actions to improve data quality:

- All the areas of errors are fedback to the coders and the importance of assigning all mandatory and relevant co-morbidities

- All the coders are made aware of importance of four step coding process to ensure accurate three and fourth character code assignment

- Coders are provided training on extracting relevant procedures from the colposcopy documentation

2.16 Mortality Indication (SHMI) and Palliative Care Coding

Mortality indicator (SHMI) and palliative care coding

The data used to produce the summary hospital mortality indicator (SHMI) is generated from data that we submit to the secondary users service (SUS). The SHMI is the ratio between the actual number of patients who die following an episode of care at the Trust and the number that we would expect to die, based on local demographics and national statistics.

Palliative care coding

% Patient deaths (coded as palliative care)		
Year	% of	National Average
Oct-14 - Sep-15	13.9%	26.6%
Jul-14 - Jun-15	14.5%	26.0%
Apr-14 - Mar-15	15.1%	25.7%

Source: Health & Social Care Information Centre (HSCIC). Note: most up to date data is only available

We consider this data is as described for the following reasons:

- We ensure that review by our specialist palliative care team is clearly evidenced in the patient record to ensure correct coding

We have taken the following actions to improve this percentage and so the quality of its services by:

- Increasing our rate of palliative care coding by ensuring accurate record-keeping when patients receive palliative care at the Trust
- Ensuring the liaison between Trust clinical staff and clinical coders continues

SHMI:

The table below shows how we are banded for SHMI. A SHMI value is calculated for each Trust. Trusts are categorised into one of the following three bandings:

- One – Where the Trust's mortality rate is 'higher than expected'
- Two – Where the Trust's mortality rate is 'as expected'
- Three – Where the Trust's mortality rate is 'lower than expected'

The following table illustrates our SHMI banding as being consistently recorded as a two, which indicates 'as expected' level of mortality

Year	Value	Banding	National Average	Highest Performer	Lowest Performer
Oct-14 - Sep-15	1.019	2	1.0004	0.652	1.177
Jul-14 - Jun-15	1.0213	2	-	-	-
Apr-14 - Mar-15	1.0148	2	-	-	-

Source: Health & Social Care Information Centre (HSCIC)

We consider that this data is as described for the following reasons:

- We have made changes to SHMI care provisions within the Trust to ensure the correct coding is recorded

We intend to take the following actions to improve this number, and so the quality of services:

- Our rate of palliative coding, whilst improving, is below the national average and does indicate that data capture of patients receiving palliative care at the Trust can be improved. Work is on-going between the Trust clinical staff and clinical coders to improve our coding, ensuring that we capture patients receiving palliative care

2.17 Patient Reported Outcome Measures (PROM's)

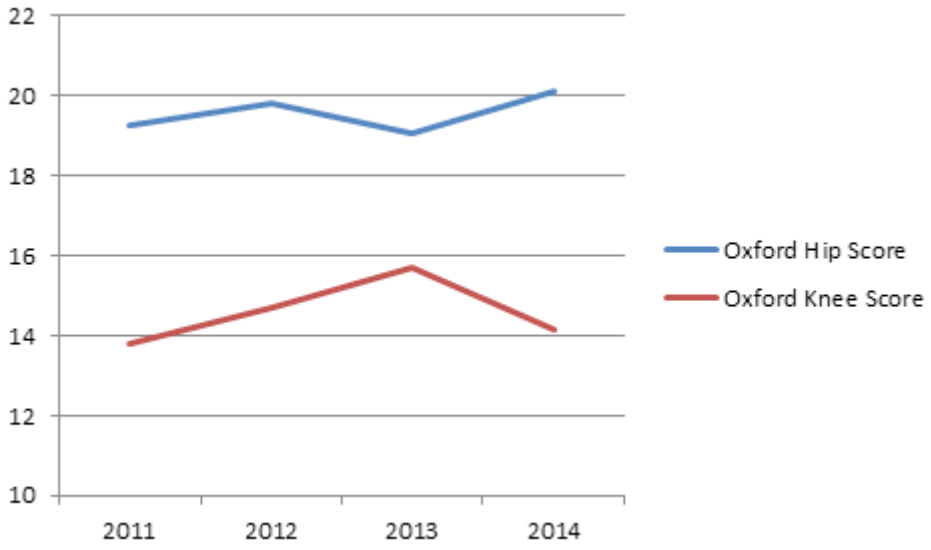
Patient reported outcome measures (PROMs) are a means of collecting information regarding the effectiveness of care delivered by the NHS as perceived by the patients themselves, utilising pre and post-operative surveys to calculate health gains. PROMs have been collected by providers of NHS care since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

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

For 2015/16 we aimed to:

- Effectively utilise PROMs data both at a service line and consultant level in order to gain a greater understanding of the variances identified and agree on any actions required to improve patient outcomes with this regard
- Undertake further analysis regarding the health gains reported against hip and knee replacement surgery in order to understand how our health gains can be improved to align with national averages
- Undertake a patient level review for those patients reporting no change or deterioration post-operatively in order to identify any emergent themes and trends

The graph below charts the results of the Oxford Hip Score and Oxford Knee Score outcome measurement tools and demonstrate an improvement in hip replacements, but deterioration in knee replacements outcomes since 2013. The 2014 figures are based on provisional data and we are liaising with Quality Health to increase participation rates to ensure outcome measurement is reflective of service provision. The reduction identified in the 2014 average health gains for knee replacement coincided with a reduction in patients attending pre-operative knee school and subsequently an improvement plan was developed in 2015 in conjunction with the Clinical Transformation Lead within orthopaedics to improve attendance at these.



A clinical audit, conducted at patient level, identified that post-operative complications were a factor in only 23% of patients reporting worsening outcomes following their knee surgery; with other co-morbidities responsible for impacting on their health gains.

From October 2015 the Trust's Vascular Service has been provided entirely by NUH consultants. The service comprises outpatient clinics at both KMH and Newark Hospital sites, day-case lists and inpatient work at KMH relating to patients who are repatriated post-surgery from NUH. Services are delivered via a one in seven vascular rota, five days a week, Monday to Friday, by a team of vascular consultants.

One stop clinics are currently being developed at SFH with an eight week pilot planned to commence on 9 May 2016. This will improve services for patients at SFH and streamline patient pathways by ensuring patients receive their outpatient appointment and diagnostic test on the same visit to the hospital.

From a pre-operative perspective, a total of 695 patients were surveyed during 2015/16 across the four procedures types. The adjusted health gains are illustrated in the following table which represents the most up-to-date information available to the Trust at the time of printing:

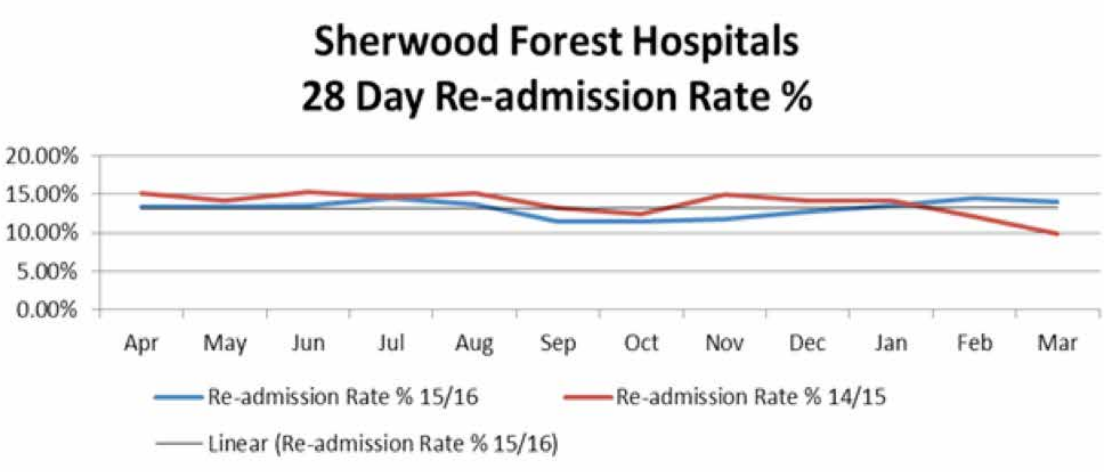
Patient reported outcome measures – adjusted average health gain score				
	2014/15		April – September 2015	
Procedure	Trust adjusted health gain	National average adjusted health gain	Trust adjusted health gain	National average adjusted health gain
Groin hernia surgery	53.5%	50.7%	61.6%	51.1%
Varicose vein surgery	50.7%	52.1%	41.9%	54.1%
Hip replacement surgery	89.9%	89.6%	95.5%	89.7%
Knee replacement surgery	77.6%	81.0%	77.4%	82.8%

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

In response to these results, an elective orthopaedic programme of works has been developed to improve the quality, with the following initiatives implemented:

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

2.18 Patients Re-admitted to a Hospital Within 28 Days of Discharge



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16
Re-admission Rate %	13.30%	13.37%	13.50%	14.44%	13.65%	11.49%	11.42%	11.82%	12.67%	13.47%	14.53%	14.05%	13.16%
Spell Discharges	2933	2999	3073	3227	2924	3037	3118	3232	3259	3155	3290	3537	37784
28 Day Readmissions	390	401	415	466	399	349	356	382	413	425	478	497	4971

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	14/15
Re-admission Rate %	15.18%	14.17%	15.26%	14.60%	15.07%	13.28%	12.44%	14.93%	14.11%	14.24%	12.07%	9.81%	13.72%
Spell Discharges	2886	2985	2896	3110	2827	2996	3094	2987	3006	2816	2859	3294	35756
28 Day Readmissions	438	423	442	454	426	398	385	446	424	401	345	323	4905

Source: Trust data warehouse – there is no data available on HSCIC related to the time period within the document including national averages

We consider that this data is as described for the following reasons:

- Over the last year we have developed and expanded a range of ambulatory services that are provided through our clinical decisions unit
- We have further embedded our consultant on-call rota to incorporate seven-day working and the provision of 'hot clinics' in order to urgently review patients within an outpatient setting

We intend to take the following actions to improve this percentage, and so the quality of services, by:

- The implementation of the Better Together programme to further strengthen pathways across the wider health and social care community thereby reducing our readmission rates
- Implementing the ambulatory emergency care pathway which is a strategic initiative to enable emergency patients to avoid A&E attendance whist still receiving care and treatment

2.19 The Trust's Responsiveness to the Personal Needs of Patients

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

- Out patient service
- In patient services
- Emergency departments
- Maternity Services

We have historically provided a complainant satisfaction survey to a selection of complainants following the closure of a complaint case, to establish how the complaint management felt for the complainant. The Trust is exploring other options to collate this feedback as part of a national project with other NHS Trusts, which is in its infancy. However is expected to be implemented in early 2016.

We consider this data is as described for the following reasons:

Information from the Staff, Friends and Family Test (FFT) is triangulated against the themes and trends identified by the Patient Experience Team though their work and conversations with patients, relative and service users. This includes the analysis of complaints, concerns and compliments.

We have taken the following actions to improve this data, and so the quality of its services by:

The Trust has procured a new external provider to collect and collate FFT data in a number of medians to ensure we continue to capture all eligible patients. The provider, Meridian Optimum, provides the nursing metrics. Therefore this will ensure the FFT feedback can be aligned and incorporated into this data to identify trends and themes of patient experience along with staffing levels and ward audits. A dedicated project facilitator will support the staff to embed the feedback mechanism throughout the Trust

We are currently obtaining the hardware to support the new systems and processes which will provide real-time feedback via tablets, email and a pilot of text messaging in the appropriate services. It is hoped this will increase the low response rates Trust-wide.

Trusts FFT performance is identified in the table below:

Friends & Family A&E	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Recommended SFHT	84.0%	84.0%	83.0%	91.0%	82.9%	83.5%	82.3%	78.6%	81.5%	72.0%	88.9%	88.7%
% Recommended National Average	87.5%	88.3%	88.3%	88.2%	88.4%	87.8%	87.2%	86.7%	87.3%	86.3%	84.9%	83.5%

Friends & Family A&E	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Recommended SFHT	-	72.3%	77.7%	78.3%	79.5%	82.1%	90.9%	92.6%	91.0%	86.9%	92.3%	81.2%
% Recommended National Average	-	86.1%	86.1%	86.3%	87.5%	86.4%	86.8%	87.4%	86.2%	88.1%	87.9%	87.0%

Friends & Family Inpatients	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Recommended SFHT	96.8%	97.8%	98.0%	97.8%	97.1%	96.7%	98.3%	98.1%	96.1%	97.7%	96.6%	97.3%
% Recommended National Average	95.5%	95.7%	95.8%	95.9%	95.8%	95.6%	95.5%	95.7%	95.6%	95.7%	95.7%	95.7%

Friends & Family Inpatients	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Recommended SFHT	-	94.7%	93.9%	93.8%	92.9%	91.6%	97.5%	94.9%	95.4%	94.3%	90.0%	96.0%
% Recommended National Average	-	94.2%	94.1%	94.2%	93.8%	93.5%	93.7%	94.6%	94.5%	94.1%	94.5%	94.6%

Friends & Family Maternity	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Recommended SFHT	98.4%	97.3%	96.6%	100.0%	100.0%	100.0%	97.2%	98.0%	91.2%	96.2%	100.0%	100.0%
% Recommended National Average	97.2%	97.0%	95.1%	97.4%	98.0%	97.0%	97.0%	98.0%	91.0%	96.6%	96.3%	96.4%

Friends & Family Maternity	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Recommended SFHT	-	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	98.9%	99.2%
% Recommended National Average	-	95.2%	95.6%	95.2%	95.3%	95.2%	94.8%	96.8%	96.6%	96.7%	96.7%	96.8%

Friends & Family Outpatients	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
% Recommended SFHT	99.2%	99.2%	99.0%	99.0%	97.9%	98.2%	98.9%	97.5%	98.7%	95.1%	94.8%	99.1%
% Recommended National Average	92.2%	91.9%	92.1%	92.2%	92.2%	92.3%	92.1%	92.4%	92.4%	92.7%	92.8%	92.7%

2.20 Staff Friends and Family Responses and Recommendations Rates

National NHS Staff Survey – 2015

The Trust participates in the national NHS Staff Survey on an annual basis. We elect to survey 850 randomly selected staff from all staff groups. The survey is undertaken from the beginning of September until early December each year.

The response rate was 45% which was above average for acute trusts in England and compares to a 44% response rate in 2014.

Summary of all key findings for 2014 and 2015

	2013 (28)	2014 (29)	2015 (32)
Best 20%	1 Area*	1 Area	2 Areas
Better than the average	7 Areas	4 Areas	3 Areas
Average	8 Areas	4 Areas	9 Areas
Worse than the average	7 Areas	11 Areas	6 Areas
Worst 20%	5 Areas	8 Areas	12 Areas

Area* this is a specific section of questioning

Overall indicator of staff engagement

The overall indicator of staff engagement for the Trust was 3.68 which is in the lowest (worst) 20% when compared to Trusts of a similar type. This compares to 3.66 last year when the Trust was below average.

NHS Staff Survey Comparison for Overall Staff Engagement - 2014 and 2015		
Overall Staff Engagement 2015	3.68	Average for acute trusts in England 3.79
Overall Staff Engagement 2014	3.67	Average for acute trusts in England 3.74

Overall staff engagement is an important indicator which incorporates the following key findings (KF):

- KF1. Staff recommendation of the trust as a place to work or receive treatment
- KF4. Staff motivation at work
- KF7. Staff ability to contribute towards improvements at work

The Trust's Quality Improvement Plan (QIP) will seek to secure improvements in these and other areas identified as concerning in the staff survey.

Where staff experience has improved

- KF24. % of staff/colleagues reporting most recent experience of violence
- KF22. % of staff experiencing physical violence from patients, relatives or the public in the last 12 months

Where the staff experience has deteriorated

- KF32. Effective use of patient/service user feedback

Top five ranking scores

- KF24. % of staff/colleagues reporting most recent experience of violence. This has improved since 2014 and we are in the highest (best) 20% of acute trusts in England
- KF 16. % of staff working extra hours. No change. We are in the lowest (best) 20% of acute Trusts in England
- KF28. % of staff witnessing potentially harmful error, near misses or incidents in the last month. No change. We are below (better) than average
- KF2. Staff satisfaction with the quality of work and patient care they are able to deliver. We are above (better) than average
- KF3. % of staff agreeing that their role makes a difference to patients/service users. We are above (better) than average

Bottom five ranking scores

- KF6. % of staff reporting good communication between senior management and staff. No change. We are in the lowest (worst) 20% of acute Trusts
- KF10. Support from immediate managers. No change. We are in the lowest (worst) 20% of acute Trusts

- KF18. % of staff feeling pressure in the last tyree months to attend work when feeling unwell. No change. We are in the highest (worst) 20% of acute Trusts
- KF32. Effective use of patient/service user feedback. Decrease (worse than 2014). We are in the lowest (worst) 20% of acute Trusts
- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents. We are in the lowest (worst) 20% of acute Trusts

It should be noted that at the time of the 2015 staff survey the Trust was facing significant challenges, including receiving the outcome of the CQC inspection, continuing to be in special measures and a focus for media attention, significant financial pressures and continued high demand on services.

KF19. Organisation and management take an interest in and action on health / wellbeing are unable to be compared with the 2014 score due to changes to the format of the survey questions this year and the ranking compared with all acute Trusts in 2015 was in the lowest 20%.

KF27 % reporting most recent experience of harassment, bullying or abuse has shown no change since the 2014 survey and the ranking compared with all acute Trusts in 2015 was average.
Despite these pressures the Trust's results showed no significant change in 19 key findings and improvements in two.

Areas identified for action following the 2014 staff survey

In response to the 2014 NHS Staff Survey findings the Trust developed a detailed action plan to address priority areas, each fronted by an identified project lead. Delivery of the actions was overseen by the Organisational Development and Workforce Committee. Areas of development included:

- Ensure senior and line managers within divisions/departments engage with staff using innovative and creative communication methods
- Develop an open and transparent culture where staff have the confidence to raise concerns via appropriate mechanisms and have confidence these will be appropriately considered by adopting an open door policy and no blame culture. Where staff have raised concerns the Trust will develop mechanisms to ensure feedback is provided
- Improve appraisal rates and achieve the Trust target of 98% compliance and ensure all staff have a personal development plan aligned to appraisals and organisational objectives
- Ensure all staff attend mandatory training
- Embed 'Quality for all' values and behaviours
- Roll out of Mentally Healthy Workplace training
- Support staff with their on health and wellbeing by promoting health and wellbeing initiatives
- Ensure all staff are consistently and fairly managed in accordance with Trust HR policies and procedures, providing support, guidance and coaching via HR business partnering, occupational health, training and development

Staff Friends and Family Test

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

Summary of results showing the percentage of staff saying they would be likely, or extremely likely, to recommend:

	Q1 FFT	Q2 FFT	Q3 Staff Survey
How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	69.69%	75%	48%
How likely would you be to recommend this organisation to friends and family as a place to work?	59.12%	73.24%	57%
Number of respondents	402	340	379

The Q3 Staff Survey questions are slightly different:
1. "I would recommend my organisation as a place to work"
2. "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"

It is a requirement for organisations to provide a free-text follow up question (What is the main reason for the answer you have chosen?) after each of the two fixed questions. This enables staff to provide more detailed feedback if they wish to. The free-text responses are not submitted to NHS England. However, the Trust recognises the value of this feedback and uses it to inform and support improvements to staff and the patient experience.
We consider that this data is as described for the following reasons:

- We have adhered to the national guidance for conducting the Staff Friends and Family Test

We intend to take the following actions to improve this percentage, and so the quality of services, by:

- Delivering the QIP workstreams for quality of care and staff engagement

Pulse Survey

In quarters one, two and four the Trust asked additional questions in the staff FFT to undertake 'pulse surveys' on the following key topics:

- Q1 – 'Quality for all'
- Q2 – Raising Concerns
- Q4 – Staff engagement

The feedback received was used alongside the information gained from exit interviews to monitor progress and inform future action with regard to initiatives to improve the staff and patient experience.

Exit Interviews

Staff leaving our employment are offered an exit interview. This can be with their line manager, higher line manager of a trained volunteer. Alternatively staff can complete an exit interview questionnaire and return it to HR.

We value the feedback staff give and HR triangulate the information from exit interviews with KPIs, staff survey and the quarterly staff FFT to better understand the staff experience. HR Business Partners and Assistant HR Business Partners utilise this information to identify trends, inform initiatives and support the coaching and mentoring work they do with managers.

Where an exit interview raises a concern, or identifies an issue, discrete work is undertaken to explore and address the problem. Any significant concerns initiate an investigation.

The number of staff agreeing to give feedback as they leave has increased, although the percentage remains low. Following a review of the exit interview process and questionnaire, the option for staff to complete a questionnaire on-line will be introduced on 1 April 2016. It is hoped that this may appeal to some staff and lead to an increase in the number of staff giving feedback as they leave the Trust.

2.21 Venous Thromboembolism

The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical and surgical care. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

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).

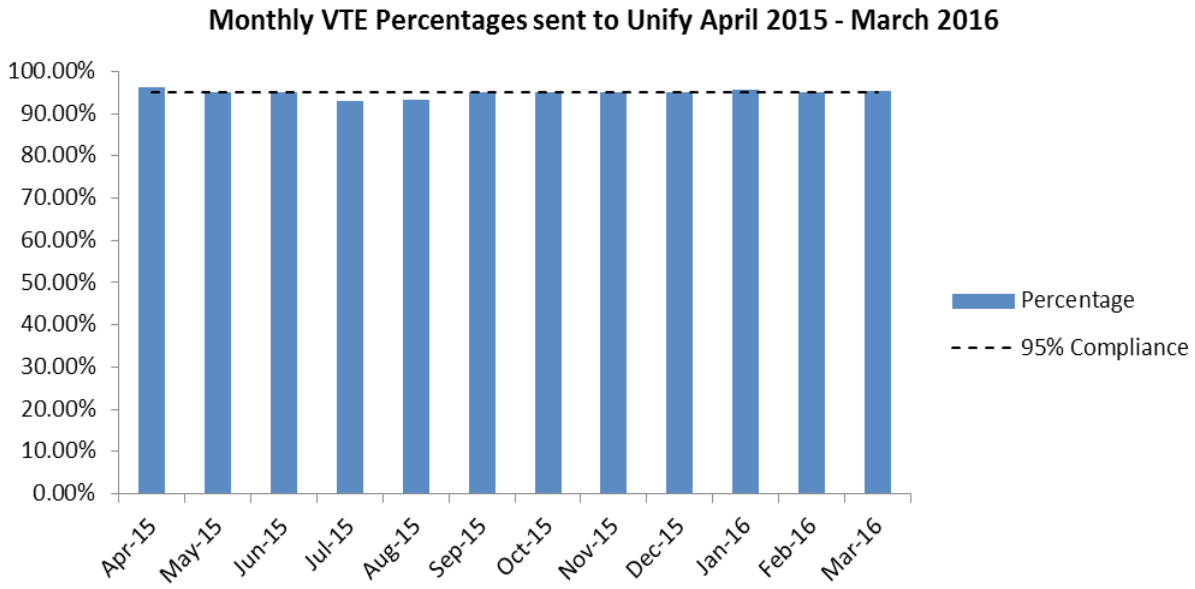
All adult patients should have a VTE risk assessment on admission to hospital using a nationally recognised risk assessment tool.

