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Sherwood Forest Hospitals NHS
NHS Foundation Trust

Annual Report & Accounts 2009/10

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Chairman's Statement

I am delighted to present our Annual Report for 2009/10.

As we celebrate our third year as a Foundation Trust, we do so with a growing reputation for the quality, safety, innovation and excellence of our services.

Strong Foundations

We have spent the last year putting in place the strong foundations required to deliver our vision to provide the best care, with the best people in the best place. I am proud of the progress we have made. We have treated more patients more quickly and to a better standard than ever before and I'm delighted that during 2009, both our patients and staff rated the quality of the care we provide more highly than ever before.

I have been privileged and proud to lead the Board as Chairman over the last two years. The vision we developed together with our staff, our Governors, and our community remains as important today as it has ever been. Quite simply it's about doing things the right way, by putting our patients at the heart of everything we do.

Our annual report summarises our performance and highlights our achievements, in particular the ways in which we have used our freedoms as a Foundation Trust to work with our members and to develop new and improved services to meet the changing needs of the community we serve.

We continue to strive to provide the best care by ensuring that quality, safety, and patient experience remain the highest priority for our Board of Directors and I am delighted that the Healthcare Commission once again rated us as 'good' for our standards of clinical services and 'excellent' for use of resources.

Although we have achieved much to be proud of over the last year, 2009/10 also marked the beginning of what will be an increasingly challenging period for the Trust. We faced increased financial, operational and strategic challenges and began to make the difficult decisions and changes necessary to ensure that we are able to meet the significant challenges ahead. Whilst we achieved the key targets in our financial plan, our operating costs increased and critically, we did not deliver a large part of our anticipated cost improvements. Looking forward, we face significant additional costs as we progress towards the completion of our new hospital and the coming years will be even more demanding.

Meeting the Challenge Ahead

Whilst we have continued to benefit from increased demand for our services and have continued to invest our surpluses in improving services over the last 12 months, we do not expect this level of continued investment and growth to continue. We are not immune to the wider impacts of the economy and the pace of growth in demand for acute services and investment in healthcare will be significantly reduced in the coming years. We recognise that in future, we will have to do more for less by further improving our productivity and reducing our costs, without compromising on quality.

Our overriding priority in the coming year is to lead the organisation through a difficult economic and financial period, while continuing to invest in further improving the quality and safety of our services and in delivering our vision - the progress we began in the latter part of 2009/10 is not yet complete.

The Board of Directors recognises the vital importance of sound financial management as we enter a period of financial challenge and the need to meet the future costs of our new hospital. Looking forward, our success will depend on our ability to engage and secure the support of our clinicians and staff to assist us to increase our flexibility and to take advantage of the opportunities that lie ahead,

accelerating the pace and scale of organisational change to truly transform 'what' we do, to reduce our costs whilst improving services for patients.

The financial challenges that we will face in the next few years make it even more imperative that we continue to embed a culture of improvement amongst our staff. In order to support this transformation, during the year, the Board of Directors entered a partnership with Unipart to help us transform and improve many of our key processes and pathways. This work – **A**chieving **B**est **C**are - will help us improve our efficiency and assist us to make sure that clinical staff – doctors, nurses and other health professionals who work directly with patients – have a more direct impact on how our services are provided in the future.

More than ever before, it is vitally important that we deliver solid, sustainable financial performance to ensure we remain viable for the future. To do this we will continue to set stretching financial targets over the coming year and to accelerate our focus on increasing our efficiency and effectiveness and on controlling our costs.

We believe that as a Trust we are well placed to manage the financial and operational risks and to seize the opportunities that these significant challenges bring.

Above all, we remain determined and ambitious. We will continue our relentless focus on improving our services, on meeting the challenges ahead and on really providing the 'Best Care, by the Best People in the Best Place'.

I am proud that people often talk about the sense of friendliness and caring at our Trust and our significant achievements during the year are down to the dedication and commitment of our staff.

On behalf of the Board of Directors, I would like to extend my personal thanks and recognition to those at the heart of our Trust – our staff and volunteers - whose talents, enthusiasm and commitment to providing the very best standards of customer and patient care are greatly appreciated. Together, they make this a very special place to work.

Tracy Doucét
Chairman **Date: 3 June 2010**

'Everyone, from the surgical team right through to ward, catering and cleaning staff were courteous, friendly and considerate' NHS Choices April 2010

INTRODUCTION TO THE TRUST

Brief History & Foundation Status – Improving Our Accountability & Transparency

Sherwood Forest Hospitals NHS Foundation Trust was granted NHS Foundation Trust status on the 1st February 2007, under the National Health Service Act 2006.