During 2015/16 the following target was agreed regarding the management of VTE:

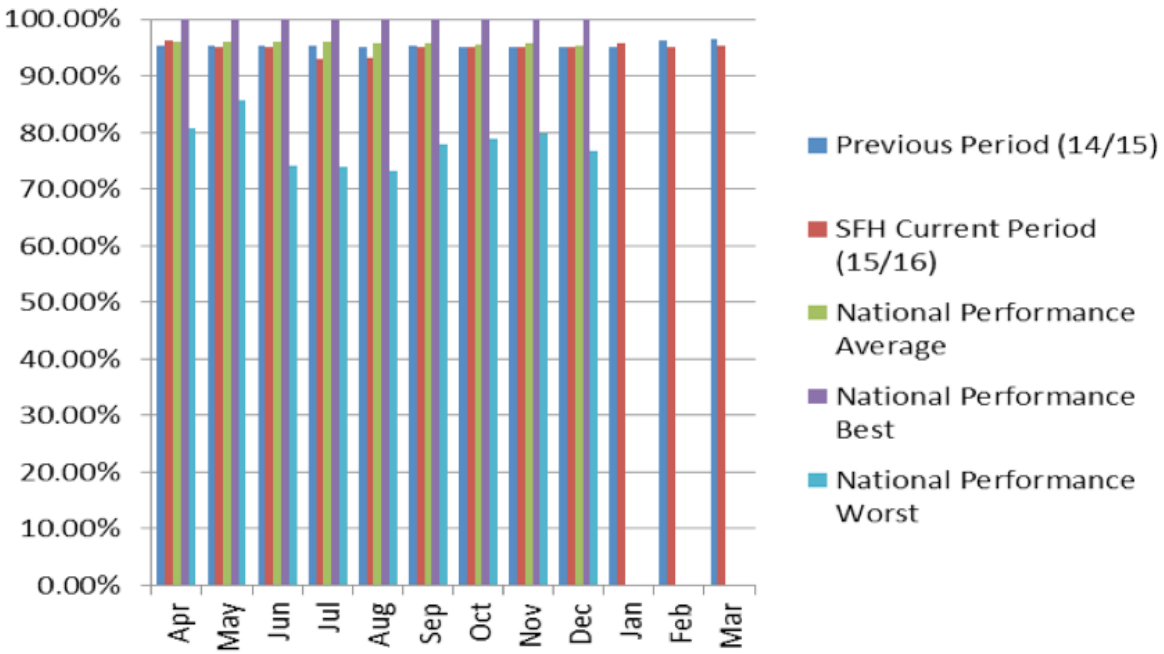
- 95% of all patients will undergo a VTE risk assessment (contractual)
- 100% of cases of hospital acquired thrombosis (HAT) will have a root cause analysis (RCA) performed (Internal)

During the reporting period April 2015 – March 2016, compliance with 95% of all patients undergoing a VTE risk assessment was achieved for 10 of the 12 months within this period. For the two months where this was not achieved, compliance was at, or close to, 93% (July 92.93% and August 93.16%) as evidenced in the following graph. Work to improve compliance included supporting the clinical teams within the Emergency Assessment Unit.

The process for reviewing 100% of cases of hospital acquired thrombosis (HAT) is currently under review. The Trust can report that no Incidents have been raised where a patient was harmed as a result of developing a hospital-acquired thrombus (during the reporting period April 2015 – March 2016) that met the NHS England Serious Incident Framework criteria.



Month	Previous Period (14/15)	SFH Current Period (15/16)	National Performance Average	National Performance Best	National Performance Worst
Apr	95.25%	96.16%	96.01%	100.00%	80.71%
May	95.24%	95.04%	96.10%	100.00%	85.74%
Jun	95.30%	95.04%	96.00%	100.00%	74.08%
Jul	95.26%	92.93%	96.10%	100.00%	73.98%
Aug	95.20%	93.16%	95.73%	100.00%	73.18%
Sep	95.27%	95.06%	95.72%	100.00%	77.96%
Oct	95.06%	95.17%	95.63%	100.00%	78.95%
Nov	95.16%	95.03%	95.80%	100.00%	79.73%
Dec	95.05%	95.01%	95.39%	100.00%	76.87%
Jan	95.09%	95.71%	Data not available	Data not available	Data not available
Feb	96.18%	95.06%	Data not available	Data not available	Data not available
Mar	96.55%	95.36%	Data not available	Data not available	Data not available



We consider that this data is as described for the following reasons:
- From an organisational perspective, we have robust screening systems and processes in place to identify at risk patients

We intend to take the following actions to improve this percentage, and so the quality of services, by:
- Formally monitoring performance against this indicator and reporting to the Patient Safety and Quality Board

2.22 Clostridium Difficile Infection

Introduction

Sherwood Forest Hospitals has seen a fivefold reduction in clostridium difficile (C. diff) acquisition rates across its acute service since 2007; it remains a major source of nosocomial infection. Prevention of infection focuses on interventions such as hand hygiene, environmental cleaning and antimicrobial stewardship.

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

The Infection Prevention and Control Team (IPCT) has implemented a raft of changes in both processes and procedures to address the issues, and eradicate the 'avoidable infection' and avoid 'lapses in care' as defined by NHS England.

We identified the reduction in the number of patients reported with a C. diff infection to less than 48 as a local CQUIN for 2015/16

What we have done in 2015/2016

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

- A review of common themes identified across organisations
- Provision of targeted education to community colleagues regarding antimicrobial prescribing, patient management, specimen sampling within community settings.

We recognised that greater emphasis on C. diff management was required within all training programmes and provision of relevant information:

- All educational programmes were adjusted to incorporate methods of how to prevent and control C. diff
- The IPCT developed new isolation posters which were distributed during April and May
- Regular information was provided to all divisional governance forums

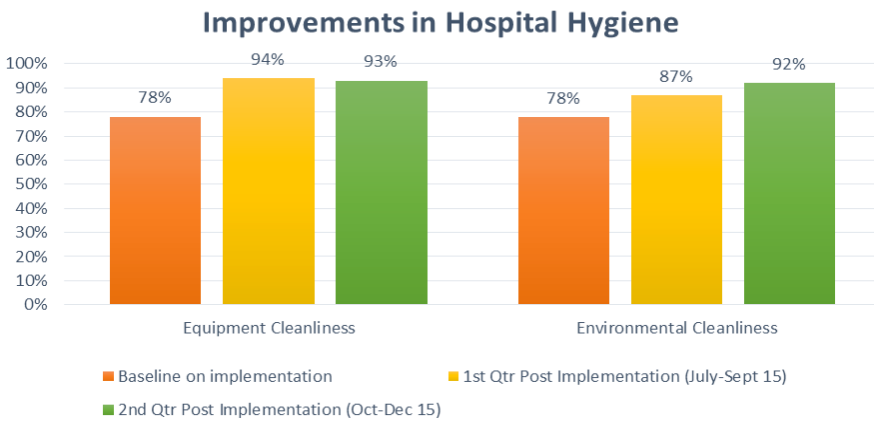
The standard of cleaning is fundamental in reducing the risks of transferring C. diff This year the IPCT worked closely with Medirest, Skanska and commercial companies to improve the consistency of the cleaning processes and ensure that all staff are aware of their responsibilities. They have introduced a number of initiatives:

- A R.A.G system for cleaning was developed and introduced in June 2015 with clear responsibilities and accountability sign off by both cleaning and clinical staff
- The introduction of a paracetic acid based cleaning product to replace the chlorine releasing agent, in recognition of its efficacy against C. diff and reduced risk of damaging equipment
- A ward, decant and deep clean process was put in place to reduce the environmental microbial load and therefore reduce the risk of cross infection

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

- A mobile system was purchased with a complete set of validated audit tools that monitors against almost one thousand standards as required within The Health Act 2008 (Department of Health 2015) the relevant quality standards produced by NICE, and other bodies including Public Health England, Department of Health, Infection Prevention Society and the Hospital Infection Society (EPIC 3)
- The Infection Prevention Team now performs standardised audits, members are able to provide photographic evidence of issues identified, provide detailed specific immediate feedback and education at time of audit
- Graph 1 illustrates the progress made since the implementation of both the audit tool and new cleaning processes since the beginning of June 2015
- The audit programme was extended to include measuring compliance following the Introduction of a stool sampling proforma during April 2015, to direct staff when and when not to send samples, compliance has been consistently between 75-85% since October 2015

Graph 1



Progress against the target

At the end of 2014/2015 Sherwood Forest Hospitals had reported 67 cases of C. diff, Graph 2 (light grey line), Table 1 and Graph 3 provide further information regarding C. diff rates (per 100,000 bed days) including a comparison of monthly rates from the preceding three years. During, 2015/16 the final numbers of C. diff cases identified is 45, which is within the national threshold.

During the start of 2015/16 genetic studies linked the cases of three patients, implementing the measures outlined above including:

- Increased audit frequency of key elements including hand hygiene; equipment cleanliness and environmental cleanliness
- Implementing deep clean programme on a rolling programme
- Increased education and training
- Implementing a stool sampling proforma

These elements have contributed to the increased understanding and awareness of staff caring for our patients, Graphs 2 and 3 both illustrate where the improvements in practice started to positively impact on the reductions of cases month by month.

C. diff is a complex organism and will continue to require aggressive monitoring and response as identified in January in February 2016.

Graph 2

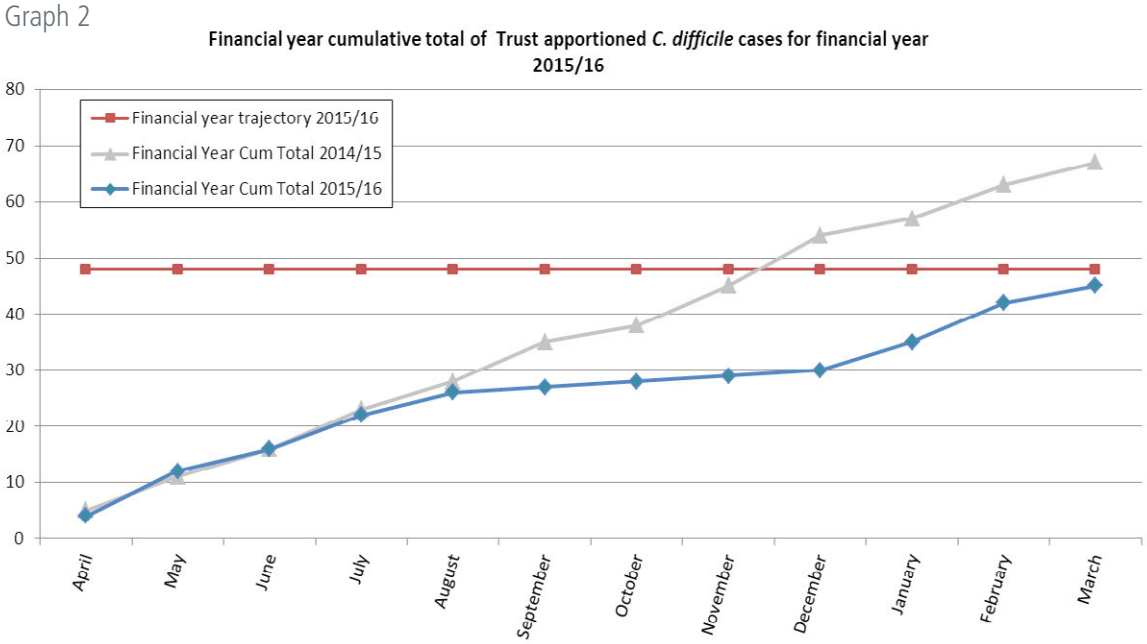
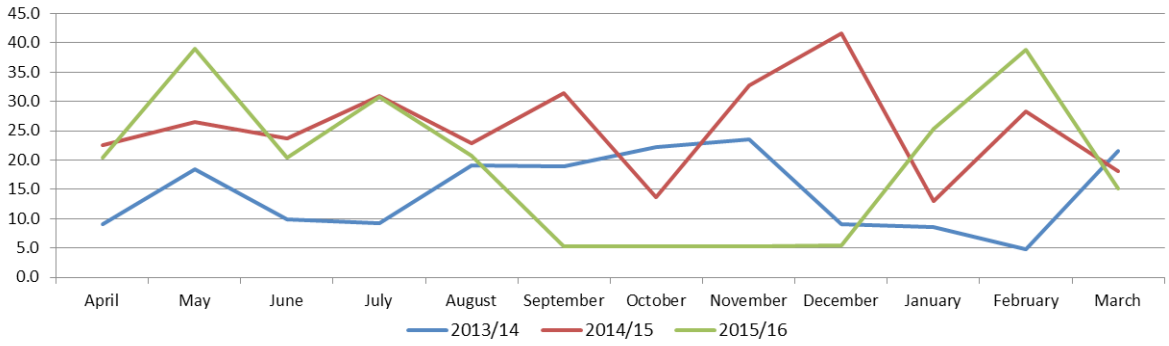


Table 1 C. diff rates per 100,000 bed days

Period	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	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

At the time of publication no national average of information is available

Graph 3 C. diff rates per 100,000 bed days



Monitoring and Reporting

All cases of C. diff infections within the Trust undergo a root cause analysis (RCA) to establish the underlying reasons for the patients to have succumbed to the infection. These are 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 target for 2016/17 is 48 cases; we have achieved this in 2015/16 and will continue to work hard to maintain this.

We consider that this data is as described for the following reasons:

- C. diff rates are reported internally via the Health Care Associated Infection Committee (HCAI), Infection Control Committee (Appendix 1) and reported externally to Public Health England, in line with national reporting requirements.

We intend to take the following actions to improve this rate, and so the quality of services:

- C. diff will remain a quality priority.
- We will continue to actively embed the actions taken in 2015/16 to further reduce the numbers of patients adversely affected by clostridium difficile
- We will deliver on the 2016/17 actions identified
- We will embed and ensure the improvements in cleaning and effective management of patients with an infection caused by clostridium difficile are sustained.

In 2016/2017 in addition to sustaining the measures brought in to regain control, there will be:

- Emphasis on antimicrobial stewardship in line with the national standard - to reduce antibiotic consumption and encourage a focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours
- Improved monitoring and management of source infections such as urinary tract infections and chest infections

2.23 Patient Safety Incidents

In accordance with national guidance and legislation, the Trust is required to record all adverse events and 'near misses', which may be observed and reported by staff/patients or the general public, whether they are:

- major/minor
- clinical or non-clinical
- affect one person or more persons and related to patients, staff, students, contractors or visitors to the Trust premises
- involve equipment, building or property

We are committed to identifying adverse events and near misses to enable the Trust to identify opportunities for learning and risk management. Incidents that affect patients are graded using the Data Quality Standards (Sept 2009) published by the National Reporting and Learning System (NRLS)

The management of incidents is described within the Trust's Incident Reporting Policy and Procedures. In March 2015, NHS England published the revised Serious Incident Framework and Never Event list. This guidance was reviewed within the Trust and the Incident Reporting Policy was updated and approved in July 2015 to reflect the requirements of the framework.

In September 2015 the Trust upgraded the web-based incident reporting system Datix. Dashboards were implemented across the Trust to provide ward/department leads and Matrons with incident information and the facility to monitor trends and themes.

We have a legal responsibility to formally offer an apology, verbally and in writing within 10 days of an incident (Duty of Candour) which is graded moderate, severe or catastrophic. A review of the Trust policy relating to Duty of Candour (Being Open) was completed and the changes were approved by the Trust Management Board in December 2015.

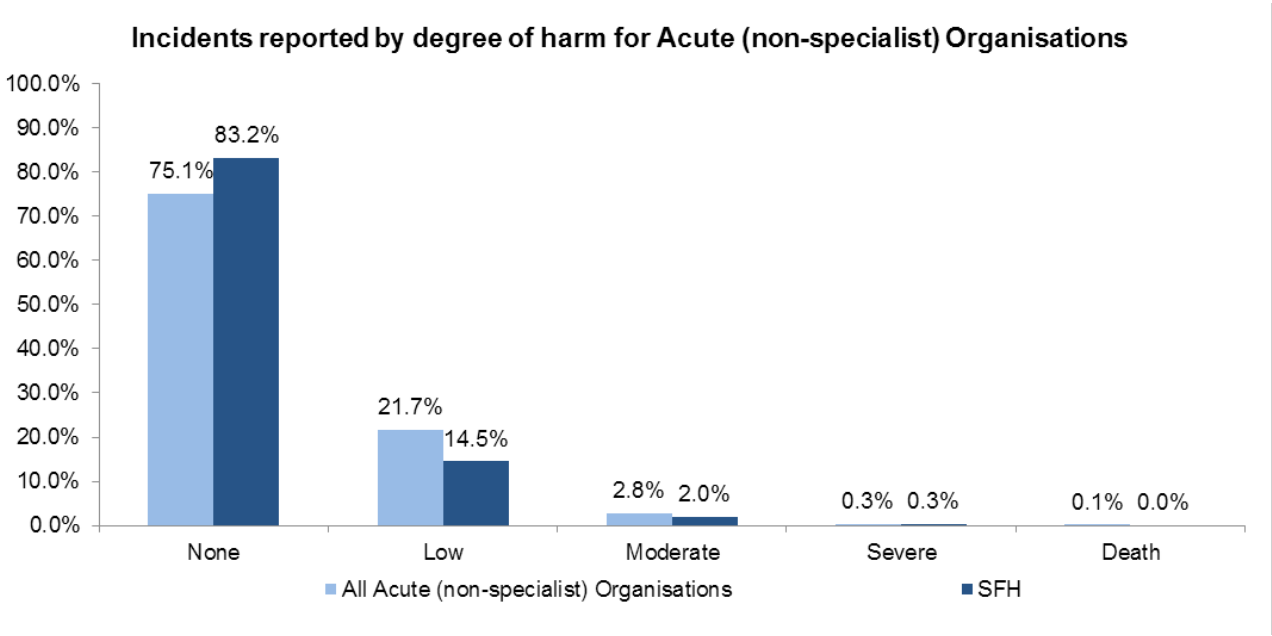
All Patient Safety Incidents are severity coded and this helps staff to determine the level of investigation required, this also helps to identify those patients or their representatives where the Duty of Candour applies. To help identify this requirement as soon as possible, the responsibility of severity coding the incident was changed on 5 April 2016 from the manager of the incident (handler) to the reporter of the incident. On the next working day the incident grading is checked and for incidents graded moderate, severe or catastrophic the Governance Support Team supports the Clinical Team to enact the Duty of Candour requirements. The Governance Support Unit has implemented a positive assurance system through the Datix module to proactively monitor compliance with Duty of Candour requirements, with routine compliance reporting for serious incidents Duty of Candour through the Patient Safety and Quality Board and for moderate incidents through the divisional tracker.

Patient Safety Incidents are reported to the National Reporting and Learning System. On a six-monthly basis the NRLS publishes a report which provides information on the types of incidents with some analysis and benchmarking with similar hospitals.

The following table further illustrates the level of incident reporting by the Trust and the associated degree of harm compared to other non-specialist acute providers.

Sherwood Forest Hospitals NHS Foundation Trust			Comparison with other Non-Specialist Acute Providers		
Year	Number of incidents	Rate per 1,000 bed days	Lowest rate per 1,000 bed days	Highest rate per 1,000 bed days	Average rate per 1,000 bed days
1st April 2015 – 30th Sept 2015	3604	32.61	18	74	38.25

Source: NRLS



We consider that this data is as described for the following reason:

Incidents are reported electronically and can be submitted anonymously in line with the Trust's whistleblowing policy; this gives staff the facility to raise concerns without the need to identify themselves.

To improve the opportunities for learning all staff are encouraged to report near misses and actual incidents.

In the reporting period 1 April 2015 – 30 September 2015, Sherwood Forest Hospitals reported 3,604 incidents (rate pre 1000 bed days of 32:61) This is an improvement on the previous reporting period 1 October 2014 – 31 March 2015, when we reported 3,570 incidents (rate pre 1000 bed days of 29).

We intend to take the following actions to improve this rate, and so the quality of services:

- Continue to include Incident reporting within staff induction programmes
- The production of an Incident reporting user guide
- Development of a Sherwood Forest Hospital Datix User forum
- Participation at the Leeds Datix User forum – Engaging the end user

Learning from Incidents

To facilitate opportunities for shared learning from incidents the Trust introduced learning boards across all wards and departments in January 2015. The boards are updated each quarter and include the following information:

- Patient story
- Learning from a serious incident
- Safety briefing
- Lesson of the month
- Learning from patient experience
- With space for a theme. The theme for March 2016 reminded staff of their responsibilities with being open and offering an apology when things go wrong.

Shared learning events were organised in March, July and November and these events provided staff with the opportunity to learn from Incidents. The Governance Support Team plans to further review the opportunities for sharing the learning and measuring the effectiveness of change.
The Trust made a commitment to 'Sign Up to Safety'

The following pledges were made and the Trust linked the underpinning actions to quality initiatives.

PLEDGE 1-Put Safety First
Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

PLEDGE 2- Continually Learn
Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

PLEDGE 3- Honesty
Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

PLEDGE 4-Collaborate
Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

PLEDGE 5-Support
Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and to celebrate the progress.

Part 3
Other information

3.1 A review of Quality Indicators During 2015/16

The following section provides an overview of our quality indicator performance during 2015/16. Three key priorities were selected together with a further nine priorities which were sub-divided into the following three domains: improving patient safety, effectiveness of clinical care and patient experience.

The three key priorities selected for 2015/16 were:
1.Reducing mortality as measured by hospital standardised mortality [see Part 2]
2.Improve the management of sepsis and reduce sepsis related mortality [see Part 2]
3.Falls reduction [see Part 2]

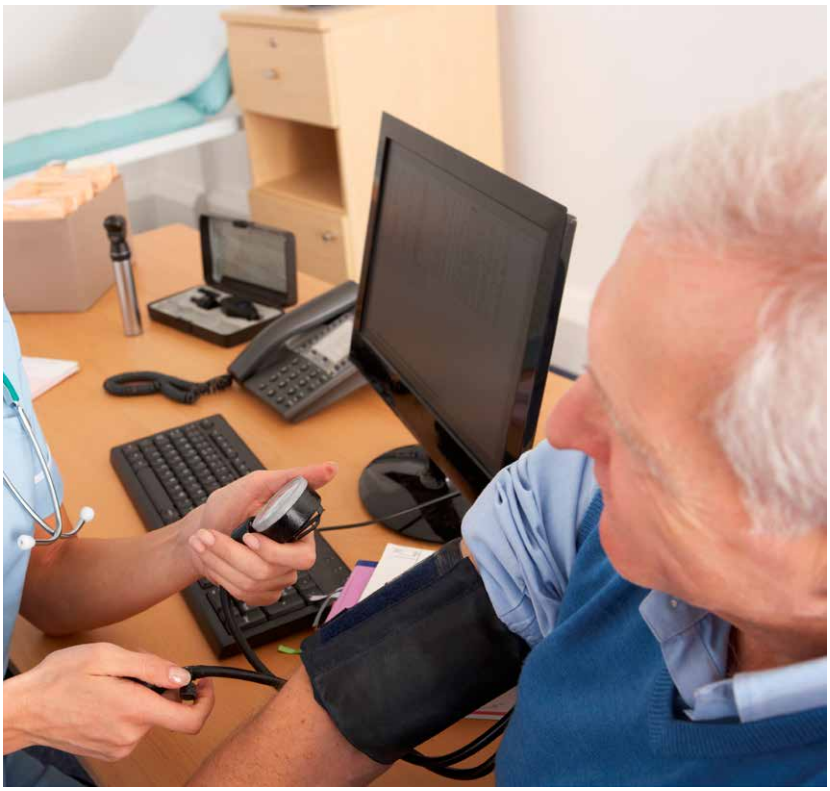
Our remaining Quality Priorities for 2015/16 were:

	2015/16 priority
Improving the safety of our patients	1. To reduce the number of Clostridium difficile (C. diff) cases reported [see Part 2]
	2. Improve medication safety [see Part 2]
	3 To reduce the number of urinary tract infections (UTIs)
Improving the effectiveness of clinical care	4. Reduce Hospital length of stay
	5. Improve the discharge information for acute kidney injury (AKI) diagnosis and treatment inhospital
	6. To improve the experience of patients who are coming to their end of life
Improving patient experience	7. Improve the experience of care for dementia patients and their carers
	8. Ensure that our complaints system and processes are robust, responsive and support organisational learning
	9. Safeguarding

This information has been formally reported and presented to a number of key committees, groups and forums within the organisation including the Board of Directors, Council of Governors, Quality Committee and Clinical Quality and Governance Committee. These were chosen following consultation with patients, staff and stakeholders and reflected the focus of quality improvement work for the Trust.

The focus of some of the quality indicators for 2015/16 changed from 2014/15. This was due to a change in the national focus and the areas where we sought to improve quality. The new quality priorities for 2015/16 were:

- To reduce the number of Clostridium difficile (C. diff) cases reported - national reporting and drive to reduce infections
- Reduce hospital Length of Stay - adaptation on 2104/15 priority
- Improve the discharge information for acute kidney injury (AKI) diagnosis and treatment in hospital – national CQUIN
- To improve the experience of patients who are coming to their end of life – local CQUIN
- Improve the experience of care for dementia patients and their carers – national CQUIN
- Ensure that our complaints system and processes are robust, responsive and support organisational learning - focus on becoming a learning organisation improvement in patient experience
- Safeguarding – an area where we sought to improve our quality of care and safety



The following sections describe our 2015/16 quality indicators in detail.

3.2 To reduce the Number of Urinary Tract Infections (UTI's)

Introduction

Healthcare associated infections (HCAIs) are a major cause of patient morbidity and mortality and result in significant cost to the Trust.

Urinary tract infections (UTI's) are one of the most common reasons for emergency hospital admissions, averaging 67 admissions per 1000,000 populations. In addition it is the second most common cause of HCAIs in the United Kingdom, amounting to 17.2% of all hospital acquired infection. Of that number 43% of patients with a UTI had a urinary catheter present within seven days prior to the onset of infection (HPA 2012). Furthermore the evidence identifies that urine contamination (bacteriuria) occurs at the rate of 3-10% per day. This rate is determined in part by the management of the urinary catheter from insertion to removal.

This issue is further compounded with the increasing risk of an urosepsis occurring in those patients with a urinary catheter. The medical technology group (MTG) has found that the NHS spends on average £2,361 per patient with a CAUTI; the costs are substantially higher if a blood stream infection is involved.

Two years ago we set an internal target to reduce the numbers of blood stream infections related to a catheter associated urinary tract infections (CAUTI). The target was set at five cases per annum. This has not been achieved.

What we have done in 2015/2016

During the past year, the Infection Prevention and Control Team (IPCT) has sought to identify the reason for there not being an improvement and to seek a solution.

The IPCT lead has focused on reducing harms associated with urinary catheter. A cross-health economy working group considering how to improve the rates of CAUTI's, has incorporated a UTI scoping group within its remit.

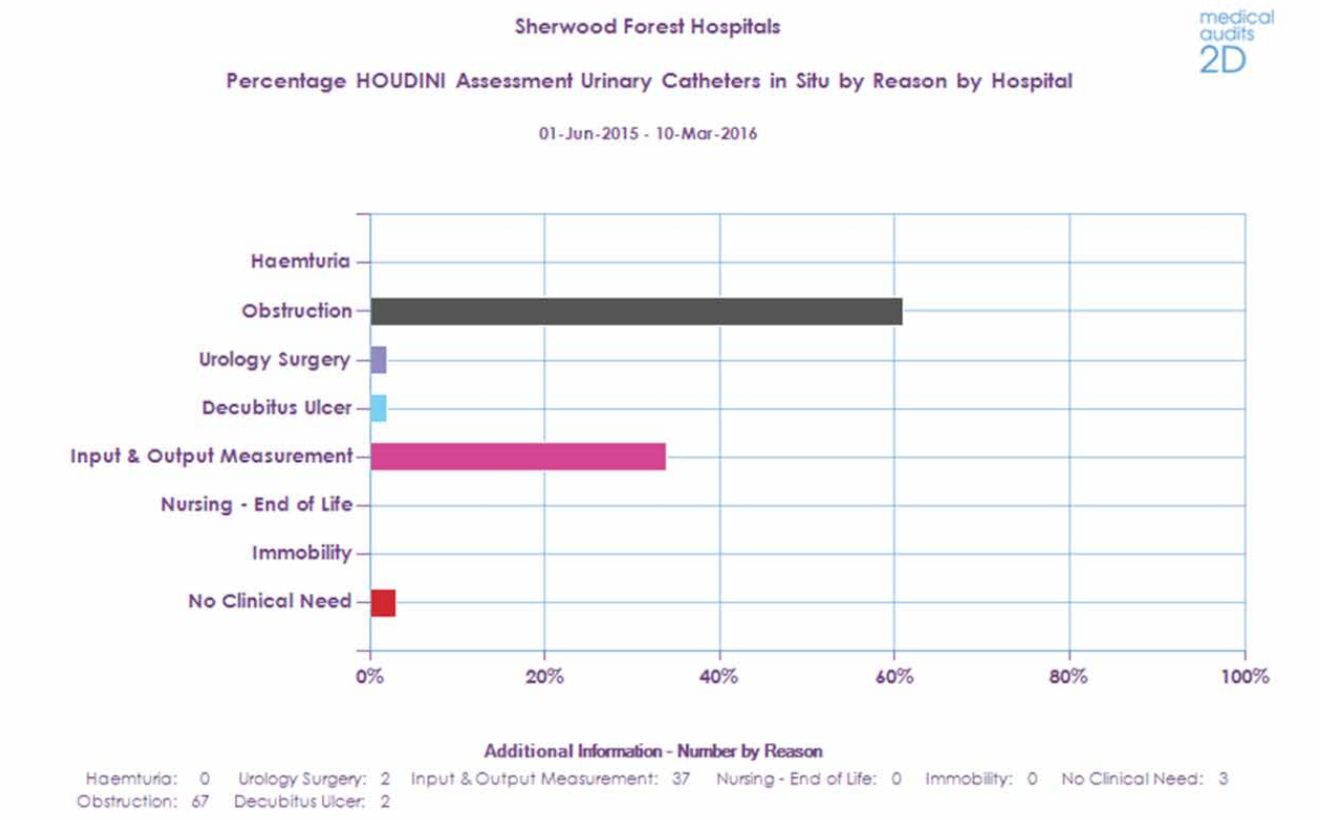
Through a process of audit the IPCT has identified issues with compliance with both practice (Table 1) and reason for insertion (Graph 1)

Table 1 shows compliance against six key elements that indicate safe practice with urinary catheter management. The standard is for 100% compliance to be achieved, at present we are reporting a compliance rate of 83%.

Table 1

Sherwood Forest Hospitals							
	Need Reviewed and Documented Daily	Drainage Bag Positioned Correctly	Daily Meatal Hygiene Performed	Closed System Continously Connected	Catheter is Emptied as per Policy	Hand Hygiene as per 5 Moments	Total
Total Observations	483	483	483	483	483	483	483
Number Compliant	415	472	431	483	482	481	402
% Compliant	85.90%	97.70%	89.20%	100%	99.80%	99.60%	83.20%

Graph 1 shows the reason documented for a catheterisation, in 3% cases no reason was documented. In 97% a reason was documented , primarily due to obstruction, though a substantial number have been inserted for fluid monitoring.



The current system in use by the hospital for urinary catheterisation does support adherence to best practice with clinicians being required to separately identify and collect different pieces of equipment to perform a catheterisation increasing the risk of non-compliant practice due to items being forgotten, or out of stock. The trial usage of an integrated urinary catheter pack evaluated extremely well and a proposal to implement it across the organisation was made. A roll-out programme is to commence in March 2016.

Progress against the target

In 2015/16 there has been no improvement on preceding years and the internal target has not been met.

Monitoring and reporting

All cases of CAUTI bacteraemia infections within the Trust undergo a root cause analysis (RCA) to establish the underlying reasons for the patients to have succumbed to the infection. These are reported back within both internal corporate and divisional governance structures and externally.

What we aim to achieve in 2016/17

Following implementation of the new urinary catheter packs it is anticipated that there will be a substantial reduction in CAUTI and therefore related blood stream infection.

From April 2016 a campaign across the whole health care economy to improve patient and staff understanding in identification and prevention of UTI's including those related to catheters.

The IPCT and Urology Outreach Team will pursue the introduction of a catheter passport

3.3 Safety – Reduce Harm from Falls

Introduction

Falls in hospitals are the most commonly reported patient-safety incident, with more than 240,000 reported in acute trusts and mental health Trusts in England and Wales each year. (National Patient Safety Agency, 2010). Falls are a major cause of disability, pain, loss of independence and loss of confidence. Injuries resulting from falls range from soft tissue trauma, fractures, head injuries and sometimes death. Falls in hospital are financially expensive, as they increase the Length of Stay and may require increased care costs upon discharge. The direct cost of falls in hospitals is around £15 million a year. (National Audit of Inpatient Falls 2015). Falls resulting in fracture of the hip cost our organisations almost £4,000 per patient. It should also be recognised that very often patients and their families feel anxiety and anger when a fall occurs leading to complaints.

Why has this indicator been chose as a priority?

Reducing harm from falls is a priority on both the local and national health care agenda.
During 2013/4 we signed up to CQUIN goals and a Lead Nurse for Falls Prevention was recruited to help staff to drive improvements in care.

In 2015/6 in addition to the CQUIN the falls agenda then became a Trust quality priority and a second Falls Nurse was seconded to support the Falls Improvement Programme

What did we achieve during 2014/15

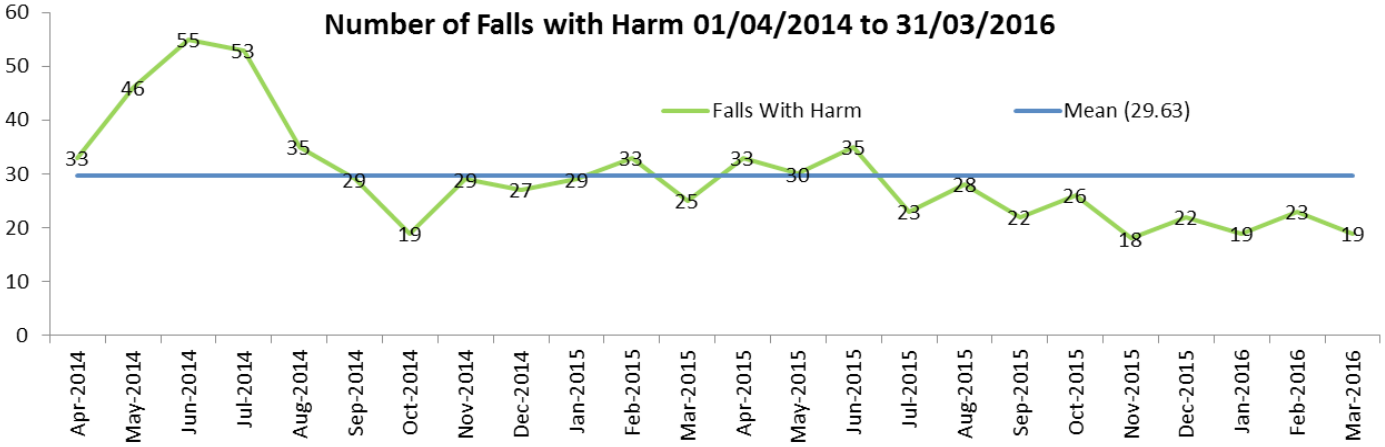
- A cultural shift in the ownership and management of falls across our in-patient wards
- A falls champion model across the organisation to disseminate best practice standards
- Falls reduction training within our nurse induction, mandatory study days and Proud to Care study sessions

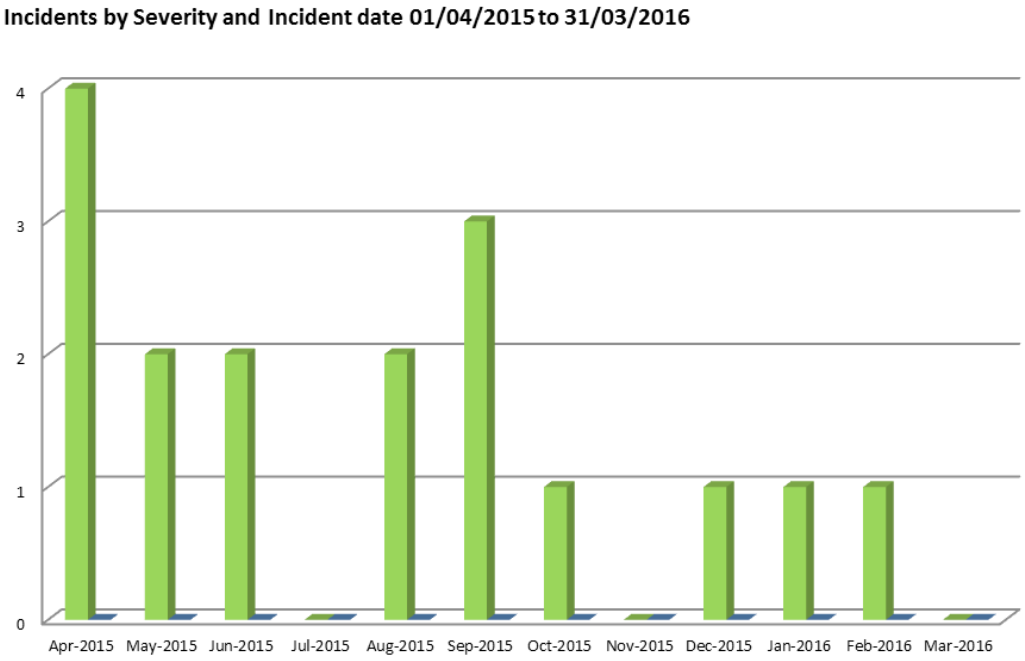
What did we aim to achieve during 2015/6

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

What did we achieve in 2015/16

The graph below (Graph1) plots the number of falls with harm over the past 24 months. The trend is beginning to demonstrate a slight downward improvement especially when compared to the mean for the period.





	Apr-2015	May-2015	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	Mar-2016
(Level 4) Severe - Permanent or long term harm	4	2	2	0	2	3	1	0	1	1	1	0
(Level 5) Catastrophic - Death	0	0	0	0	0	0	0	0	0	0	0	0

We continue to demonstrate a reducing percentage of falls per 1000 bed days
There were no severe or catastrophic harms reported in March.

What did we achieve during 2015/6?

Over the past 12 months through national networking and educational events the falls nurses have developed new ways of working that will aim to reduce the harm from falls.

A seven-day service was provided by the Falls Nurses, where possible, which enabled the nurses to provide support and education to staff outside of the normal working hours and to respond to incidents as required.

The reformed Falls and Safety Group met on the 21 January. The focus of work is to agree a Trust-wide strategy to reduce falls with associated work-streams.
The Falls Lead Nurse post is now substantive from 1 April 2016.
The following provides further detail regarding our performance

Education:

Education and safety improvement programmes always incorporate local and national themes.

- There is continued ward and departmental data analysis and plans of action made in those areas that need to improve on falls prevention. For example, within the Emergency Department, better signage has been developed to enable patients to locate the call bells more easily. There are also changes in the risk assessment documentation
- CareFall/Falls-safe, e-learning courses via the E-ACADEMY on line educational programme within the Trust, which incorporates falls training for doctors and nurses, will be available in the coming months

- A joint study day was held in December 2015 to cover the link between dementia and falls. It was open to Trust staff and nursing/care home staff. Evaluations were positive. The day involved speakers from various specialty areas
- On 1st April 2016 the Falls Nurses held an April No Falls Day in the King's Mill Street and also visited all wards with educational packs. Information was available around falls prevention in both hospital and at home

- In March the Falls Lead Nurses were invited to present an educational and practical session on an 'Inter-professional l Learning Day' at King's Mill Hospital. The session covered the National picture alongside the Trusts performance and included a patient story
- Mandatory training and staff induction sessions are delivered by the Falls Lead Nurse

Management of Risks identified

- Analysis of the Trust's incident monitoring system by the Lead Nurses has enabled prompt response to any concerns raised
- In response to data analysis and by visiting patients who have fallen on the wards there was a theme concerning management of delirium and falls prevention. The Lead Falls Nurse distributed written guidance to wards and departments which addresses areas to consider, for example, environment and pain when assessing a patient's individual risk
- In learning from investigation reports and the requirement to implement change in practice, an example of this being patients with toe to knee bandages on and patients with oedematous feet being at a greater risk from slips due to their own footwear being inappropriate, there has now been a purchase of firm fitting slippers in various sizes.
- The pilot safety equipment has been received. The Falls Nurses have contacted the Research & Innovation department for advice in order to enable evaluation of the equipment's effectiveness against falls prevention
- The emergency department have installed patient buzzers in all cubicles
- A system to improve patients who fall in the emergency department now includes the use of an alert sticker on the front of the documentation that is used for 12 months. If patients are successfully discharged from the Emergency Department they are referred to the Community Falls Team for follow up
- Good practice around falls prevention in ward and department areas is always highlighted, an example of this being an educational and recording document for lying and standing blood pressure recordings, developed and shared by a ward Charge Nurse.
- In February it was identified that there was an increase in the number of patient falls on the Stroke Unit. The ward has been provided with additional educational support. The number of patient falls slightly decreased in March. It should be noted that a majority of patients on the Stroke Unit are involved in a rehabilitation programme and research shows that the risk of falls may increase in stroke care as patients' mobility and independence are promoted. Reducing these risks are an essential element in rehabilitation strategies, the major challenge is to reduce the number of falls without lowering the levels of activity.

Royal College of Physicians National Audit of Inpatient falls.

The Trust's overall performance in the National Inpatient Audit has been circulated to the Falls Group. Going forward there is to be a re-audit in September 2016.

- The gap analysis for the National Inpatient Falls that we participated in May 2015, with 12 key recommendations as the key agenda has been evaluated and the recommendations in the audit are used to guide the falls prevention and education. Examples are, to address the recommendation for the assessment of medications that increase the risk of falls. Information and guidance has been provided by the Pharmacist that is available on the Intranet and identifies the drugs that may increase the risk of falls
- The revised Nursing metric audit questions, which reflects recommendations in the National Audit of Inpatient Falls, commences in April 2016

Corporate

- Woodland Ward has continued to show a reduction in the number of patient falls. Staff are visibly engaged with patients in the bays using the patient workstations. From data analysis it has been noted that there are now fewer falls in the bay areas. The Falls Lead Nurse is working with the Practice Development Team to roll out a project "Patient Station Not Nurses Station" to four further ward areas .The Falls Lead Nurse has gained positive verbal feedback from patients, relatives and staff as to the new working practices

- The Falls Nurses suggested, and it was agreed, that the current falls data presented at the Geriatric Governance Meetings would be more beneficial if it was replaced by the data and narrative obtained by the Falls Nurses

Monitoring, measurement and reporting

- The first Falls and Safety Group meeting was held on 21 January 2016. The group addresses issues from a multi-disciplinary perspective
- The Falls and Safety Group will operationally lead the Falls Reduction Strategy. This group will report into the Clinical Quality and Governance Committee and in turn the Board of Directors, via the Quality Committee. Progress against this priority will be monitored by the Quality Committee
- We monitor our falls performance at monthly assurance meetings and performance is published on the ward communication boards
- From a governance perspective recent improvement to the data collection systems, Datix has allowed improved data production to ensure it informs our continuous improvement work

2016/2017 plans for sustained improvement.

- Reducing falls continues a priority and for some of the aspects focused on to improve the safety culture related to falls includes:
- Develop and maintain a programme of work for falls prevention in conjunction with Nottingham University Hospitals
- Continue to develop partnership working with the community to improve communication systems and provide education in the community around falls prevention in hospitals
- Roll out the purchased safety equipment and evaluate its effectiveness within falls prevention
- Continue to progress with research-based practise and develop safety improvement programmes through learning from best practice and innovations

3.4 Effectiveness – Reduce Hospital Length of Stay

Introduction

The most significant issue is not about the numbers of people presenting at Emergency Department, but the ability to discharge patients safely and quickly from the hospital as a whole.
Organisations should focus on improving the flow of patients through the hospital and increase the speed at which patients are discharged.
What's behind the A&E Crisis. Nuffield Trust Policy Briefing March 2015.

This is a quote from a report produced by the Nuffield Trust in March 2015 that was written in response to the perceived A&E crisis across the UK during the winter of 2014/15. It was an important quote for the Trust because it demonstrated that our plan to focus on 'patient flow' had some credibility with national experts.

The recognition that discharging patients was an important element of maintaining a safe and calm hospital was fully supported by the wealth of clinical evidence that verified ensuring patients are discharged back to their usual place of residence, wherever possible, in a safe and timely manner was a key part in maintaining patients' independence and functionality, especially for our older frail patients.

It was also recognised that the Length of Stay (LoS) for some of our patients exceeds that of patients in similar sized hospitals, with similar conditions across the UK. Sometimes that means our patients stay with us for days more than a patient being cared for with the same problem in a different hospital. We all recognise that generally patients like to be at home. Reducing our LoS means we reduce the number of days a patient is in a hospital bed which in turn can reduce the number of beds we have to keep staffed. Because the NHS has a shortage of clinical staff, ensuring our staff care for patients who actually need to be in hospital ensures the most efficient use of precious resources.

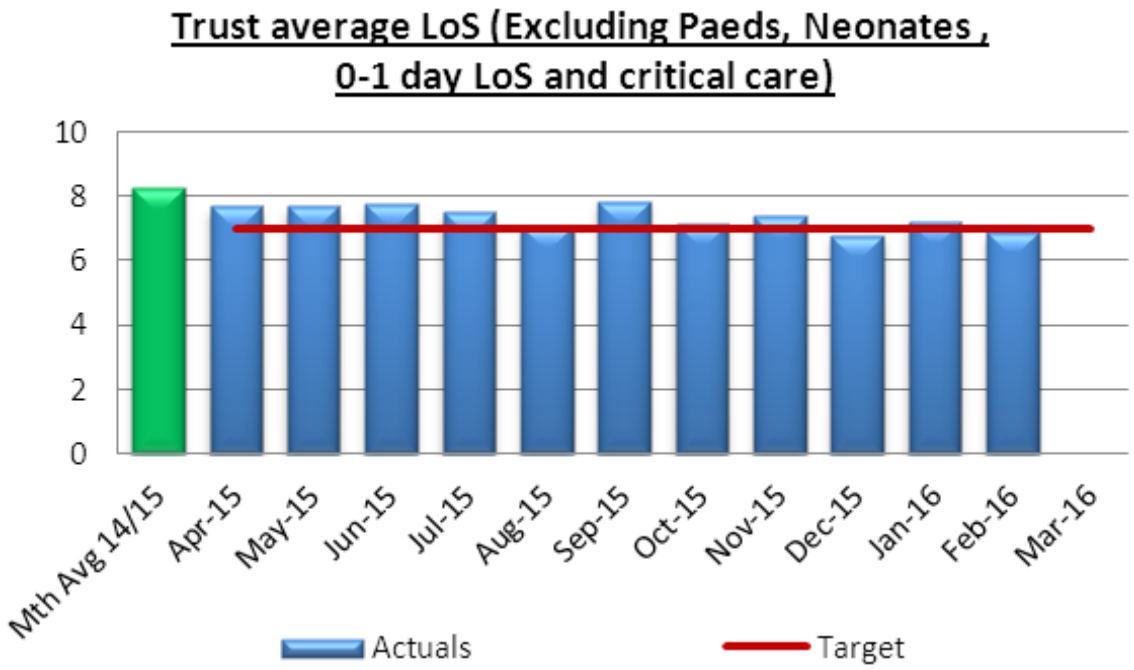
In short, reducing patient's LoS, by focussing on prompt care delivered compassionately and planning for discharge as part of the admission process, was clinically the right course of action to take.

What did we aim to achieve in 2015/2016

There was an agreement with Monitor that during 2015/2016 our average LoS needed to reduce from 8.3 days to an average of 7.0 days. This is based on hospital spells discharged each month and excludes all 0-1 days' length of stays and all neonates, children and patients in critical care.

How are we performing against this target?

The table below demonstrates that as at 29 February 2016 the organisation had reduced its average LoS to 6.9 days.



How did we achieve this?

We have specifically focussed on ensuring that if our older, frail patients can be safely cared for by our clinical colleagues in the community they are not admitted to hospital. When the patient's clinical condition requires admission we begin to plan for their discharge at the time of their admission. This means that the number of patients who had an LoS in excess of 14 days has reduced. On 7 January 2015 there were 288 patients who had occupied nearly 11,000 bed days in total (meaning they had an average LoS of 37.9 days). By 15 September there were 228 patients who had occupied 7353 bed days, averaging 32.25 LoS.

In order to ensure we maintained a focus on reducing our LoS, we have now started to focus on the patients whose LoS exceeds 10 days. On 29 March 2016 there were 260 patients who had been a patient longer than 10 days. Cumulatively their total number of occupied bed days was 6838 meaning they had an average LoS of 26.3 days.

We have embedded the Discharge Co-ordinators into the multi-disciplinary teams on wards and their role is to ensure patient discharge is robustly managed from the time of admission.

We have established daily 'delayed transfer of care' meetings with our social care and community health care colleagues to ensure patients whose LoS is beginning to exceed that which is expected have a plan for discharge that is being managed by the whole health and social care team.

During our work in 2015/16 it has been recognised that we need to undertake further focussed work on ensuring that we plan patient discharges more effectively. Planning for discharge should encompass all those caring for the patient and most importantly the patient themselves. Improved and proactive identification of a defined date of discharge, together with improved information supporting a patient's discharge will reduce their LoS and ensure the patient's discharge is safer. In 2016/17 we will undertake specific work to improve discharge planning.

Monitoring and reporting for Sustained Improvement

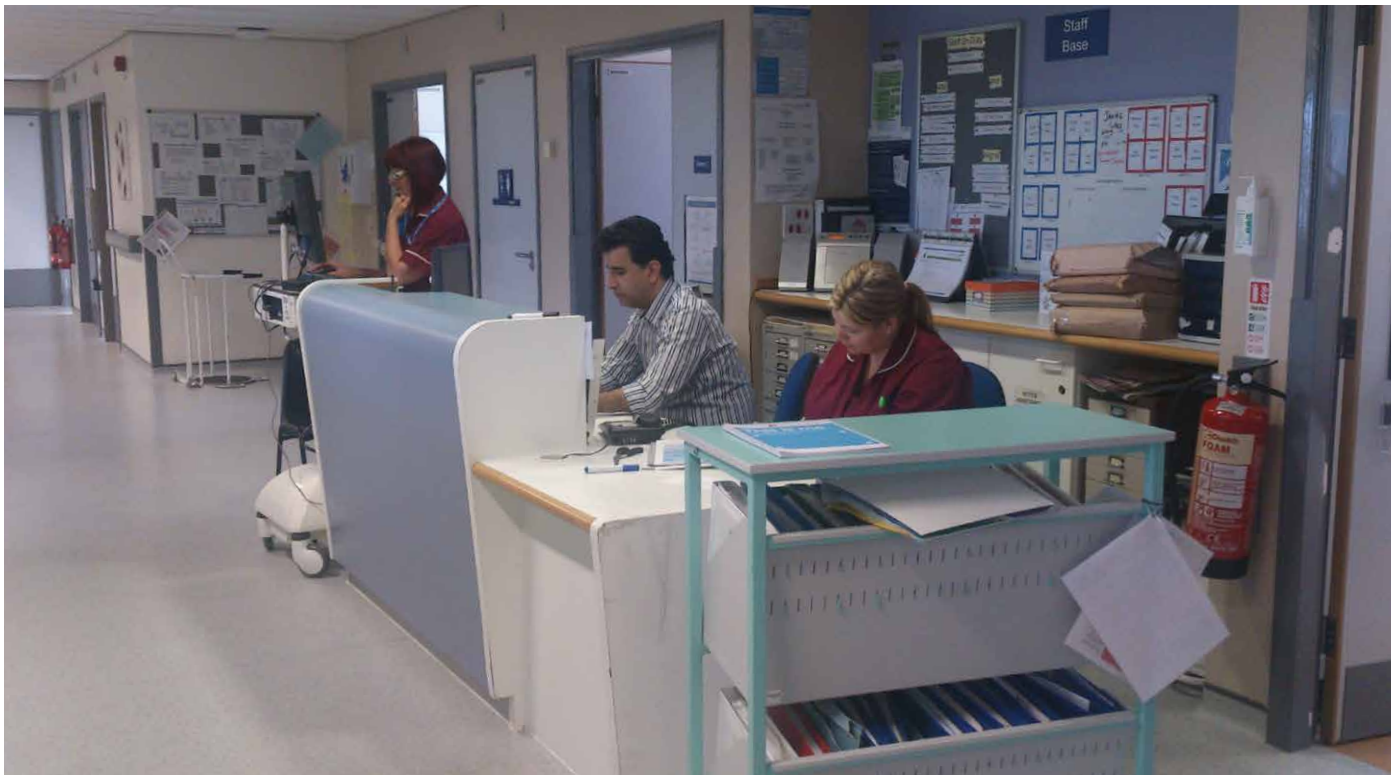
There is a daily report on the number of patients whose LoS exceeds 10 and 20 days that is circulated widely to ward clinical teams and managers.

The daily meeting, described above, is continuing.

The is now a daily meeting, chaired by the Divisional General Manager, which reviews the patients who have a delay transfer of care caused by internal causes to SFH.

There is a weekly performance meeting chaired by the Chief Operating Officer at which length of stay is discussed.

The Trust Board of Directors receives monthly information about of length of stay.



3.5 Effectiveness – Improve Discharge Information for Acute Kidney Injury, Diagnosis and Treatment in Hospital

Introduction

Acute Kidney Injury (AKI) is a clinical problem that affects many of our patients. It is often identified at the time of admission and sometimes develops during an admission. There are multiple causes and early treatment is vital to protect the kidneys from long term damage. It is frequently caused by dehydration due to acute illness so fluid replacement forms part of the plan when treating the underlying illness. NICE have provided guidelines around the management of AKI because it such a widespread and potentially high risk condition. It is also very treatable. In 2015/16 acute kidney injury was identified as a national CQUIN and as a result of this the Trust included it as one of the quality priorities.

What did we aim to achieve in 2015/16?

National concern has also been focussed on the information that GPs receive on discharge about AKI in their patients.

We set ourselves the following goals:

- To record the stage of acute kidney injury in the medical records and communicate this to the patient's General Practitioner (GP)
- To demonstrate evidence of a medication review having been undertaken
- To communicate to the patient's GP the 'type and frequency of blood tests required on discharge' for monitoring

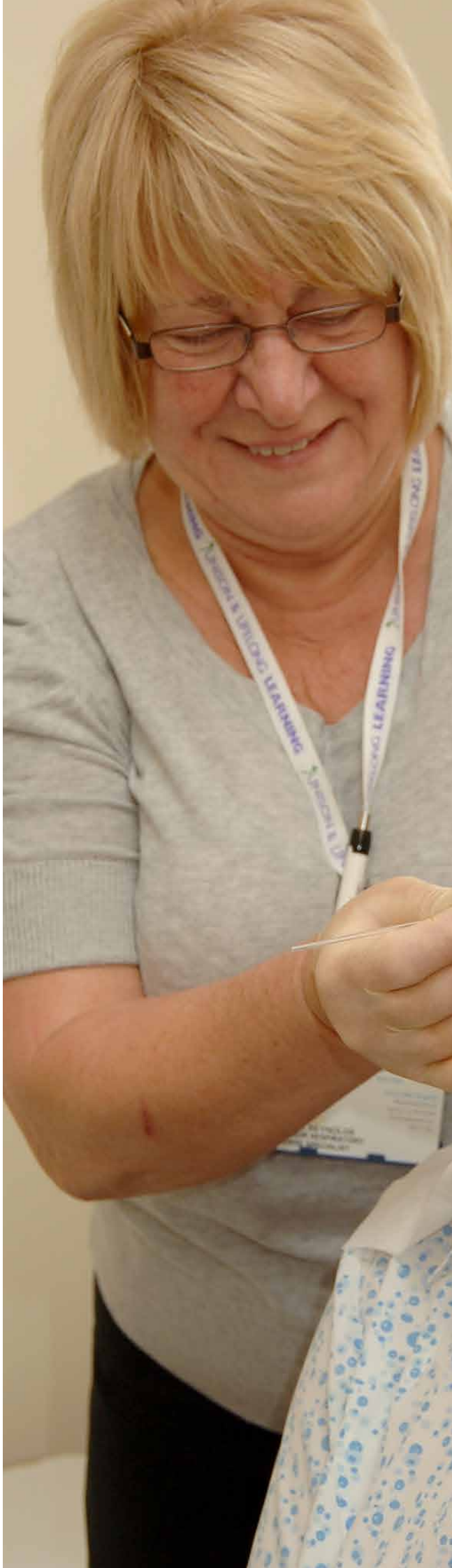
How are we performing against this target?

At the end of quarter four 2015/16, having met our targets for all previous quarters, we are on target to achieve a greater than 90% rate of informing GPs about AKI, its management and the follow up required.

How did we achieve this?

We worked with our IT team to introduce a section of the discharge letter that had to be filled out in the form of questions that need to be answered about AKI. We informed doctors about the change and reiterated its importance to patient care. Compliance has been excellent. For each quarter, we have met and surpassed our reporting target and are now achieving a greater than 90%, meaning that GPs are more informed about patient care in hospital allowing them to monitor kidney function appropriately.

AKI will always be a clinical area requiring attention. A new renal consultant has joined our team in partnership with the Renal Team at Nottingham University Hospitals have worked with us on the management of renal patients at SFH. Along with our consultant, Nottingham University Hospitals



provide a daily review service for patients with AKI and other renal problems and provide advice on their management. This management and advice can now be fed back to the GP via the discharge letter.

Monitoring and reporting for sustained improvement

At the end of 2014/2015 we introduced a care bundle, designed to ensure that, where AKI was identified, the correct tests and investigations were put in place straight away and appropriate monitoring of the condition was commenced. We are currently completing an audit of compliance with this bundle of care against the NICE Guidelines. This audit has been created using the Trust's electronic audit system, Meridian, and will be completed annually to ensure that care for our AKI patients remains optimal. Following completion of the CQUIN, we will incorporate review of the AKI discharge process to ensure that we continue to inform GPs about the on-going management needs for their patients.

We have been using and benefiting from an electronic alerting system for AKI for the last two and a half years, allowing clinicians to see a message that there is an AKI and what stage it is when they look at the blood results. We received notification at the end of 2014 that a national alerting system was being introduced with which all Trust's must comply by March 2015. It was designed so that statistics regarding AKI could be collected at a national level. We adapted our processes and had our system ready in March 2015, although delays in the national programme meant that it went fully live later in the year. We have been informed that we are one of only 70 (out of 120) Trusts whose data is uploading correctly to HES (Hospital Episode Statistics).

3.6 Effectiveness – To Improve the Experience of Patients who are Coming to the End of their Life.

Introduction

Improving the palliative and end of life care remains a public priority across the country and for our local communities. Many people are affected by the death of a member of their family or a friend.

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

Becoming more confident to talk about our beliefs about dying and our needs for achieving comfort and dignity is essential and we are committed to supporting 'advance care planning' and training staff to listen to patients choices and preference for their treatment or care and help support people who are bereaved.

We aspire to improving the standard of care and be one of the best, following national guidance and learning from local people's experiences; understanding the priorities for care of the patient and those important to them. We promote a positive culture of care that has compassion and kindness at its heart which is delivered by good teamwork and communication. This helps us provide an individualised care plan to support the patient at the right time and in the right place. This sometimes means getting patients back home, to a hospice or care homes or help them in hospital depending on their preferred place of care and death.

In recognising the importance of improving palliative and end of life care, we identified this area as both a quality priority and agreed a related CQUIN with commissioners.

What did we set out to achieve during 2015/16?

During this year we set out to improve many aspects of care and were guided by using a range of information especially from listening to patients and those important to them. Improving the leadership and governance of end of life care was essential to ensure the quality and standards were met.

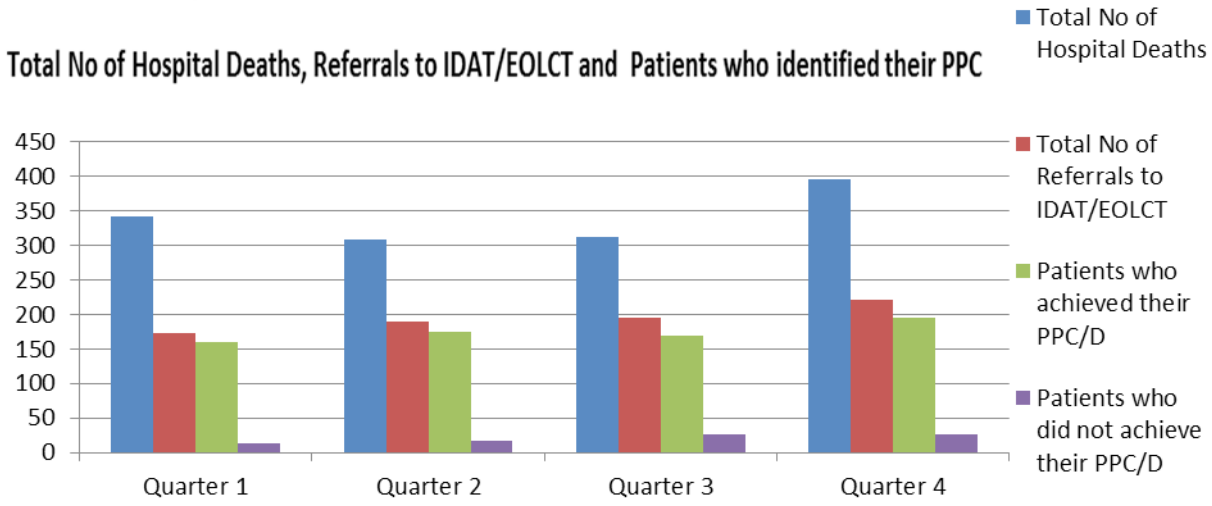
The following reflects what the Trust aimed to achieve.

- Have End of Life Care (EOLC) Clinical Champion in place
- Increase in the number of inpatients who die in their place of preference, evidenced through audit and a reduction in the number of hospital deaths
- Ensuring patients are discharged safely and effectively
- Evidence of improved rates of staff training in end of life care

How are we performing against these targets?

In April 2015, the Trust appointed a Clinical Champion to work within the End of Life Care Team. In addition we have end of life care champions across all of our wards to provide support and share good practice.

During 2015/16 we continued to monitor the number of hospital deaths and measure Preferred Place of Care (PPC). The following graphs summarise how we achieved the patients Preferred Place of Care (PPC) and where patients died before we could achieve their PPC

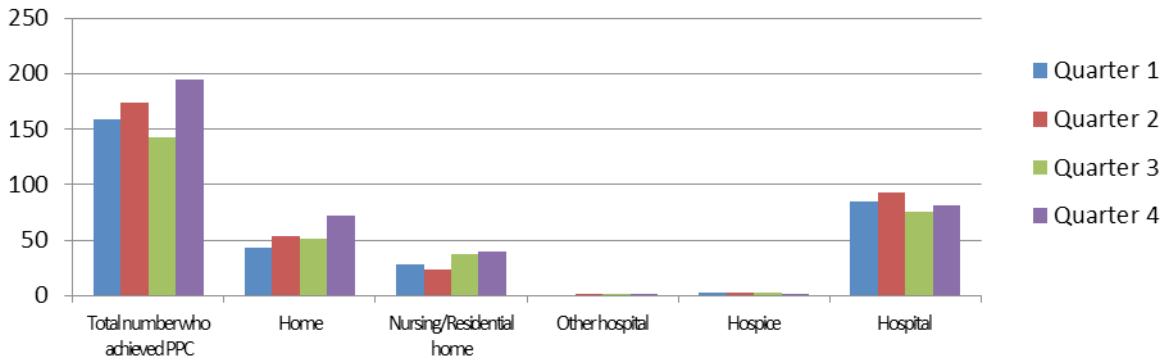


The data above shows that between 1 April 2015 and 31 March 2016 there was a total of 1,358 deaths in hospital.

A total of 779 (57%) patients were referred to the Integrated Discharge Team and End of Life Care Team in order to achieve their preferred place of care and death.
We achieved the PPC for a total of 697 (89%) patients.
We did not achieve the PPC for a total of 82 (11%) patients because they died before they could be discharged.

We continued to monitor the quality of discharges against the parameters on the CQUIN. The following graph shows that 352 (52%) of patients were discharged to: Home 219 (31%), Nursing/Residential Home 129 (19%), Hospice 10 (1%) Other hospital 4 (1%) and 335 (48%) chose to stay in this Trust.

Discharged to their normal place of residence and chose hospital as their PPC



Achieving significant changes in performance was challenging as many factors that influence patient choice were beyond the Trust's control. As part of this programme of work we collected information about what stopped patients care being delivered in their place of choice and are working proactively with partners to remove challenges.

Ensuring patients are discharged safely and effectively

Between 1 April 2015 - 31 March 2016 the table below shows the total number of Fast Track discharges to the patient's PPC and the number of patients discharged with Anticipatory Medications; Communication to GPs/ Healthcare Professionals; CNCS/ Out of Hours notification; AND; and Care Plan in place.

	Total No of Fast Track Discharges	Anticipatory Medications prescribed	GP's/Healthcare Professionals were communicated to	CNCS/ Out of Hours were notified	Average rate per 1,000 bed days	Care Plans in place
2015/16	352	342 (97%)	309 (88%)	282 (80%)	324 (92%)	336 (95%)

By process of the on-going audits and monitoring patient experience through this CQUIN, the End of Life Care Team and Integrated Discharge Advisory Team (IDAT) are more focused on patient outcome. Although there has been no significant reduction/increase in hospital deaths, the evidence suggests that patients are being given the opportunity to express their preferences and we are identifying their preferred place of care/death at the earliest opportunity to facilitate a discharge to the appropriate place.

National End of Life Care Audit

The results for the national audit for End of Life Care have been published and a summary of the audit findings are below:

- The Trust has [positively] exceeded the national average in all the five summary clinical indicators
- The Trust has improved its performance since the last audit 2014-15 (NB: some audit criteria have changed slightly)
- The Trust favoured positively in benchmarking with comparator Trusts
- The Trust met seven out of eight organisational audit indicators, indicator 6 (representative lay member of the Trust Board for End of Life Care) was met in December 2015 after the data was submitted

Key areas for improvement:

Clinical assisted Hydration and Nutrition.

There is a requirement for further involvement of and support for relatives in decisions relating to clinical assisted hydration and nutrition.

Specialist Palliative Care (SPC)

The national audit reflects on-going local concern that the current SPC Hospital Support Service requires review.

Needs of the families and others

Although the report demonstrates a positive comparison to national data, the actual result is lower than we expected for support of the people most important to the patient.

Staff training in end of life care

Good progress has been made with training to achieve the planned training within the annual Training Programme 2015/16. Analysis of the training delivered over 2015/16 shows an increased opportunity for staff to access training. A training needs analysis has been undertaken to understand the medical and nursing staff knowledge and skills on end of life care, and their further training requirements.

Mandatory Update

Between 1 April 2015 and 31 March 2016, 1782 staff, which included nursing/OPD, HCA/ANP, (excluding paediatric/NICU & midwifery) qualified therapy and assistants and Chaplaincy completed and passed the End of Life workbook on the Mandatory Update. The current compliance as at 31 March 2016 of permanent staff is 79%.

Induction Training

Between 1 April 2015 and 31 March 2016 a total of 385 newly registered and non-registered nurses and 120 junior doctors attended induction training.

Additional Quality and Improvement Priorities

CQC Inspection and Quality Improvement Plan

The End of Life Care Team as part of a Trust-wide response has responded to the learning from inspection and other review processes. The improvements have been monitored through the Quality Improvement Plan.

Quality Governance

The Trust has a strengthened General Palliative and End of Life Strategy Group with a new executive lead and a non–executive director as part of its membership. This group looks at the Trust strategy, the culture and quality of the service and submits monthly reports. The group considers risks in the strategy and delivery of care and has escalated concerns where necessary.

Trust Board

The Trust Board receives reports from the General Palliative and End of Life Strategy Group. Members of the Board are also members of this group. Further work was completed to ensure the Board was informed of the achievements we have made, the challenges we face and our plans for the future. In December 2015 the story of a patient was told by a bereaved family and clinicians to the Trust Board. This story emphasised particularly the experiences of the last few days and weeks of the patient's life and the impact on the family. The story helped to identify good practice and positive experiences of care as well as what needed to change.

Safety

Incident Reporting: Between 1 April 2015 and 31 March 2016 there were no Never Events or STEIS reportable incidents. There was one Serious Incident and 33 clinical incidents. All Datix incidents during this period were reviewed by the group and, where necessary, further investigations and reports from the relevant teams were requested and received.

Patient Experience

Complaints: Between 1 April 2015 and 31 March 2016, there were 21 complaints received from patients. These complaints were investigated, working with the Patient Experience Team and resolved in a timely manner.

Bereavement Survey: Between 1 April 2015 and 31 March 2016, 893 questionnaires were sent out to those families/people who had suffered bereavement. These people had agreed to participate in this survey. 354 (40%) responded to this survey. Overall the results are consistently positive and continuous improvements in standards of care, in particular around environment, caring and compassion and treated sensitively. Relatives felt confident in the care offered by nurses and doctors, that where possible, patients' preferences as to where they want to die is acted on; they were treated with dignity and respect and felt involved in decision making regarding care and treatment. Since January 2016 this survey allows, with the family's permission (where respondents have waived their anonymity), to identify the specific issues and people involved. This has helped us give feedback to staff on both good practice and areas for improvement.

End of Life Care Summit

The Trust participated in the Mid Nottinghamshire End of Life Care Summit. This helped us to identify our good practice, themes for improvement and allowed us to promote joined up working with other providers and commissioners.

Monitoring and reporting for sustained improvement

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

Other areas we have focussed our efforts on include:

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

For 2016/17 we plan:
The quality of palliative and end of life care for patients and those people important to them remains a quality priority for the trust and we will focus on:

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

3.7 Patient Experience – Improve the Experience of Care for Dementia Patients and their Carers

Introduction

Dementia is a progressive illness which causes decline in mental ability severe enough to interfere with daily life. The progression of dementia is often associated with complex needs and high levels of dependency. Identification of people living with dementia is imperative to ensure early diagnosis, treatment and supportive care for the person and their carers. This is the third year that dementia has been a Trust priority.

What have we achieved in previous years?

Dementia has been a national CQUIN for the past three years. The goal of the national dementia CQUIN has been to improve the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that we deliver high quality care to people with dementia and support their carers. Over the past three years, processes have been developed to ensure at least 90% of emergency admissions are screened for dementia on admission and are referred for appropriate specialist assessment when required. The next graph (over the page) shows the journey of improvement against this target.

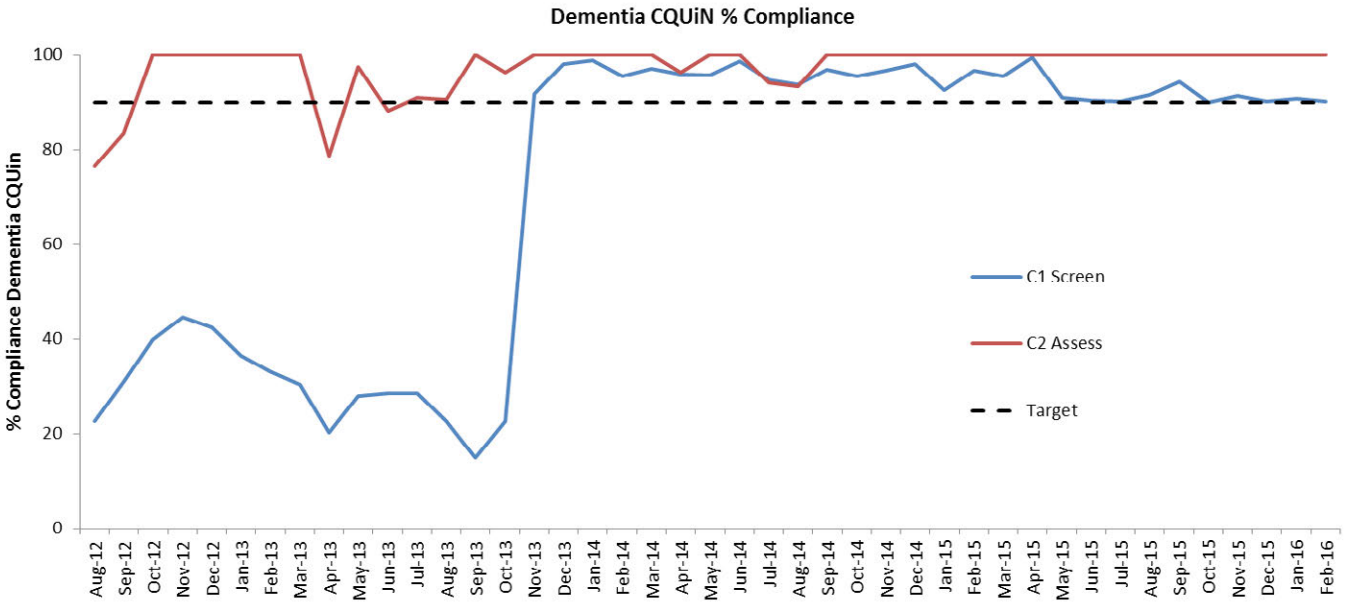
The training programme has been developed to ensure all staff joining the organisation have dementia awareness training and key staff groups receive this on a yearly basis.

Carer surveys have been developed (including different ways of collecting feedback) in order to ensure that carers for people with dementia feel adequately supported.

What did we set out to achieve during 2015/2016?

- 90% of all emergency admissions over 75 years (exclusion criteria within CQUIN) will be screened for dementia and ensure that those with positive screens are appropriately assessed. For those referred for further diagnostic advice, ensure outcomes from the assessment and care plans are shared with the patient's GP
- Ensure that appropriate levels of dementia training are available to all staff
- Ensure that carers of people with dementia and delirium feel adequately supported.

How are we performing against this target?



I) FAIRI (Find, Assess, Investigate, Refer, Inform)- Screening patients for dementia:

A cognitive screening assessment is performed during nurse triage in the Emergency Department for all patients 75 years and over; this includes a four-point abbreviated mental test score. Patients who are identified as vulnerable from this assessment are cared for in observable areas and are identified on the patient location board using a red plaque (to ensure all staff are aware that the patient is vulnerable and may need extra observation and supervision).

- Patients identified as having impaired cognition, from the initial screen in the Emergency Department, are screened using the 10 point abbreviated mental test score when admitted to hospital. This is a more detailed assessment and also includes questions about the history of a person's memory problems. A referral to the Rapid Response Liaison Psychiatry team is made for patients who score less than seven
- During 2015/2016 we achieved above 90% for dementia screening and our data demonstrates that for those who are identified as having memory problems that they have investigations and appropriate referrals to specialist services

II) Personalised care

Personalised care means that care is patient-centred and individualised; tailoring care to the needs, beliefs, values and aspirations of the patient.

The following is in place to promote personalised care:

- 'This is me' (patient passport) is available in clinical practice to be given to families and carers of patients with dementia. Relatives and carers are encouraged to complete 'This is Me' as the information assists the nursing staff to plan individualised, person centred care. A covering letter has been added to the packs with more details about the importance of 'This is Me' and contact details of the Dementia Lead Nurse
- The 'Forget Me Not' scheme has been implemented across the organisation with the aim of improving dementia care. The scheme involves using 'forget me not' magnets on the care and comfort boards, at the side of patient beds, as an alert system to members of staff that the person has memory problems and may need more time, extra support and supervision
- The Care & Comfort patient boards have been modified throughout the organisation to include a section on 'What matters most to me'. When a patient is admitted, the nurse will ask the patient and relatives/carers about the person (e.g. 'likes listening to Radio 2, likes tea with two sugars…'). This will help the staff to provide person centred care even if a patient cannot communicate their choices/ preferences
- A food passport has been developed in collaboration with Medirest colleagues. The purpose of the food passport is to establish more information on a person's usual food preferences and routines. It is used for patients who have difficulties in communicating their choices and preferences
- A Dementia Café has been started once a month on Sconce Ward, Newark Hospital. The Dementia Café provides a safe, comfortable and supportive environment for people with dementia and their carers to socialise. This concept is to be replicated at King's Mill Hospital and at Mansfield Community Hospital
- The library at King's Mill Hospital continues to provide activity items for people with dementia (e.g. reminiscence books, jigsaws, books on different topics such as holidays, gardening etc). These items are available to all wards at the Trust. Additional items for activities have been purchased for Woodland Ward and the wards at Newark and Mansfield Community Hospital. Items include; bingo, dominoes, reminiscence books and playing cards. It is important that older people have the opportunity to take part in activity, including activities of daily living that helps to maintain or improve their health and mental wellbeing
- The role of Activity Co-ordinator has been trialled on Ward 35. There is firm evidence to support the Activity Co-ordinator role to improve the patient experience and to reduce distress and anxiety for patients with dementia and cognitive impairment. The plan for 2016/17 is to implement the Activity Co-ordinator role on Woodland Ward.

III) Environment

Evidence from the King's Fund (2013) identified that modifications to hospital environments were required to meet the needs of people with dementia. The evidence identified that people with dementia may:

- Become confused, agitated and restless in unfamiliar environments
- Become restless and distracted in over-stimulating environment,
- Have difficulty seeing handrails, toilet seats or doors, or the food on their plate, if these are the same colour as the background
- Avoid stepping on coloured strips on flooring, because they may look like a change in level
- Resist walking on shiny flooring because it looks wet or slippery
- Misinterpret reflections in mirrors, windows & shiny surfaces
- Have difficulty hearing or understanding conversations if there is competing noise
- Feel curious and want to walk around

At Sherwood Forest Hospitals environmental modifications have been implemented to account for the difficulties that people with dementia may experience.

- The Dementia Care Appeal has enabled funds to be raised for environmental changes throughout the Trust in order to create a dementia friendly organisation. Examples of changes implemented are; improved signage in wards and departments, provision of red coloured toilet seats to improve visibility and identification of the toilet, 100 dementia clocks have been installed across the Trust, the design of which changes from day to night and improves orientation of the person with dementia
- The Ward 52 project has involved a complete environmental change to the Ward, now known as Woodland Ward. The new unit is a dedicated Medical & Mental Health Unit for older people with the most complex needs. The new environment has a seated area in the foyer for patients and relatives, a memory wall, a dedicated end of life care side room with facilities for relatives, colour coded bays, themed murals along the corridor, cinema style seating along the corridor, an activities room and portable nurse stations within the bays. The design of the ward has facilitated different ways of working to enable the nursing staff to spend more time and have more meaningful interactions with the patients

IV) Training

With an ageing population, the number of people in the UK living with dementia is continuing to rise. The UK government has recognised that, as a society, we need to improve dementia awareness. Dementia awareness training is, therefore, a key priority for the entire health and care workforce.

- Dementia awareness training continues to be delivered on the Mandatory Update and on the Orientation Day for all new starters to the Trust. During this year 2909 staff received dementia awareness training
- A dementia awareness event was held in September at the Annual General Meeting for members of the public, governors and staff. This proved a real success as it raised the awareness of dementia and the Trust's commitment to becoming a dementia friendly organisation
- A study day called 'Linking the Thinking' was held on 4 December 2015, which focused on dementia and falls. The study day had a multi-professional focus, with colleagues from the community services and staff from within the hospital

- Dementia awareness is now part of the education programme for medical students and is delivered by the Dementia Lead Nurse
- A programme of meaningful activity and distressed behaviour training began in February 2016 and will continue once per month throughout the year. The training is aimed at clinical staff who care for patients with dementia on a regular basis. The training includes communication skills, person centred care, managing distressed behaviour and facilitating activity

V) Support for Carers

There are estimated to be over 670,000 people in the UK acting as primary, unpaid carers for people with dementia. Caring can be an overwhelming experience, bringing irreversible changes to lives and relationships. Carers must be provided with comprehensive support, including assistance with day-to-day caring and emotional support (Alzheimer's Society 2014).
Support in place for carers at Sherwood Forest Hospitals includes:

- The library at King's Mill Hospital is a resource point for staff and carers to gain items for activity and advice leaflets
- The Trust works in collaboration with the third sector (e.g. charities and carer support groups) and we have an Age UK advocate on site who is available for advice and support for patients and relatives
- The Dementia Lead Nurse and Dementia Champions are available and can be contacted for advice and support for patients and carers. Contact details are included in 'This is Me' packs
- The Alzheimer's Society road show dementia bus was on site at King's Mill Hospital on 1 November 2015. The purpose of the bus was to provide members of the public with information, advice and support about dementia. Visitors were able to receive free, tailored, and confidential advice if they were worried about their memory or that of a loved one, and living or caring for someone with dementia. The support and advice service was provided by locally trained Alzheimer's Society staff
- Gathering carer feedback has been a challenge throughout the year. Various methods of feedback collection have been in place; paper survey (now included within 'This is Me' packs), joint survey with Mental Health Services for Older People (Nottinghamshire Health Care), and focused conversations with carers led by the Dementia Lead Nurse. Despite various methods, the number of carers providing feedback has remained low. The Dementia Lead Nurse has close links with an external carer support group and has attended the group to gain further feedback on carer support and experiences. All the feedback collected has suggested that carers do feel supported and they have also given feedback on how services can be improved.

Monitoring and reporting for sustained improvement

Performance regarding dementia screening, assessment and referral are reported to the Trust Board on a quarterly basis.

For 2016/2017 we plan to:

- Expand our links with the third sector to improve support and services for people living with dementia and their carers.
- Be recognised nationally for our dementia care due to the investment in environmental changes, emphasis on personalised care and the Woodland Ward project.
- Replicate the success of the Dementia Café at Newark Hospital and run regular Dementia Cafés at King's Mill Hospital and Mansfield Community Hospital. This will enhance the support of people with dementia and their carers.
- Develop more reliable processes to gather meaningful carer feedback which will help to further develop our services.
- Implement the use of a dementia care plan for people with dementia who use our acute hospital services. The new care plan will address some of the common problems that a person with dementia faces in an acute hospital setting.
- The nursing metrics questions for dementia have been reviewed to measure how the "This is Me" is being utilised to promote person centred care. The new questions will be in use from April 2016 onwards.


Quality for all
Sherwood Forest Hospitals NHS
Nurse of the Year Awards
2015
Nursing Team of the Year
Winner
Oakham Ward
2015
NURSING TEAM
OF THE YEAR
OAKHAM WARD

3.8 Patient Experience – Ensure our Complaints Systems and Processes are Robust, Responsive and Support Organisational Learning

This report provides a summary of patient complaints received in 2015/16. It includes details of numbers of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman investigations and action taken by the Trust in response to complaints.

The Patient Experience Team continued to manage concerns, complaints and compliments by the processes and procedures introduced in September 2015 following the service restructure, verbally acknowledging all concerns and formal complaints between one to three working days, seeking to provide a prompt resolution wherever possible, or escalation to a formal complaint in accordance with NHS Complaints Regulations and Trust Policy. All new complainants received direct contact from the Divisional Patient Experience Lead. The team contacts patients by telephone, where possible on receipt of their complaint, to talk through their concerns and try to resolve informally. i.e. speaking directly with the head of department, Matron, operations manager which are often resolved promptly. Prior to this process, all complaints were logged as formal and not as quickly resolved. The positive impact of this more responsive approach, contributed to a decrease in the number of complaints received during 2015/16.

In 2015/16 the Patient Experience Committee continued to meet bi-monthly with membership across the health community including representation from the CCG and Healthwatch.

Key points to note for 2015/16:

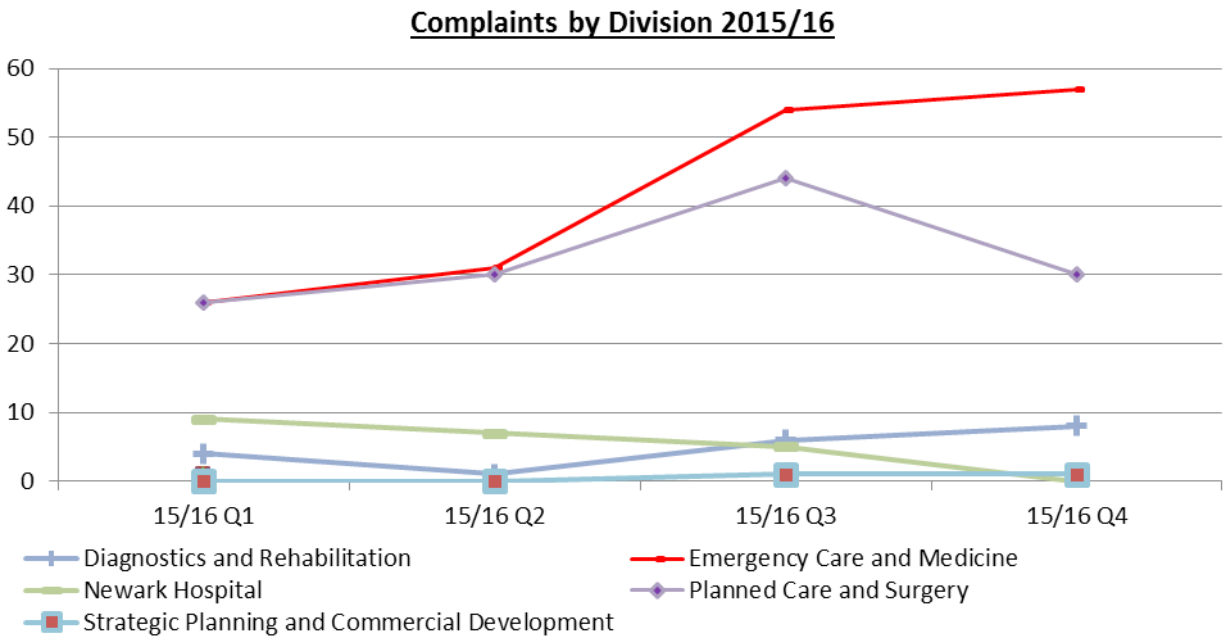
- The Trust received a total of 361 complaints in 2015/16, representing a 34% decrease compared to 2014/15
- 3992 concerns were recorded for 2015/16 demonstrating less than 1% decrease in 2014/15, indicating single point of access for patients and relatives complaint, concerns and compliments is working effective ensuring the appropriate level of investigation is completed, and improvements are identified
- A total of seven cases were referred by complainants to the Parliamentary and Health Service Ombudsman (PHSO) for review representing less than 2% of cases, and a 59% decrease of the applications received during 2014/15. This evidences the extent of local resolution provided by the Patient Experience Team to ensure complainants concerns are robustly investigated and all avenues of resolution are exhausted prior to referral to the PHSO

All complaints continue to be managed in accordance with the policy as follows:

- 100% complaints were verbally and formally (written acknowledgement) within three working days
- End of year performance shows 96% of complaints received were responded to within 25 working days against the Trust internal target of 90%
- 46% of complaints were upheld in full or part after investigation, showing an increase from 2014/15 providing an opportunity for service improvement.

Complaints Activity

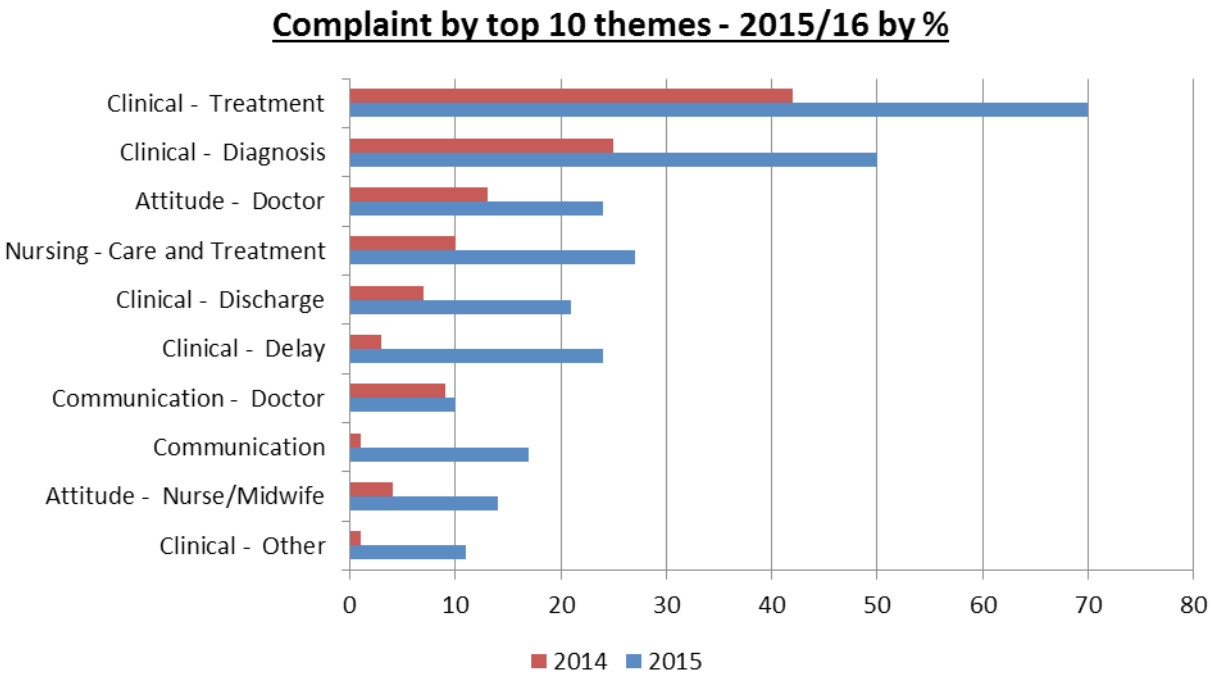
Fig. 1 Number of formal complaints by division



Complaints by Themes

The top 10 subjects of complaints have remained largely unchanged from 2015/16; clinical treatment remains the subject raised most frequently with a noticeable increase of 40%, followed by clinical diagnosis (50%), attitude of doctor (24%), nursing care and treatment (27%) and clinical discharge (21%). The top 10 themes as shown below have all increased significantly, however this is explained by the cleansing of subject fields within the data system to ensure complaints and concerns are highlighting hotspots within the Trust.

Fig 2 Complaints by Theme



There has been a significant theme for complaints and concerns relating to the Outpatient Department, including the cancellation of appointments and waiting times in outpatients which reflects the difficulties we have experienced involving both administration processes and systems. As a result of patients feedback we have an Outpatient Improvement Programme Board reviewing the current outpatient arrangements which includes senior managers to lead the service improvements and was established in April 2015. All complaints and concerns are shared with the Board and the Patient Experience Manager attends the fortnightly meeting which has led to an improvement in patient experience due to the following improvements:

- Introduction of call centre technology – ensuring patients are aware they are placed in a queue with timescales provided to them regarding the length of wait
- Reception cover – staggered hours to ensure clinic reception is covered all day
- Medical records – recruitment of additional staff to provide adequately prepared medical records in a timely manner prior to consultations
- Clinic cancellations – any clinic cancellations within two weeks prior to appointment will be now notified by telephone and letter to ensure patients are advised in a timely manner and a new appointment is allocated

Complaint Performance

We aim to acknowledge all complaints within three working days; for 2015/16 the Trust acknowledged 100% of all complaints within three working days, both verbally and by a written letter of acknowledgement in accordance with national regulations.

We have an internal target that a written response to the complainant should be sent within 25 working days in 90% of cases. The Trust responded to 93% of complaints within 25 working days, or an agreed timescales with the complainant for complex cases and investigations. We exceeded the internal target achieving 96% across the divisions.

All communication and correspondence with patients and families for complaints escalated to serious incidents (SI) is managed by the Patient Experience Team, ensuring patients and families are updated and timescales are agreed and meetings arranged to share SI reports.

The Head of Patient Experience coordinates the Duty of Candour for the Trust, and with the support of the patient experience leads, a total of 16 serious investigations linked to complaints and 17 serious investigations reports unrelated to complaints were shared with patients and relatives, which included a meeting to discuss the investigation findings. This demonstrated an increase of 67% from the previous year.

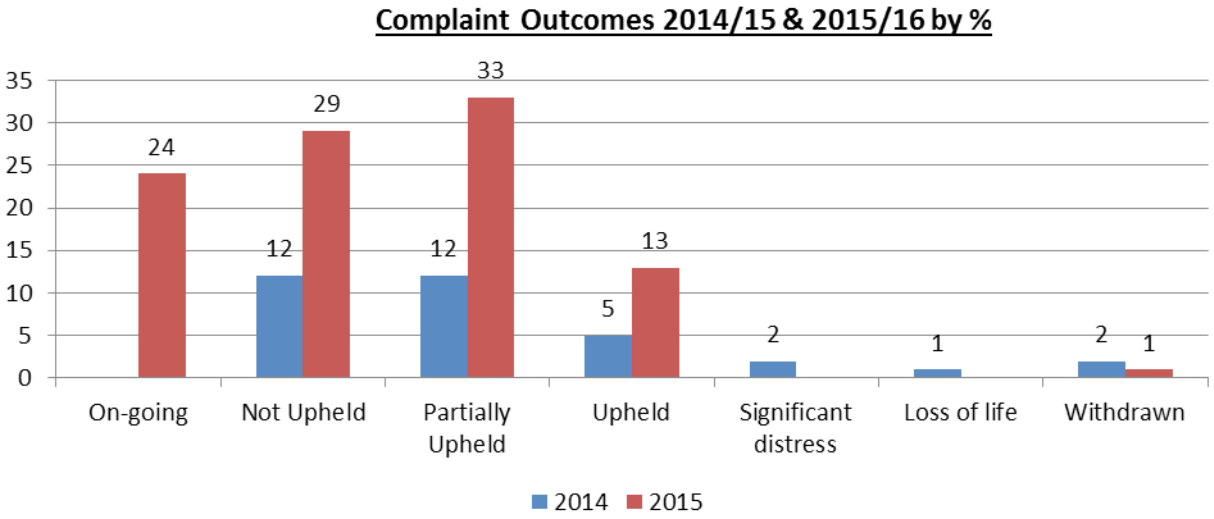
We received seven applications from the PHSO during 2015/16 which demonstrates a 59% decrease compared to 2014/15. Of the seven cases referred, six are on-going and one investigation completed, however not upheld.

Of the five on-going cases with the PHSO from 2014/15, these investigations were completed during 2015/16, of which four were partly upheld and one not upheld. The four cases partly upheld related to medical care and decision-making which have been escalated to the clinical lead of the service and Medical Director to develop an action plan and letter of apology to the patients/relatives. Issues relating to the complaint management were also highlighted which have been addressed as part the introduction of the complaints systems and processes in September 2014.

Complaint Outcomes

We are committed to providing an open, honest and straightforward response, with robust complaint handling at a local level. Of the complaints investigated in 2015/16, 6% of cases were re-opened for further local resolution, indicating the complainants were dissatisfied with the response they received from the Trust. This number remained static compared to the 2014/15.
The Trust is required under the complaints legislation to assess and record whether or not the issues were considered to be substantiated following investigation. From December 2014, 46% of the complaints investigated were upheld or partially upheld. This graph below shows the comparison between previous year:

Fig.3 Complaint Outcomes 2014/15 & 2015/16



*Please note during 2014/15 outcomes were measured from January 2015 ONLY following new Head of Patient Experience. Outcomes are no longer measured against loss of life or significant distress which is aligned to the national benchmarking and DoH data returns.

Learning from Complaints

It is essential that we continue to learn from complaints and concerns, ensuring service improvements are embedded into everyday practice. The Patient Experience Manager and divisional patient experience leads are currently working with the divisional teams to support the implementation of the action plans for all upheld/partially upheld complaints and action trackers to ensure implementation of the agreed actions and service improvements are undertaken. The following section provides a summary of Trust-wide service improvements implemented during 2015/16 which have included treatment in the:

- Paediatric Emergency Department, fracture diagnosis and delays in referral to endoscopy. As shown above, the complaints relate to both inpatient and outpatient departments, including Clinical Discharge - some of which relate to the provision of care in the community and ensuring families are informed of the decisions and arrangements
- Emergency Department – Improve the current pathway relating to patients attending or appropriate service
- Bereavement Centre – Introduction of system and procedures to capture accurate details of all deceased patients
- Updated Mortuary Standard Operating Procedures for patient admissions
- All patients to be notified by telephone wherever possible of outpatient appointments which are cancelled within two weeks of appointment to avoid attendance to the clinic
- Continue to ensure staff are working to the Trust 'Quality for all' values and behaviours
- To review the current reporting arrangements between complaints, Serious Investigations and Coroners Reports to avoid duplication of investigations and consistent dialogue with patient/family.

The Patient Experience Team is working closely with the Governance Team to ensure triangulation of learning from all spheres of patient feedback including complaints, incidents and inquests.

The Patient Experience Manager and divisional patient experience leads are working with divisional teams, including nursing and medical staff to provide investigational training and action plan implementation, to embed the learning and shape service improvements.

In 2015/16 we successfully procured a new external provider for the provision of the Friends and Family Test, and a dedicated project facilitator to support the staff to embed the feedback mechanism throughout the Trust.

We have historically provided a complainant satisfaction survey to a selection of complainants following the closure of a complaint case, to establish how the complaint management felt for the complainant. We are exploring other options to collate this feedback as part of a national project with other NHS Trusts which is in its infancy, however is expected to be implemented in early 2016.

The Patient Experience Team is developing strong links with the Bereavement Centre to assist in the coordination and management of relatives concerns and providing a single point of contact for families in such difficult circumstances.

We continue to develop an open and transparent culture for staff, patients and relatives to ensure concerns and complaints can be raised and managed proactively, to capture the learning and implement improvements. To ensure that we are communicating timely and effectively when incidents occur, the Duty of Candour and Being Open Policy and Procedures are being embedded to ensure staff understand the importance of clear and effective communication with patients and relatives following an incident. We are currently implementing a robust procedure and provides adequate training for staff to communicate this confidently.

3.9 Patient Experience – Safeguarding

Safeguarding Adults – (Quality Schedule)
Safeguarding Adults targets for 2016/17 are:

1. Undertake and report against The Safeguarding Adults Self-Assessment (SAAF)
2. Implement the Intercollegiate training document and National Capability framework Training figures
3. Actively participate in the Multiagency Safeguarding Hub (MASH)
4. Implementation of the PREVENT strategy

How are we performing against this target

1. Undertake and report against The Safeguarding Adults Self-Assessment (SAFF)

The self-assessment has been reviewed for 2015/16 and submitted to the Trusts Safeguarding Adults Board and the Clinical Governance and Quality Committee (CGQC). The output of the self-assessment forms the basis of the Safeguarding adults work plan.

The work plan for 2015/16 has been developed and is in line with the Nottinghamshire Safeguarding Adults Board (NSAB) strategy and work programme this was taken to the Trust's Safeguarding Board in October. The main work in quarter (Q) 3 has been to:

Continue to embed Mental Capacity Assessment (MCA) and best interest systems and processes within clinical practice:

- A full day's scenario based training is offered to staff which gives them opportunity to practice the application of Mental Capacity Act and Deprivation of Liberty
- Three MCA days took place during Q4. This course runs monthly. The team had the potential to train a total of 120 staff during these days, the actual number of people present was just 67 (32 did not attend courses, and no prior cancelation). The numbers of qualified staff attending this course has decreased slightly from 63 in Q3 to 56 in Q4
- Mental Capacity Act is also taught on nursing induction and mandatory. Training is also available on request or if identified
- The Safeguarding Team will implement a bi-monthly ward and department round to audit the MCA, DOLs, Domestic Abuse, LD and Safeguarding referrals

Vulnerable Adult Champion Update.

From February 2015, five study days were arranged to increase the knowledge base of all nominated Vulnerable Adult Champions.
One study day was cancelled due to lack of attendance; the remaining four study days were well attended and evaluated extremely well.
There are 65 champions across 43 wards/departments.
Emails and letters have been sent out to all Vulnerable Adult Champions and the relevant Ward/ Department Leader to inform them of three half day up-date forums arranged for 2016/17 to facilitate the champions' development.
All champions are required to attend one of the half day forums.

2. Implement the Intercollegiate document and National Capability framework training figures

The training schedule for Safeguarding meets the requirements of the Inter-collegiate document. Safeguarding training is in line with the national Capability framework. The figures below are the percentage of staff who have completed mandatory training.

	Q1	Q2	Q3	Q4
Mental capacity training figures (%)	95%	96%	96%	97%
Mental capacity training full day (Number)	-	23	83	67
Safeguarding Adults training (%)	77%	82%	90%	94%

Mental capacity training full day – (Number of staff who attended)

3. Actively participate in the Multiagency Safeguarding Hub (MASH)

The Trust's Safeguarding Adults Team has a close working relationship with the Multi Agency Safeguarding Hub (MASH) and the Safeguarding Adults Advisor attends the quarterly MASH health meetings.

There have been 146 referrals to the Safeguarding Team in quarter 4, 13 of these referrals were referred to MASH for investigation.

The same themes continue to be identified from Safeguarding concerns regarding the Trust. These themes are: staff not following MCA, and communication with other healthcare providers particularly on discharge.

4. Implementation of the PREVENT strategy

The Trust's Safeguarding Adults team is ensuring the PREVENT training strategy is being implemented across the staff teams. All staff complete the Home Office standard e module for PREVENT.

Mitigation plan (actions to date and future planning)

We have commissioned a development programme relating to Safeguarding activities. A final report has been written by Professor Amanda Ashton and was submitted to the Safeguarding Board in October. The recommendations from this have been included in the Trust's Quality Improvement Plan (QIP).

The actions in the QIP include:

- Ensure patients' mental capacity to make decisions is assessed in line with current guidance and legislation. – This will be evidenced by implementation of bi-monthly ward and department audits
- Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities. – This will be evidenced by implementation of bi-monthly ward and department audits
- Ensure the training programmes for safeguarding adults are in accordance with [Nottingham County guidance on Safeguarding] – this action has now been completed
- An Interim Head of Safeguarding for both children and adults has been appointed since March 2016 to support the Trust in meeting its Safeguarding requirements and the CQC action plan

3.10 Mandatory Key Performance indicators

The following table provides an overview of the mandatory key performance indicators that are formally reported to Monitor and provides a comparison against the previous two reporting periods

Integrated performance measure	Reportable to	Threshold	2015/16	14/15	13/14
Maximum time of 18 weeks from point of referral to treatment in aggregate – arithmetic average for Yr2015/16	Monitor	18 weeks 92%	92.03%	89.40%	92.40%
A&E clinical quality: total time in A&E dept. (% <4hour wait)	Monitor	4 Hours > 95%	94.43%	92.33%	95.66%
Cancer 2 week wait: all cancers	Monitor	93%	95.20%	93.50%	94.80%
Cancer 2 week wait: breast symptomatic	Monitor	93%	95.60%	95.10%	95.00%
Cancer 31 day wait: from diagnosis to first treatment	Monitor	96%	98.40%	98.80%	99.70%
Cancer 31 day wait: for subsequent treatment – surgery	Monitor	94%	99.00%	97.80%	99.10%
Cancer 31 day wait: for subsequent treatment –drugs	Monitor	98%	99.70%	99.70%	99.40%
Cancer 62 day wait: urgent referral to treatment	Monitor	85%	84.00%	86.00%	89.10%
Cancer 62 day wait: for first treatment – screening	Monitor	90%	96.40%	95.50%	98.80%
C. difficile – meeting the C. difficile objective	Monitor	Local targets	45 total of which 22 were due to lapses in care	67	36
Infection prevention control: MRSA bacteraemia (no. of cases attributed to Trust)	Monitor	0	1	0	3
Access to healthcare for people with LD	Monitor	Compliant	Compliant	Compliant	Compliant
Data completeness: community services: referral to treatment information	Monitor	50%	96.67%	92.00%	86.30%
Referral information	Monitor	50%	54.80%	54.80%	54.20%
Treatment activity information	Monitor	50%	77.63%	76.80%	76.40%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3.11 Annex 1 – Statements from Commissioners, Health Scrutiny Committee and Governors.

This section includes the statements from our stakeholders about the Trust's quality performance during 2015/16 following review by stakeholders

Statement from Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Groups (CCGs) Date 23-0516

From both a quality and governance perspective 2015/16 continued to be challenging for the organisation, and the Trust remained in special measures. The CCGs worked with the Sherwood Forest Hospitals NHS Foundation Trust and other stakeholders to support and monitor the implementation of improvements against an agreed Quality Improvement Plan. As commissioners of services from the Trust we have undertaken announced and unannounced visits throughout the year to gain added assurance that the actions taken are improving patient experience and safety. During these visits we continued to see many examples of caring and committed staff. The Trust has shown improvement in the quality priorities identified at the start of the year, including:

- The management of Sepsis cases
- Management of fluid balance (acute kidney injury)
- Reduction in the number of cases of C-Difficile
- Identifying and learning lessons from incidents.

The Trust also worked to improve the quality of services offered to patients with dementia. The Trust remained a member of the mid-Nottinghamshire Better Together programme, set up to lead to improvements in services for the population of Mansfield, Ashfield, Newark and Sherwood and is a member of our Alliance that will deliver those transformations.

Statement from the Health Scrutiny Committee. Date: 25th May 2016

The Health Scrutiny Committee welcomes this opportunity to comment on the Trust's Quality Account. In the committee's view, there is considerable evidence that the Trust is making significant headway towards extracting itself from the description of inadequate. Progress has been made in 9 of the mandatory key performance indicators and standards are above those required in 11 of the 14. There are clearly many challenges remaining, particularly in building staff confidence in themselves, their colleagues and their leaders (Section 2.20). A key way of building this trust and creating a sense of being part of a team, is in ensuring that progress is celebrated and achievements acknowledged. This is not specifically mentioned in the quality report, but may be implicit. We recognise that the reality of the CQC judgements, the challenges of increased demand, the frequent changes in leadership in recent years and the uncertain future of the Trust will have contributed to staff anxieties. Hopefully, early development of the partnership with NUH will enable staff to feel more committed and supported. The committee also notes the overwhelmingly successful performance on CQUIN goals (section 2.11), although we are concerned to understand the problem with the Better Together initiative, also identified within the context of trying to reduce length of stays (Section 3.4). We fear that there may be too much pressure to send people home when home circumstances do not offer adequate support, and perhaps this is also a factor in the lack of improvement in re-admission rates (2.18).

Generally, Sherwood Forest Hospitals Trust seems to have an appropriate set of strategies and tactics to address the areas where it is underachieving. We welcome the progress made and hope that further progress will flow from a confirmed merger with Nottingham University Hospitals, and from improved staff confidence in their better performance.

Statement from the Governors: Date: 25th May 2016

The governors of Sherwood Forest hospitals NHS foundation trust are pleased to have the opportunity to include a comment for the Quality Report for 2015/16.

We support the trust focus on patient safety and quality and take this opportunity to reinforce our and the Trust's belief that quality of service and the safety of patients is paramount.

Our members were concerned that the trust performance had fallen below the standards is aspires to, as described in the CQC report, but as governors we have witnessed first-hand the dedication and commitment shown by the trust in implementing the required action plans.

We continue to support the trust in ensuring the safety and quality of patient experience is not compromised in light of the savings the NHS is required to make in the coming years and in light of being in special measures.

We are pleased to report that the governors continued to play an active role in the last year in supporting the organisation to drive for quality and improvement of the patient experience through our committee work and participation in other assurance activities.

We look forward to working closely with the board the coming year and continue to support them in making Sherwood Forest hospitals NHS foundation trust a caring and compassionate provider for healthcare.

Statement from the Healthwatch: Date: 26th May 2016

As the independent watchdog for health and social care in the County, we work to ensure that patient and carer voices are heard by providers and commissioners. We are grateful to be given the opportunity to view and comment on the Quality Account.

As the independent watchdog for health and social care in the County, we work to ensure that patient and carer voices are heard by providers and commissioners. We are grateful to be given the opportunity to view and comment on the Quality Account.

Healthwatch Nottinghamshire has a constructive relationship with SFHT with the CEO sitting on the Oversight Group. This is tasked with ensuring that the Quality Improvement Plan, developed in response to the CQC Report, is implemented and that improvements are embedded. We are satisfied that robust processes have been put in place to maximise the potential for positive change; acknowledging systemic challenges, in relation for example, to recruitment and retention of key clinical staff.

Healthwatch Nottinghamshire would like to highlight a number of recognised successes presented in the Account and to seek assurance and guidance from the Trust in addressing under performance and the areas of significant risk and concern that remain.

Successes

During 2015/16 the Trust achieved many of their quality priorities and we wish to recognise the following:

- Introduction of a seven day Falls Service;
- Achieving zero medication-related never-events;
- Meeting national targets for all sepsis and;
- Achieving over 90% for dementia screening and increased and improved dementia
- training for staff.

We were pleased that the CQC acknowledged the Trust as a caring organisation rating across all hospitals as 'good'. Staff were found to be hard-working, passionate and caring
and to provide care that is kind and respectful with good interactions between staff and patients.

Improvements/Concerns

Healthwatch Nottinghamshire believes that patient engagement is an important element and with regards patient experience, we were disappointed to see very brief information about how patient feedback is collected. The draft of the Quality Account that we saw talks about three sources: National Patient Survey, Complainant Satisfaction Survey and Family and Friends Test. The National audits for 2016/2017 are very staff-centric with little focus on patient experience. We would like to see more emphasis on patient feedback in the future.

Our Community and Partnership Worker for Mid-Notts works with the Patient Experience Committee at SFHT. This is an excellent meeting, attended by the Chief Nurse and Divisional Matrons, who can take operation decisions to improve patient experience. Unfortunately this meeting was suspended on 24th March 2016. Healthwatch is concerned that this will have a detrimental effect on improvements in patient experience going forward.

Healthwatch Nottinghamshire is fully aware and has been engaged in the outcome of the recent Trust CQC Inspection and welcome the Quality Improvement Plan. Our view is that the merger with NUH will, in time, significantly enhance SFHT's prospects and performance. There is an immediate focus on supporting SFHT in their efforts to bring them out of "special measures". In the mid to longer term, a single merged Trust will, we think, be more likely to recruit and retain key staff; not least because of the increased potential for career development across all of the sites and specialisms. This view is based on some arrangement being made to address the significant PFI debt SFHT currently is being burdened by.

Presentation of the Quality Account

The structure of the Quality Account as a whole is not easy to navigate for the reader. Although the draft of the documents we saw has explanation and contextual information, it would be beneficial to reduce the amount of jargon to make the document more accessible to members of the public. In terms of the formatting of the document, we recommend that any tables are not split over two pages. We also felt that there were several graphs that were unclear and so did not add value to the narrative. There is also some repetition of content and typographical errors.

Comments received by Healthwatch Nottinghamshire

During 2015/16 we collected 406 experiences about services that the Trust provides (see the dashboard overleaf for an overview of our data). All of our data is thematically coded and we used 76 codes in total – 38 of which were positive and 38 were negative. Most experiences have been collected through online monitoring (i.e. comments that are picked up through Twitter, blogs and news articles) and 56% of these are positive. It is important to note that, in contrast, 65% of experiences that came directly to Healthwatch were negative. We can clearly see that over 50% experiences that are not shared directly with us are positive, and this highlights the need for the Trust to continue working with us to ensure that patient experiences from many sources are considered when improving services and patient experience. We are pleased that our data show positive interaction with staff, and feel that this should be celebrated.

Actions / Recommendations

Healthwatch Nottinghamshire seeks clarification on the following:

1. Plans to ensure reduction in 'never events' for 2016/17.
2. To understand why ten actions from the Quality Improvement Plan are rated as red (have failed to deliver to agreed timescales/are off track and unlikely to deliver to the agreed date), and what efforts are being made to ensure that this target will be met.

Healthwatch welcomes improvements in a number of the priority areas set for 2015/16, but we also recognise the challenges still faced by the Trust. We look forward to seeing further improvements in 2016/17. We will continue to work with the Trust, to monitor any issues which arise, and ensure that we represent the views of local people.

Appendix 2 details Healthwatch's Sherwood Forest Hospitals Quality Assurance Dashboard.

3.12 Annex 2 – Statement of Directors Responsibilities for the Quality Report

The Quality Report must include a Statement of Directors' Responsibilities, in the following form of words:
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor 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 2015/16 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 2015 to 26th May 2016
- papers relating to Quality reported to the board over the period April 2015 to 26th May 2016
- feedback from commissioners dated 23rd May 2016
- feedback from governors dated 25th May 2016
- feedback from Overview and Scrutiny Committee dated 25th May 2016

- feedback from Healthwatch dated 26th May 2016
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, -final annual report is not yet published
- the latest national patient survey- awaiting publication of the 2015 survey
- the national staff survey 23rd February 2016
- the Head of Internal Audit's annual opinion over the trust's control environment dated 26th May 2016
- CQC Intelligent Monitoring Report dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

NB: sign and date in any colour ink except black

Sean Lyons, Chairman

Peter Herring
Interim Chief Executive Officer

3.13 Annex 3- Independent Assurance Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sherwood Forest Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners; 23 May 2016
- feedback from governors; 25 May 2016
- feedback from Healthwatch Nottinghamshire; 26 May 2016
- feedback from Health Scrutiny Committee; 25 May 2016
- the 2015 national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; and
- the CQC Intelligent Monitoring Report – October 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (cllectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sherwood Forest Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the incicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Anrual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

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 resut in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Sherwood Forest Hospitals NHS Foundation Trust.

Basis for qualified conclusion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

We found discrepancies with the "start or stop times" recorded in the Trust's Patient Administration System in 20% of the cases tested. We also identified 2.8% of relevant pathways where the pathway identified by the system was not the current incomplete pathway at the census date. As a consequence we are unable to conclude on the completeness, reliability, validity and accuracy of the Incomplete Pathways within 18 weeks indicator included in the published Quality Report.

As a result of the issues described above, we are unable to give limited assurance on the Incomplete Pathways within 18 weeks indicator for the year ended 31 March 2016.

A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge

We found from our testing that supporting data did not corroborate the "start or stop times" recorded by the Trust in 30% of the cases tested. As a consequence we are unable to conclude on the completeness, reliability, validity and accuracy of the 4 hours A&E indicator included in the published Quality Report.

As a result of the issues described above, we are unable to give limited assurance on the 4 Hour A&E Wait indicator for the year ended 31 March 2016.

Qualified Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance; and
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance.

KPMG LLP.

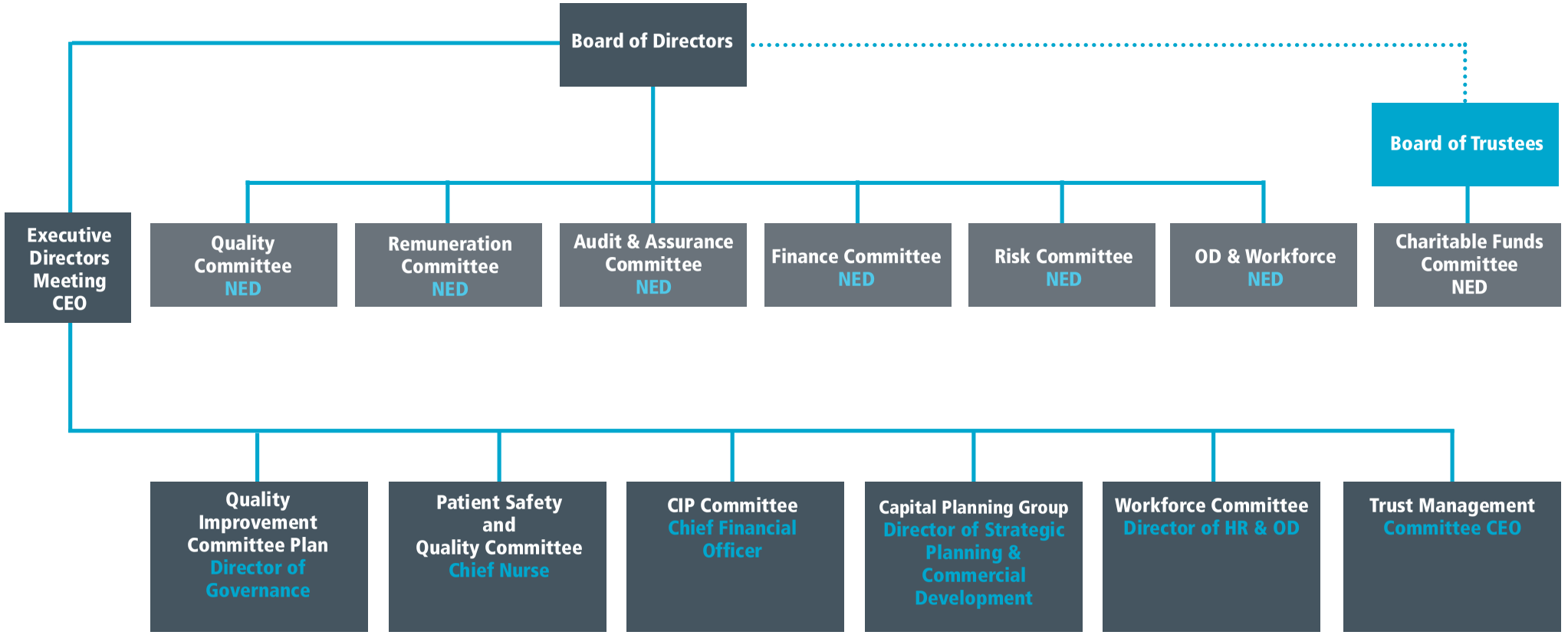
KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

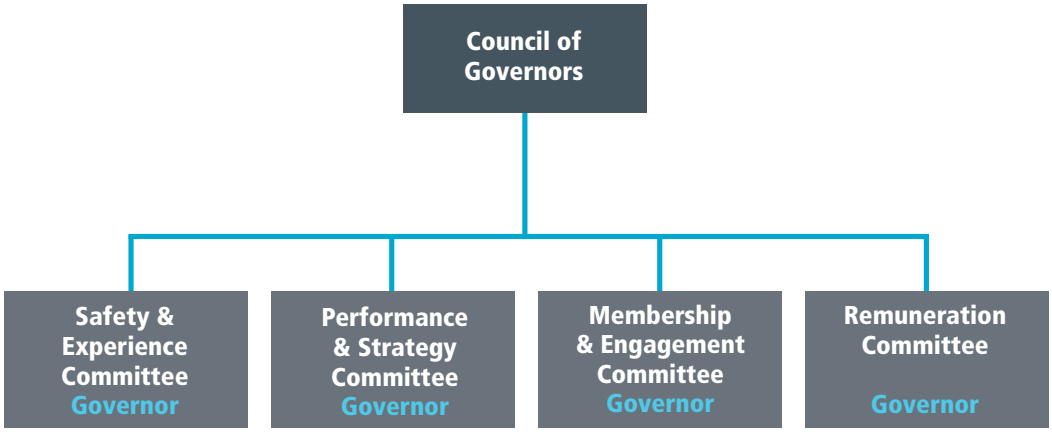
26 May 2016

Acronyms

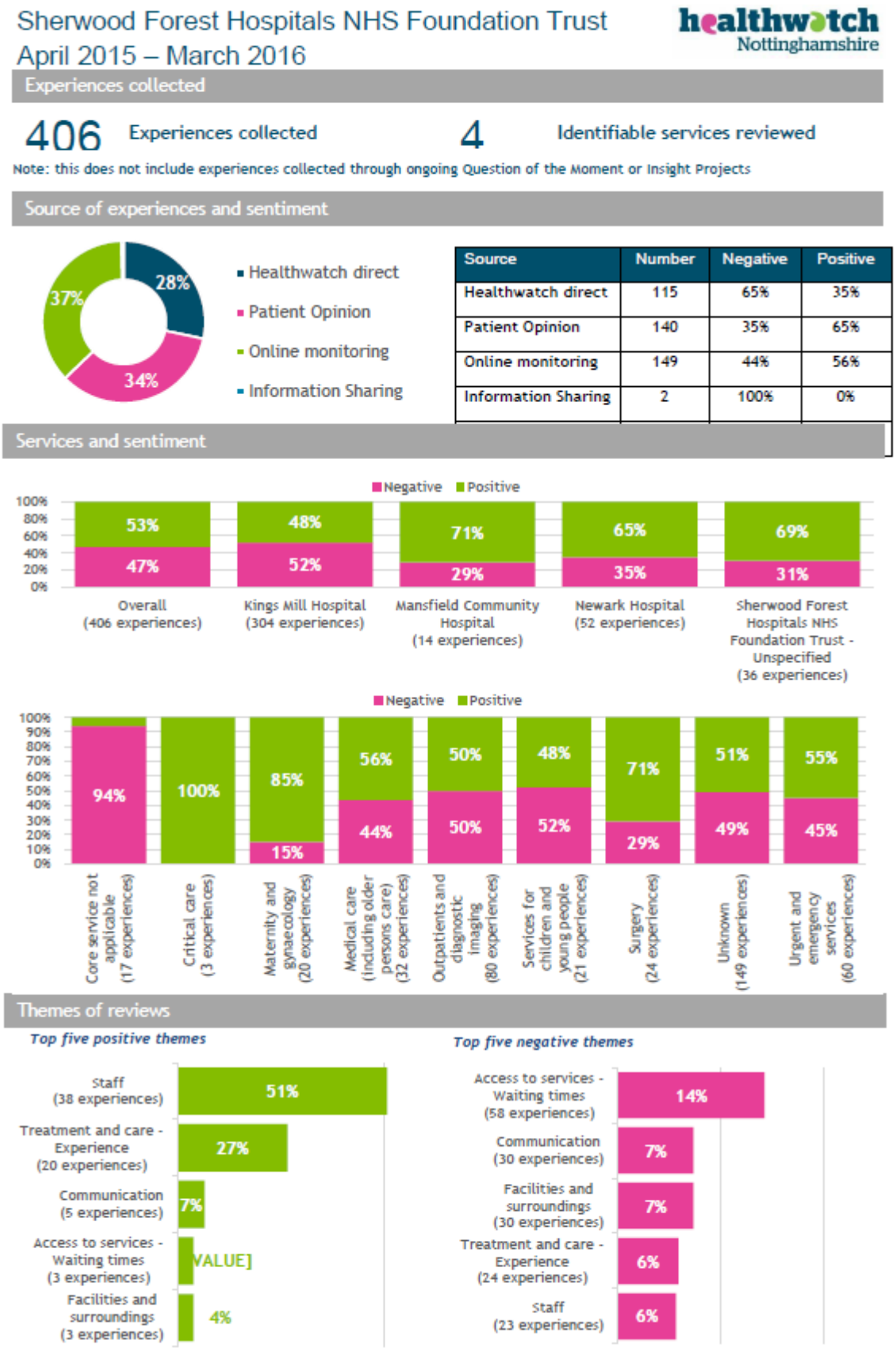
A&E	Accident & emergency
AKI	Acute kidney injury
CCG	Clinical Commissioning Group
C Diff	Clostridium difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRT	Cardiac resynchronisation therapy
COPD	Chronic obstructive pulmonary disease
DH	Department of Health
ECHO	Echocardiogram
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

3.15 Appendix 1




Council of Governors
Safety & Experience Committee Governor
Performance & Strategy Committee Governor
Membership & Engagement Committee Governor
Remuneration Committee Governor

3.16 Appendix 2 - Healthwatch's Sherwood Forest Hospitals Quality Assurance Dashboard.



Forward to the Accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2016, 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.

Peter Herring
Chief Executive Officer
26 May 2016

Statement of Comprehensive Income

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities	3	226,463	224,224
Other operating income	4	70,248	59,912
Total operating income from continuing operations		**296,711**	**284,136**
Operating expenses	5, 7	(304,827)	(280,196)
Operating surplus/(deficit) from continuing operations		**(8,116)**	**3,940**
Finance income	10	37	35
Finance expenses	11	(18,452)	(17,861)
PDC dividends payable		-	-
Net finance costs		**(18,415)**	**(17,826)**
Corporation tax expense	12	-	-
Surplus/(deficit) for the year from continuing operations		**(26,531)**	**(13,886)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	**-**
Surplus/(deficit) for the year		**(26,531)**	**(13,886)**

Surplus/(deficit) for the year		**(26,531)**	**(13,886)**
Reversal of impairment	6	(32,635)	(19,093)
Impairment	6	4,120	382
Surplus / (deficit) from continuing operations excluding the impact of impairments		**(55,046)**	**(32,597)**

Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	-
Revaluations	16	2,111	1,970
Other recognised gains and losses		-	-
Other reserve movements		-	-
Total comprehensive income/(expense) for the period		**(24,420)**	**(11,916)**

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	13	5,335	4,186
Property, plant and equipment	14	271,856	243,901
Trade and other receivables	18	652	942
Other financial assets	19	-	-
Other assets	19	-	-
Total non-current assets		**277,843**	**249,029**
Current assets			
Inventories	17	3,239	3,006
Trade and other receivables	18	14,159	10,346
Other financial assets	19	-	-
Non-current assets for sale and assets in disposal groups	20	-	-
Cash and cash equivalents	21	1,456	744
Total current assets		**18,854**	**14,096**
Current liabilities			
Trade and other payables	22	(30,492)	(25,166)
Other liabilities	23	(6,810)	(7,270)
Borrowings	24	(6,348)	(5,680)
Other financial liabilities	23	-	-
Provisions	25	(703)	(821)
Liabilities in disposal groups	20	-	-
Total current liabilities		**(44,353)**	**(38,937)**
Total assets less current liabilities		**252,344**	**224,188**
Non-current liabilities			
Trade and other payables	22	(1,567)	(2,488)
Other liabilities	23	-	-
Borrowings	24	(392,930)	(339,791)
Other financial liabilities	23	-	-
Provisions	25	(389)	(408)
Total non-current liabilities		**(394,886)**	**(342,687)**
Total assets employed		**(142,542)**	**(118,499)**
Financed by			
Public dividend capital		144,513	144,136
Revaluation reserve		14,949	13,005
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(302,004)	(275,640)
Total taxpayers' equity		**(142,542)**	**(118,499)**

The Financial statements on pages 214 to 255 were approved by the Board and signed on its behalf by:

Peter Herring
Chief Executive Officer
26 May 2016

Statement of Changes in Equity for the year ended 31 March 2016	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**144,136**	**13,005**	**-**	**-**	**-**	**(275,640)**	**(118,499)**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(26,531)	**(26,531)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Other transfers between reserves	-	(167)	-	-	-	167	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	2,111	-	-	-	-	**2,111**
Public dividend capital received	377	-	-	-	-	-	**377**
Taxpayers' and others' equity at 31 March 2016	**144,513**	**14,949**	**-**	**-**	**-**	**(302,004)**	**(142,542)**

Statement of Changes in Equity for the year ended 31 March 2015	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**112,400**	**11,900**	**-**	**-**	**-**	**(262,619)**	**(138,319)**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2014 - restated	**112,400**	**11,900**	**-**	**-**	**-**	**(262,619)**	**(138,319)**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(13,886)	**(13,886)**
Other transfers between reserves	-	(134)	-	-	-	134	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	1,970	-	-	-	-	**1,970**
Transfer to retained earnings on disposal of assets	-	(731)	-	-	-	731	**-**
Public dividend capital received	55,910	-	-	-	-	-	**55,910**
Public dividend capital repaid	(24,174)	-	-	-	-	-	**(24,174)**
Taxpayers' and others' equity at 31 March 2015	**144,136**	**13,005**	**-**	**-**	**-**	**(275,640)**	**(118,499)**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.Income and expenditure reserveThe balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(8,116)	3,940
Non-cash income and expense:			
Depreciation and amortisation	5.1	9,460	7,319
Impairments and reversals of impairments	6	(28,515)	(18,711)
(Gain)/loss on disposal of non-current assets	5.1	51	134
Income recognised in respect of capital donations	4	(547)	(205)
(Increase)/decrease in receivables and other assets		(3,522)	1,552
(Increase)/decrease in inventories		(233)	(207)
Increase/(decrease) in payables and other liabilities		4,474	156
Increase/(decrease) in provisions		(137)	192
Net cash generated from/(used in) operating activities		**(27,085)**	**(5,830)**
Cash flows from investing activities			
Interest received		36	35
Purchase of intangible assets		(2,310)	(3,926)
Purchase of property, plant, equipment and investment property		(6,208)	(5,374)
Receipt of cash donations to purchase capital assets		547	205
Net cash generated from/(used in) investing activities		**(7,935)**	**(9,060)**
Cash flows from financing activities			
Public dividend capital received		377	55,910
Public dividend capital repaid		-	(24,174)
Movement on loans from the Department of Health		59,487	6,214
Capital element of PFI, LIFT and other service concession payments		(5,680)	(5,399)
Interest paid on PFI, LIFT and other service concession obligations		(17,541)	(17,861)
Other interest paid		(911)	-
Net cash generated from/(used in) financing activities		**35,732**	**14,690**
Increase/(decrease) in cash and cash equivalents		**712**	**(200)**
Cash and cash equivalents at 1 April		**744**	**944**
Cash and cash equivalents at 31 March	21	**1,456**	**744**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

The financial statements are prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

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 2015/16 the Trust is reporting a deficit of (£26.5m). Adjusting for the impairments this deficit is (£55.04m) including costs associated with Long Term Partnership (LTP) with Nottingham University Hospitals NHS Trust (NUH). Removing these costs, which were £2.04m the Trust is reporting a deficit of (£53.0m). This is adverse to the plan by £8.8m. It is however, within the revised and Monitor agreed control total of a (£53.3m) deficit. To support this financial position the Trust has receive £47m in interim revenue support loans and has utilised a further £12.3m in working capital facility (WCF), £6.2m of which was drawn down in 2014/15.

NHS Improvement have set a control total of a maximum deficit of (£41.1m) in 2016/17 before any further costs of LTP, which includes receipt of £10.3m of Sustainability and Transformation (S&T) funding. To support this deficit and to repay PFI debt and previous capital loan the Trust will require £52.7m of cash support before further costs of LTP. NHS Improvement is aware of the need for cash support and the value has formally been notified via the submission of the plan on 18th April 2016. Initial discussions with NHS Improvement have indicated that cash will be available, with specific details to be agreed through finalisation of the planning process. When cash guidance becomes available the impact will be analysed and documented. It is anticipated that this will mean simpler and more ready access to agreed levels of cash funding.

The Trust Board agreed a financial plan that would deliver the control total on 31st March 2016. Included within this is a cost improvement programme (CIP) of £12.6m. Development of the CIP programme dedicated support from a CIP Director with a workstream lead identified for each area of the programme. Targets have been identified for each workstream based on opportunities with ongoing work to develop schemes to delivery stage. The Trust is aiming to identify £16m of opportunity to enable delivery of the £12.6m target.

Monitor notified the Trust at the end of April 2015 that a Section 106 condition had been imposed as a result of the Trust breaching conditions Co33(1), FT4(5)(a), FT4(5)(d) and FT4(5)(g). This is because of concerns over its financial governance and the sustainability of its long term financial plan, as well as the unforeseen deterioration in the financial position.

Monitor has also decided to impose the additional licence condition under section 111 of the Health and Social Care Act 2012. This requires the Trust to ensure that it has in place sufficient and effective Board management and clinical leadership capacity and capability. Any failure to comply with the additional licence condition would render the Trust liable to further formal action to Monitor, this could include requiring the Trust to remove one or more of its Directors, or members of the Council of Governors.

Going concern (continued)

The Board recognises that whilst this position will continue to place the Trust in breach of its terms of authorisation, it acknowledges that the Trust requires a viable long term partner, which has been identified as Nottingham University Hospitals NHS Trust. The Board of Sherwood Forest Hospitals NHS Foundation Trust and the Board of Nottingham University Hospitals NHS Trust have agreed a merger. It is likely that this merger will take effect during 2016/17 with forecast costs of £15.9m, which will need cash support. Discussions are ongoing with NHS Improvement regarding these costs.

Judgements, estimates and assumptions

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

Note 1.1 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund.
The Trust has no interests in other entities.

Note 1.2 Income

"Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Where income has not been received prior to the year end but the provision of a healthcare service has commenced, i.e. partially completed patient spells, then income relating to the patient activity is accrued.

Conversely In year income has been received relating to the 'maternity pathway' which is received after 14 weeks for the whole period of treatment. Where income has been received prior to completion of the provision of the healthcare service, then income relating to the patient activity has been deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract."

Note 1.3 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5 Trust Specific Context

Post Balance Sheet events

The Trust is not aware of any events since the close of the accounting period, which would affect the position reported or the Trust's assessment of its going concern basis.

Third Party Assets

The Trust held £1k (£1k in 2014/15) as cash in hand or at bank at 31 March 2016 on behalf of patients or other third parties.

Related party transactions

Sherwood Forest Hospitals NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Sherwood Forest Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent entity. A detailed schedule of income and expenditure is shown in note 37.

The Trust has also received revenue and capital payments from Sherwood Forest Hospitals General Charitable Fund for which the Trust is the corporate Trustee. Sherwood Forest Hospitals General Charitable Fund purchased goods and services for the Trust during the financial year, and also provided purchases for patients and staff at Sherwood Forest Hospitals. The administration of the Charity is carried out by the Trust, and during the financial year the Trust charged the Charity for this service.

The Audited Accounts / Summary Financial Statements of the Funds Held on Trust are available separately.

Note 1.6 Property, plant and equipment

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 and
- the cost of the item can be measured reliably.

Capitalisation thresholds

Property, plant and equipment is capitalised where:

It has a value including non-recoverable VAT of £5,000 or more

It has a value of £250 or more and is classed as part of a larger grouped-asset which has a value equal to or exceeding £5,000.

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. All property assets are reviewed by an independent valuer to ensure that, where of a material value, components of property assets are separately reported and depreciated accordingly. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	70
Dwellings	1	70
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	10

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

Note 1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably. "

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

Expenditure on research is not capitalised.

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

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

Note 1.8 Intangible assets Recognition

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

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

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

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

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

Note 1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is held to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

Note 1.10 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 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent to which, performance occurs, i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

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

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

Classification and measurement
Financial assets are categorised as 'fair value through income and expenditure', 'loans and receivables' or 'available-for-sale financial assets'. Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at "fair value through income and expenditure
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Assets and liabilities in this category are classified as current assets and current liabilities.

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

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

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

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

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

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

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

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

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices and/or independent appraisals."

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced."

Note 1.12 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease."

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is £106.32m (2014/15 £60.54m).

Non-clinical risk pooling

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

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 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, 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 trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Working capital Facility

The Working Capital Facility is a facility which allows for temporary borrowing. A temporary borrowing facility of £30.6m was agreed with the Department of Health in 2015/16 Interest is payable at a rate of 3.5%. As at 31st March 2016 a total of £12.3m of this facility has been utilised.

Note 1.17 Value added tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

No liability for corporate tax has been recognised or incurred when applying current legislation.

Note 1.19 Foreign exchange

The functional and presentational currencies of the trust are sterling.

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items."

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.21 Cash and cash equivalents

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

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

As required by IAS 8, the Trust is required to disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector. The Trust is not impacted by any of the standards, amendments or interpretations that have been issued.

Change published	Published by IASB	Financial year for which the change first applies
IFRS 11 (amendment) – acquisition of an interest in a joint operation	*May-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	*May-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	*Jun-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 27 (amendment) – equity method in separate financial statements	*Aug-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	*Sep-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	*Dec-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IAS 1 (amendment) – disclosure initiative	*Dec-14*	*Not yet EU adopted. Expected to be effective from 2016/17.*
IFRS 15 Revenue from contracts with customers	*May-14*	*Not yet EU adopted. Expected to be effective from 2017/18.*
Annual improvements to IFRS: 2012-15 cycle	*Sep-14*	*Not yet EU adopted. Expected to be effective from 2017/18.*
IFRS 9 Financial Instruments	*Jul-14*	*Not yet EU adopted. Expected to be effective from 2018/19.*

Note 1.25 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

In-year a revaluation was undertaken by the 'Valuation Agency Office' of the land and building assets of the Trust under the modern equivalent cost valuation method and the movements in market value reflected in the financial position.

As part of the year end process, estimates have been made regarding outstanding income, expenditure and provisions. No estimates have been made regarding land and buildings as these have all been revalued in year. The Trust is not aware of any material uncertainty within these estimates which would impact on the figures disclosed within the primary statements and notes to the accounts.

Note 2 Operating Segments

Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare.

The Trust is split into 5 clinical divisions, Urgent Care, Medicine, Surgery, Women's and Childrens and Diagnostics & Outpatients. In addition there is a supporting Corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16 £000	2014/15 £000
Acute services		
Elective income	36,189	34,281
Non elective income	71,379	70,122
Outpatient income	45,453	40,638
A & E income	13,324	11,866
Other NHS clinical income	59,058	64,838
All services		
Additional income for delivery of healthcare services	-	-
Private patient income	117	121
Other clinical income	943	2,358
Total income from activities	**226,463**	**224,224**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16 £000	2014/15 £000
CCGs and NHS England	222,541	216,913
Local authorities	2,745	4,800
Department of Health	-	-
Other NHS foundation trusts	-	22
NHS trusts	20	1,500
NHS other	57	-
Non-NHS: private patients	117	121
Non-NHS: overseas patients (chargeable to patient)	40	10
NHS injury scheme (was RTA)	943	858
Non NHS: other	-	-
Additional income for delivery of healthcare services	-	-
Total income from activities	**226,463**	**224,224**
Of which:		
Related to continuing operations	226,463	224,224
Related to discontinued operations	-	-

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 21.99% to reflect expected rates of collection. (18.9% 2014/15)

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16 £000	2014/15 £000
Income recognised this year	40	10
Cash payments received in-year	7	4
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2015/16 £000	2014/15 £000
Research and development	956	987
Education and training	11,456	11,972
Receipt of capital grants and donations	547	204
Charitable and other contributions to expenditure	257	204
Non-patient care services to other bodies	5,477	6,233
Support from the Department of Health for mergers	-	-
Profit on disposal of non-current assets	-	-
Reversal of impairments	32,635	19,093
Rental revenue from operating leases	1,967	1,943
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	-	-
Other income	16,953	19,276
Total other operating income	**70,248**	**59,912**
Of which:		
Related to continuing operations	70,248	59,912
Related to discontinued operations	-	-

Other income relates mainly to recharges arising from the PFI schemes and the locally hosted HIS.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2015/16 £000	2014/15 £000
services	226,463	224,224
Income from services not designated as commissioner requested services	(1,060)	(979)
Total	**225,403**	**223,245**

Note 4.2 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 5.1 Operating expenses

	2015/16 £000	2014/15 £000
Services from NHS foundation trusts	380	179
Services from NHS trusts	435	195
Services from CCGs and NHS England	164	-
Services from other NHS bodies	5	2
Purchase of healthcare from non NHS bodies	1,124	856
Purchase of social care	-	-
Employee expenses - executive directors	444	1,576
Remuneration of non-executive directors	153	148
Employee expenses - staff	185,008	171,979
Supplies and services - clinical	23,716	23,242
Supplies and services - general	1,640	1,080
Establishment	2,896	3,090
Transport	326	834
Premises	16,984	18,455
Increase/(decrease) in provision for impairment of receivables	220	(10)
Change in provisions discount rate(s)	-	4
Drug costs	-	507
Drugs Inventories consumed	21,321	18,313
Rentals under operating leases	474	326
Depreciation on property, plant and equipment	8,299	6,694
Amortisation on intangible assets	1,161	625
Impairments	4,120	382
Audit fees payable to the external auditor		
audit services- statutory audit	69	67
other auditor remuneration (external auditor only)	34	29
Clinical negligence	7,731	5,100
Loss on disposal of non-current assets	51	134
Legal fees	393	154
Consultancy costs	4,223	3,173
Internal audit costs	136	125
Training, courses and conferences	714	538
Car parking & security	164	-
Early retirements	52	-
Hospitality	198	196
Losses, ex gratia & special payments	7	28
Other	22,185	22,175
Total	**304,827**	**280,196**
Of which:		
Related to continuing operations	304,827	280,196
Related to discontinued operations	-	-

Other expenditure relates almost solely to the PFI 'unitary charge payments' in both financial years. This is disclosed in note 31.3.

Note 5.2 Other auditor remuneration

	2015/16 £000	2014/15 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	34	29
Total	**34**	**29**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £0.5m (2014/15: £0.5m).

Note 6 Impairment of assets

	2015/16 £000	2014/15 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	(28,515)	(18,711)
Other	-	-
Total net impairments charged to operating surplus / deficit	**(28,515)**	**(18,711)**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**(28,515)**	**(18,711)**

Impairments during the period arose from:	2015/16 £000	2014/15 £000
Reversal of previous impairment	32,635	19,093
Impairment charged to operating expenditure	(4,120)	(382)
Impact on Retained (Deficit) for the year	28,515	18,711

Note 7 Employee benefits

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	134,814	183	**134,997**	133,362
Social security costs	10,360	-	**10,360**	9,636
Employer's contributions to NHS pensions	16,029	-	**16,029**	15,761
Pension cost - other	-	-	**-**	53
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	175
Agency/contract staff	-	24,394	**24,394**	14,568
Total gross staff costs	**161,203**	**24,577**	**185,780**	**173,555**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**161,203**	**24,577**	**185,780**	**173,555**
Of which				
Costs capitalised as part of assets	-	276	**276**	-

Note 7.1 Retirements due to ill-health

During 2015/16 there were 6 early retirements from the trust agreed on the grounds of ill-health (10 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £233k (£409k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	1,242	1,586
Taxable benefits	13	16
Performance related bonuses	-	-
Employer's pension contributions	88	123
Total	**1,343**	**1,725**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Operating leases

Note 8.1 Sherwood Forest Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Sherwood Forest Hospitals NHS Foundation Trust is the lessor.

Contingent Rent described in Operating Lease revenue is a technical disclosure resulting from the IFRS disclosure requirements in respect of the PFI asset.

Operating lease revenue	**2015/16 £000**	**2014/15 £000**
Minimum lease receipts	-	-
Contingent rent	1,967	1,943
Other	-	-
Total	**1,967**	**1,943**

	2015/16 £000	**2014/15 £000**
Future minimum lease receipts due:		
- not later than one year;	1,321	1,773
- later than one year and not later than five years;	4,742	6,748
- later than five years.	1,311	2,813
Total	**7,374**	**11,334**

Note 8.2 Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sherwood Forest Hospitals NHS Foundation Trust FT is the lessee.

	2015/16 £000	**2014/15 £000**
Operating lease expense		
Minimum lease payments	474	326
Contingent rents	-	-
Less sublease payments received	-	-
Total	**474**	**326**

	2015/16 £000	**2014/15 £000**
Future minimum lease payments due:		
- not later than one year;	249	143
- later than one year and not later than five years;	787	229
- later than five years.	-	16
Total	**1,036**	**388**
Future minimum sublease payments to be received	-	-

Note 9 Finance income

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

	2015/16 £000	2014/15 £000
Interest on bank accounts	37	35
Total	**37**	**35**

Note 10.1 Finance expenditure

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

	2015/16 £000	2014/15 £000
Interest expense:		
Loans from the Department of Health	911	-
Main finance costs on PFI and LIFT schemes obligations	17,541	17,861
Total interest expense	**18,452**	**17,861**
Other finance costs	-	-
Total	**18,452**	**17,861**

Note 10.2 The Late Payment of Commercial Debts (interest) Act 1988

No amounts have been included in finance costs (2014/15 nil) and no compensation has been paid to cover debt recovery costs under this legislation

Note 11 Corporation Tax

No liability for corporation tax has been recognised or incurred when applying current legislation

Note 12.1 Intangible assets

	2015/16 £000	2014/15 £000
	Software licences £000	Software licences £000
Valuation/gross cost at 1 April - brought forward	**10,046**	**6,120**
Transfers by absorption	-	-
Additions	2,310	3,926
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Revaluations	-	-
Transfers to/ from assets held for sale	-	-
Disposals / derecognition	-	-
Gross cost at 31 March	**12,356**	**10,046**
Amortisation at 1 April - brought forward	**5,860**	**5,235**
Transfers by absorption	-	-
Provided during the year	1,161	625
Impairments	-	-
Reversals of impairments	-	-
Reclassifications	-	-
Revaluations	-	-
Transfers to/ from assets held for sale	-	-
Disposals / derecognition	-	-
Amortisation at 31 March	**7,021**	**5,860**
Net book value at 31 March	**5,335**	**4,186**

Note 13.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**17,341**	**211,236**	**1,339**	**-**	**29,496**	**-**	**6,800**	**294**	**266,506**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	2,841	157	-	2,079	-	602	-	**5,679**
Impairments	-	(4,120)	-	-	-	-	-	-	**(4,120)**
Reversals of impairments	-	32,635	-	-	-	-	-	-	**32,635**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	2,253	-	-	-	-	-	-	**2,253**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(156)	(5,090)	-	-	(690)	-	(7)	-	**(5,943)**
Valuation/gross cost at 31 March 2016	**17,185**	**239,755**	**1,496**	**-**	**30,885**	**-**	**7,395**	**294**	**297,010**
Accumulated depreciation at 1 April 2015 - brought forward	**-**	**-**	**-**	**-**	**18,099**	**-**	**4,317**	**189**	**22,605**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	5,090	14	-	2,315	-	858	22	**8,299**
Revaluations	156	-	(14)	-	-	-	-	-	**142**
Disposals/ derecognition	(156)	(5,090)	-	-	(639)	-	(7)	-	**(5,892)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**19,775**	**-**	**5,168**	**211**	**25,154**
Net book value at 31 March 2016	**17,185**	**239,755**	**1,496**	**-**	**11,110**	**-**	**2,227**	**83**	**271,856**
Net book value at 1 April 2015	**17,341**	**211,236**	**1,339**	**-**	**11,397**	**-**	**2,483**	**105**	**243,901**

During 2015/16 there was a remeasure of the Trust's built assets following the implementation of a new room numbering system by Skanska Facilities Services and the need for the Trust to ensure estate was accurately measured and accounted for. This remeasure was undertaken by an external consultancy who checked the database areas for accuracy and identified non-operational space, eg under crofts and roof space. A report was produced called floor area reconciliation which matched off buildings and floor areas and any discrepancies against the previous register and the findings are articulated within the report and associated drawings. The difference between the valuation has arisen from two factors, a change in beacon value (the substantial increase in value), and the re-classification of built assets due to a change in block.

Note 13.2 Property, plant and equipment 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014	**16,053**	**475,632**	**1,193**	**-**	**28,761**	**-**	**5,990**	**291**	**527,920**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions - purchased/ leased/ grants/ donations	-	1,740	146	-	2,230	-	841	3	**4,960**
Impairments	-	(382)	-	-	-	-	-	-	**(382)**
Reversals of impairments	-	16,447	-	-	-	-	-	-	**16,447**
Reclassifications	-	39	-	-	(976)	-	-	-	**(937)**
Revaluations	1,288	(237,179)	-	-	-	-	-	-	**(235,891)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(45,061)	-	-	(519)	-	(31)	-	**(45,611)**
Valuation/gross cost at 31 March 2015	**17,341**	**211,236**	**1,339**	**-**	**29,496**	**-**	**6,800**	**294**	**266,506**
Accumulated depreciation at 1 April 2014	**-**	**282,921**	**-**	**-**	**16,269**	**-**	**3,486**	**156**	**302,832**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,583	-	-	2,220	-	858	33	**6,694**
Reversals of impairments	-	(2,646)	-	-	-	-	-	-	**(2,646)**
Reclassifications	-	(937)	-	-	-	-	-	-	**(937)**
Revaluations	-	(237,861)	-	-	-	-	-	-	**(237,861)**
Disposals / derecognition	-	(45,060)	-	-	(390)	-	(27)	-	**(45,477)**
Accumulated depreciation at 31 March 2015	**-**	**-**	**-**	**-**	**18,099**	**-**	**4,317**	**189**	**22,605**
Net book value at 31 March 2015	**17,341**	**211,236**	**1,339**	**-**	**11,397**	**-**	**2,483**	**105**	**243,901**
Net book value at 1 April 2014	**16,053**	**192,711**	**1,193**	**-**	**12,492**	**-**	**2,504**	**135**	**225,088**

Note 13.3 Property, plant and equipment financing - 2015/16									
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	17,185	11,328	-	-	9,697	-	2,216	67	**40,493**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	227,167	-	-	-	-	-	-	**227,167**
PFI residual interests	-	-	1,496	-	-	-	-	-	**1,496**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	-	1,260	-	-	1,413	-	11	16	**2,700**
NBV total at 31 March 2016	**17,185**	**239,755**	**1,496**	**-**	**11,110**	**-**	**2,227**	**83**	**271,856**

Note 14.4 Property, plant and equipment financing - 2014/15									
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	17,341	12,451	-	-	9,886	-	2,469	85	**42,232**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	197,483	-	-	-	-	-	-	**197,483**
PFI residual interests	-	-	1,339	-	-	-	-	-	**1,339**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	-	1,302	-	-	1,511	-	14	20	**2,847**
NBV total at 31 March 2015	**17,341**	**211,236**	**1,339**	**-**	**11,397**	**-**	**2,483**	**105**	**243,901**

Note 14 Donations of property, plant and equipment

The trust received donations during the year of £547k . (2014/15 £205k)

Note 15 Revaluations of property, plant and equipment

An independent 'desktop' revaluation was undertaken of the Trust's buildings by the District Valuer with an effective date of 31st March 2016.

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 approriate asset lives were adjusted accordingly.

Notge 16 Inventories

	2015/16 £000	2014/15 £000
Drugs	1,243	1,096
Work In progress	-	-
Consumables	1,908	1,822
Energy	88	88
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**3,239**	**3,006**

Inventories recognised in expenses for the year were -£25,216k (2014/15: -£22,093k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 17.1 Trade receivables and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
Trade receivables due from NHS bodies	7,137	6,612
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,509	461
Capital receivables	-	-
Provision for impaired receivables	(159)	(138)
Deposits and advances	-	-
Prepayments (non-PFI)	2,868	793
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	173	944
Interest receivable	1	-
VAT receivable	1,576	1,450
Other receivables	1,054	224
Total current trade and other receivables	**14,159**	**10,346**
Non-current		
Trade receivables due from NHS bodies	-	-
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,086	986
Capital receivables	-	-
Provision for impaired receivables	(500)	(301)
Deposits and advances	-	-
Prepayments (non-PFI)	66	69
Other receivables	-	188
Total non-current trade and other receivables	**652**	**942**

Note 17.2 Provision for impairment of receivables

	2015/16 £000	2014/15 £000
At 1 April as previously stated	**439**	**449**
Prior period adjustments	-	-
At 1 April - restated	**439**	**449**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	243	24
Amounts utilised	-	-
Unused amounts reversed	(23)	(34)
At 31 March	**659**	**439**

Note 17.3 Analysis of impaired receivables

	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	30	-	28	-
30-60 Days	22	-	43	-
60-90 days	12	-	23	-
90- 180 days	95	-	40	-
Over 180 days	500	-	305	-
Total	**659**	**-**	**439**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	8,749	-	3,497	-
30-60 Days	1,133	-	522	-
60-90 days	1,114	-	44	-
90- 180 days	981	-	756	-
Over 180 days	2,175	-	1,742	-
Total	**14,152**	**-**	**6,561**	**-**

Note 18 Other financial assets

The Trust did not hold any other financial assets in either the current or previous periods.

Note 19 Non-current assets for sale and assets in disposal groups

The Trust did not hold any non-current assets for sale and assets in disposal groups, in either the current or previous periods.

Note 20 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.

	2015/16 £000	2014/15 £000
At 1 April	**744**	**944**
Prior period adjustments	-	-
At 1 April (restated)	**744**	**944**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	712	(200)
At 31 March	**1,456**	**744**
Broken down into:		
Cash at commercial banks and in hand	-	-
Cash with the Government Banking Service	1,456	744
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**1,456**	**744**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,456**	**744**

Note 20.1 Third party assets held by the NHS foundation trust

Sherwood Forest Hospitals NHS Foundation Trust held £1k in cash or cash equivalents which relates to monies held on behalf of patients or other parties in the current period (2014/15 £1k).

Note 21 Trade and other payables

	2016 £000	2015 £000
Current		
Receipts in advance	-	324
NHS trade payables	6,925	3,255
Amounts due to other related parties	-	135
Other trade payables	6,251	6,389
Capital payables	1,870	2,399
Social security costs	1,492	2,992
VAT payable	-	-
Other taxes payable	1,489	-
Other payables	2,636	2,148
Accruals	9,829	7,524
PDC dividend payable	-	-
Total current trade and other payables	**30,492**	**25,166**
Non-current		
Receipts in advance	-	-
NHS trade payables	1,235	1,495
Amounts due to other related parties	332	993
Other trade payables	-	-
Total non-current trade and other payables	**1,567**	**2,488**

Note 22 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	6,810	7,270
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	**6,810**	**7,270**

Note 23 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health	373	-
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	5,975	5,680
Total current borrowings	**6,348**	**5,680**
Non-current		
Loans from the Department of Health	65,328	6,214
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI, LIFT or other service concession contracts	327,602	333,577
Total non-current borrowings	**392,930**	**339,791**

Note 24 Provisions for liabilities and charges analysis

	Pensions - other staff £000	Other legal claims £000	Agenda for change £000	Other £000	Total £000
At 1 April 2015	**397**	**185**	**581**	**66**	**1,229**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	**-**
Arising during the year	38	113	-	-	**151**
Utilised during the year	(52)	(119)	-	-	**(171)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	(6)	(55)	(56)	-	**(117)**
Unwinding of discount	-	-	-	-	**-**
At 31 March 2016	**377**	**124**	**525**	**66**	**1,092**
Expected timing of cash flows:					
- not later than one year;	49	124	525	5	**703**
- later than one year and not later than five years;	196	-	-	20	**216**
- later than five years.	132	-	-	41	**173**
Total	**377**	**124**	**525**	**66**	**1,092**

Note 24.1 Clinical negligence liabilities

At 31 March 2016, £106,322k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2015: £60,540k).

Note 25 Contingent assets and liabilities

	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	(79)	(99)
Gross value of contingent liabilities	**(79)**	**(99)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(79)**	**(99)**
Net value of contingent assets	**-**	**-**

Note 26 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	353	2,838
Intangible assets	166	-
Total	**519**	**2,838**

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 Annual Reporting Manual issued by Monitor. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the asset as if it were an asset of the Trust.

As referenced in Note 1.6 the annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme applied to the opening lease liability for the period and is recognised in finance costs.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA), to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a current estimated capital value of £1.3m. Throughout the term of the agreement there is a requirement to keep the premises clean tidy and in good order and to keep in good and substantial repair and condition in accordance with the Operating Agreement.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional consideration.

The annual charge relating to the MAS scheme is subject to an annual inflation uplift based on RPI. The LHA schemes are a fixed charge over the life of the contract. All liquidity and associated market and financing risks for both schemes rests with Central Nottinghamshire plc and Leicester Housing Association respectively.

Note 28.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes as disclosed in note 28.

	2016 £000	2015 £000
Gross PFI, LIFT or other service concession liabilities	**333,577**	**339,257**
Of which liabilities are due		
- not later than one year;	5,975	5,680
- later than one year and not later than five years;	27,168	26,092
- later than five years.	300,434	307,485
Finance charges allocated to future periods	-	-
Net PFI, LIFT or other service concession arrangement obligation	**333,577**	**339,257**
- not later than one year;	5,975	5,680
- later than one year and not later than five years;	27,168	26,092
- later than five years.	300,434	307,485

Note 28.2 Total On-SoFP PFI LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	2016 £000	2015 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,934,409	1,981,125
Of which liabilities are due:		
- not later than one year;	45,538	42,836
- later than one year and not later than five years;	200,272	171,344
- later than five years.	1,688,599	1,766,945

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's expenditure in 2015/16:

	2016 £000	2015 £000
Unitary payment payable to service concession operator	42,836	43,133
Consisting of:		
- Interest charge	17,541	17,861
- Repayment of finance lease liability	5,680	5,399
- Service element	19,615	19,873
- Capital lifecycle maintenance	-	-
- Revenue lifecyle maintenance	-	-
- Contingent rent	-	-
- Other	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Consisting of:		
- Services purchased	-	-
- Other	-	-
Total amount paid to service concession operator	**42,836**	**43,133**

Note 29 Off-SoFP PFI LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position LIFT obligations:

Leicester Housing Association

The Trust is currently committed to one 'off statement of financial position' PFI scheme relating to residential accommodation for the King's Mill site. The transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, but the Trust does not have control. Accordingly the Trust does not recognise the scheme as an asset of the Trust.

The arrangement is with Leicester Housing Association, and includes the construction of new residential accommodation and the upgrade of existing accommodation combined with a 35 year contract to manage and operate the accommodation. The Trust has guaranteed to utilise a minimum level of the overall accommodation but the majority of risks associated with operating and letting the properties have been transferred to Leicester Housing Association. The estimated capital value of the scheme is £5.7m

The annual charge is fixed over the life of the contract and the only liability to the Trust is a minimum room usage guarantee. All liquidity and associated market and financing risks rests with Leicester Housing Association.

The Trust has recognised the following items within its accounts for the year ended 31 March 2016:

	2016 £000	2015 £000
Charge in respect of the off SoFP, LIFT arrangement for the period	106	146
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	162	106
- later than one year and not later than five years;	704	735
- later than five years.	3,674	3,814
Total	**4,540**	**4,655**

Note 30 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	12,181	-	-	-	**12,181**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	1,456	-	-	-	**1,456**
Total at 31 March 2016	**13,637**	**-**	**-**	**-**	**13,637**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	9,614	-	-	-	**9,614**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	744	-	-	-	**744**
Total at 31 March 2015	**10,358**	**-**	**-**	**-**	**10,358**

Note 31 Financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	65,701	-	**65,701**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	333,577	-	**333,577**
Trade and other payables excluding non financial liabilities	27,553	-	**27,553**
Other financial liabilities	-	-	**-**
Provisions under contract	1,092	-	**1,092**
Total at 31 March 2016	**427,923**	**-**	**427,923**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2015			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	6,214	-	**6,214**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	339,257	-	**339,257**
Trade and other payables excluding non financial liabilities	23,107	-	**23,107**
Other financial liabilities	-	-	**-**
Provisions under contract	1,229	-	**1,229**
Total at 31 March 2015	**369,807**	**-**	**369,807**

Note 32 Maturity of financial liabilities

	2016 £000	2015 £000
In one year or less	94,346	30,550
In more than one year but not more than two years	5,975	5,680
In more than two years but not more than five years	27,168	26,092
In more than five years	300,434	307,485
Total	**427,923**	**369,807**

Note 33 Fair values of financial assets at 31 March 2016

	Book value £000	Fair value £000
Non-current trade and other receivables excluding non financial assets	652	652
Other investments	-	-
Other	-	-
Total	**652**	**652**

Note 34 Fair values of financial liabilities at 31 March 2016

	Book value £000	Fair value £000
Non-current trade and other payables excluding non financial liabilities	1,567	1,567
Provisions under contract	389	389
Loans	-	-
Other	-	-
Total	**1,956**	**1,956**

Note 35 Losses and special payments

	2015/16		2014/15	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	4	1	10	2
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	222	4	322	5
Stores losses and damage to property	-	-	-	-
Total losses	**226**	**5**	**332**	**7**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	1	15	1	20
Special severence payments	-	-	-	-
Ex-gratia payments	26	7	42	183
Total special payments	**27**	**22**	**43**	**203**
Total losses and special payments	**253**	**27**	**375**	**210**
Compensation payments received		-		-

Note 36 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. The significant transactions are as follows:

A full schedule by NHS organisation is available on request.

	Income	Expenditure	Debtor	Creditor
Customer Name	£'000	£'000	£'000	£'000
Mansfield & Ashfield CCG	113,204	26	871	663
Newark & Sherwood CCG	57,464	15	342	395
NHS ENGLAND	14,873	61	1,251	26
Hardwick CCG	14,254	0	103	28
HEALTH EDUCATION ENGLAND	11,601	95	232	0
Southern Derbyshire CCG	6,521	0	27	0
Nottingham North & East CCG	5,859	7	446	6
NHS PROPERTY SERVICES	4,538	4,310	1,863	3,426
Rushcliffe CCG	5,532	314	0	14
NOTTINGHAM UNIVERSITY HOSPS	3,883	4,217	554	3,256
NOTTINGHAMSHIRE COUNTY COUNCIL	2,740	285	291	0
Nottingham HealthCare NHS Foundation Trust	2,253	1,759	280	122
Lincolnshire West CCG	2,194	0	305	0
Nottingham City CCG	1,948	0	99	3
Nottingham West CCG	1,804	0	61	2
NHS Pensions Scheme		16,029		2,151
HM Revenue & Customs (Tax/NI)		10,360		2,981

The 2015/16 FT ARM requires changes to the structure of the annual report and accounts. As a result, some previous accounts disclosures are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the FTC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Note 44 Average number of employees (WTE basis)

	Permanent Number	Other Number	2015/16 Total Number	2014/15 Total Number
Medical and dental	417	138	**555**	501
Ambulance staff	-	-	**-**	-
Administration and estates	855	120	**975**	969
Healthcare assistants and other support staff	813	-	**813**	525
Nursing, midwifery and health visiting staff	1,118	182	**1,300**	1,347
Nursing, midwifery and health visiting learners	4	-	**4**	-
Scientific, therapeutic and technical staff	329	15	**344**	515
Healthcare science staff	109	-	**109**	109
Social care staff	-	-	**-**	-
Agency and contract staff	-	-	**-**	-
Bank staff	-	-	**-**	-
Other	40	-	**40**	-
Total average numbers	**3,685**	**455**	**4,140**	**3,966**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	-

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated FTC1 to FTC38 excluding FTC0, FTC8a and FTC8b of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2016, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the audited financial statements which are also published in the consolidation schedules.

Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

The auditor's report includes an Emphasis of Matter paragraph; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements.

Our opinion on the audited financial statements included an emphasis of matter paragraph in respect of going concern and the associated funding and structure uncertainties heading into 2016/17.

Andrew Bostock
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

26 May 2016

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2016 set out on pages 3 to 47. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

2. Emphasis of Matter – Going Concern

In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosures made in Note 1 to the financial statements concerning the ability of the Trust to continue as a going concern.

For the year ending 2015/16 the Trust is reporting a deficit of £55.04m. To support this financial position the Trust has received £47m in interim revenue support loans and has utilised a further £12.3m in working capital facility (WCF).

The Trust has developed a financial plan for 2016/17 which will deliver control total deficit of £41.1m. Achieving this control total is dependent on the Trust receiving additional financial support totalling £52.7m. This is in addition to the £10.3m of Sustainability and Transformation (S&T) funding to be provided from NHS Improvement. While the £10.3m of S&T funding has been approved, contingent on the Trust achieving its control total and performance targets, receipt of the remaining £52.7 million is predicated upon NHS Improvement approving the Trust's short term financial plan which was provided to NHS Improvement on 18 April 2016.

Alongside the on-going funding requirements, the Trust is also planning for an integration with Nottingham University Hospitals NHS Trust. This is following the announcement on 22 January 2016 by the Trust's Board, that the Trust required a long term partnership with another organisation to help improve the quality of services it provides. On 16 February 2016, the Trust's Board named Nottingham University Hospitals NHS Trust as its preferred partner, and both Trusts, along with NHS Improvement, have been developing a business case to support a formal transaction to integrate the two organisations. However, the integration is yet to receive final approval by NHS Improvement.

These matters, along with other matters explained in Note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern.

3. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows (there are no changes in the risks included below from the prior year):

Property plant and equipment (including associated PFI disclosures) – £ 243 million (£211m 2014-15)

Refer to page 11 (accounting policy) and pages 29 to 32 (financial disclosures).

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site. These assumptions can have potentially significant effects on the valuation. In 2015/16 the Trust commissioned a desktop revaluation of all land and buildings by an external valuer which comprised of a site 'walkaround' as at 31 March 2016.

Our response: In this area our audit procedures included:

- Assessing the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual;
- Obtaining the instructions provided to the external valuer and checking that the list of properties to be valued was complete and in line with our knowledge of the Trust;
- Critically assessing with the assistance of our own valuation specialists the appropriateness of the valuation bases and assumptions applied to a sample of material assets subject to the revaluation exercise by reference to property records held by the Trust on the condition of the assets, the basis of ownership and the basis of their use;
- Undertaking work to understand the basis upon which impairment to land and buildings had been classified by the Trust and determining whether the recognition of these losses in the financial statements complied with the requirements of the ARM;
- Considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities; and
- Considering the adequacy of the disclosures in relation to the Private Finance Initiative (PFI) arrangements and their compliance with the requirements of SIC 29.

Income Recognition – £297 million (£284m 2014-15)

Refer to page 9 (accounting policy) and pages 21 to 22 (financial disclosures).

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 86% of income from activities. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department's resource account. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Trust

and its counter parties at the balance sheet date. Mismatches can occur for a number of reasons, but the most significant arise where:

- the Trust and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced;
- income relating to partially completed period of healthcare is apportioned across the financial years and the commissioners and the Trust make different apportionment assumptions;
- accruals for out-of-area treatments not covered by direct contracts with commissioners, but authorised by, for example, GPs on behalf of commissioners, are not recognised by commissioners; or
- there is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mismatches can be classified as formal disputes and referred to NHS England Area Teams for resolution.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- reconciling the income recorded in the financial statements to signed contracts with material counter parties and reviewing material variations supported by explanations from the Trust;
- assessing whether the Trust was in formal dispute or arbitration in relation to any material income balances and examining the supporting correspondence, including - if appropriate - any legal advice, for consistency with the treatment of these balances within the financial statements;
- inspecting third party confirmations from other NHS counter parties and comparing the values disclosed within their financial statements to the values recorded in the Trust's financial statements through the English AoB exercise;
- for estimated accruals (including for completed and partially-completed periods of healthcare), comparing a sample of accrued amounts to invoices raised in the new financial year and checking evidence of payment and acceptance;
- carrying out testing of invoices raised around the financial year-end to determine whether income had been recognised in the appropriate period.

4. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £3.8m (£5.3m 2014-15), determined with reference to a benchmark of income from operations of £264m (£265m 2014-15) of which it represents 1.5% (2% 2014-15). We consider income from operations to be a more stable benchmark due to its non-volatile nature.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £190k (£250k 2014-15), in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's head office in Kingsmill Hospital, Sutton-in-Ashfield.

5. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- 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 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

6. We have nothing to report in respect of the following matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- the disclosures set out in the FT Code of Governance section of the Annual Report does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in respect of the above responsibilities.

7. Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report by exception if we conclude that we are not satisfied that the Trust has put in place proper arrangements to secure value for money in its use of resources for the relevant period.

In September 2012 Monitor notified the Trust that it was in significant breach of its terms of authorisation, and in August 2013 Monitor placed the Trust in special measures and invoked its powers under Section 106 of the Health and Social Care Act 2012. The Trust has remained in Special

Measures since that time and throughout 2015/16. Monitor removed the Section 106 condition relating to regulatory compliance at the end of April 2015, because it considered that adequate progress to address the weaknesses identified had been made. However, a new Section 106 condition was imposed upon the Trust in April 2015 because of concerns over its financial governance and the sustainability of the long term financial plan, as well as the worsening financial position. At the same time, Monitor has also imposed a Section 111 condition on the Trust, requiring it to ensure that it has in place sufficient and effective management and clinical leadership capacity and capability. This is because Monitor considers that the Board is failing to secure compliance with the Trust's licence conditions, and failing properly to take steps to reduce the breaches of those conditions.

In October 2015, the Care Quality Commission (CQC) published the results from its latest inspection of the Trust carried out in June 2015. This rated the Trust overall as 'Inadequate' including rating two of the five of the CQC sub categories for Safe and Well-led as 'Inadequate'.

As a result of these matters, we are unable to satisfy ourselves that the Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page [XX] the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2015. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), 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. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Sherwood Forest Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Andrew Bostock

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

One Snowhill

Snow Hill Queensway

Birmingham

B4 6GH

26 May 2016

Quality *for all*