We are proud to be one of the 129 Foundation Trusts, who collectively provide more than half of all NHS hospital services. Foundation Trusts are a result of the Government's drive to devolve decision making from central to local organisations and communities and all NHS Foundation Trusts are not-for-profit, public benefit corporations. We provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.

As a Foundation Trust, we remain firmly within the NHS, but we differ from NHS Trusts in that we are not directed by Government, so have greater freedom to decide our own strategy and the way our services are run. In addition, we retain our surpluses and can borrow to invest in new and improved services for our patients and service users. Most importantly, we are accountable to our local community through our members and Governors, to our commissioners through our contract and to Parliament through Monitor, the Foundation Trust regulator.

Our Board of Directors are responsible for the strategic and operational running of the Trust and for ensuring good governance and continued compliance with the terms of our authorisation. We are committed to using our Foundation Trust freedoms to continuously improve the quality and safety of the care we provide and to invest further in developing the range of services for our community. Over the last three years, we have done this by working closely with our Governors, listening to their views and understanding the changing needs of our patients - improving how we deliver those things that really do matter most to our patients and to our community.

We are accountable to our community through our 19,016 public members whose interests are represented by 20 democratically elected public Governors and to our 5,222 staff members and wider stakeholders through their election and appointment to our Board of Governors.

Gaining Foundation Trust status in 2007 has enabled us to improve our accountability and transparency and to be more responsive to the needs and wishes of our local community.

We are grateful for the significant contribution of our Board of Governors and members since we gained our Foundation Trust licence, in helping us to create a truly shared vision for our Trust and for working with us to invest in new services and to improve the quality, safety, effectiveness and transparency of everything we do.

Our Principal Activities

We are the main acute hospitals Trust providing high quality healthcare services for the people of Mansfield, Ashfield, Newark, Sherwood and mid Nottinghamshire.

The levels of urbanisation, deprivation and population concentration vary considerably across the area with the main hubs of population in the west being focused around the towns of Mansfield and Sutton-in-Ashfield and the town of Newark to the east. Much of the area is rural, particularly towards Newark, and the higher levels of urbanisation seen in and around Sutton-in-Ashfield and Mansfield are matched by increased levels of deprivation and health need.

The geographic areas served by the Trust have comparatively low indices of socio-economic measurement, with high levels of respiratory problems and other causes of chronic illness and long term disability, as a result of the industrial past and the high levels of employment in the coal mining and textiles industries.

The overall impact of this local socio-economic context is higher than national average hospitalisation rates, particularly levels of emergency admissions, and this high level of health need has been reflected in the Trust's future activity modelling.

All three areas have a greater proportion of older people within their population than the England average, and the population as a whole is expected to continue to increase by a rate higher than the national average.

Although the majority of our patients live within Central Nottinghamshire, an increasing number (approximately 14%) of our patients choose to come from other surrounding areas such as south Nottinghamshire, Derbyshire and Lincolnshire.

We provide a wide range of diagnostic services, treatment and care from our two main district hospital sites - Newark Hospital and King's Mill Hospital and continue to deliver a range of services from Mansfield and Ashfield Community Hospitals.

We employ more than 4,500 staff, the majority of whom live within the Central Nottinghamshire area. As such, we continue to play a vital role in the regeneration of our local economy as one of the largest employers in the area.

King's Mill Hospital

King's Mill Hospital provides medical, surgical, paediatric, obstetric and gynaecological services from a range of settings including inpatient wards, a diagnostic and treatment centre, an emergency care centre, a critical care unit, a day case unit, and a neonatal intensive care unit. We also have an angiography laboratory, a new endoscopy suite and an oncology department. We have a full range of diagnostic and support services on the site.

The hospital is nearing the end of a major £367m redevelopment, scheduled to be completed in 2010/11 which will create truly world-class facilities for our community. The re-development of the hospital was agreed in 2005 by all local health community partners, as part of a wider modernising acute service project. It is funded via the private finance initiative (PFI), details of the financial aspects of the PFI scheme are included in the Trust's accounts.

The first phase opened in July 2008 providing new outpatient facilities set in the contemporary and spacious King's Treatment Centre. During 2009/10 we provided more outpatient appointments than ever before and saw more than 270,000 people in our outpatient clinics.

In April 2009, we completed phase two with the opening of the first two of our three inpatient towers, providing new medical and surgical wards with 50% ensuite single rooms and larger 4 bed bays, significantly improving our patient experience.

During 2009/10 we treated more than 76,000 people from 634 inpatient beds and treated 30,000 day case patients in our new day-case unit without the need for an overnight stay.

During the year we also opened the first part of our new Emergency Care Assessment Centre treating more than 99,000 people.

More than 3,100 babies were born at King's Mill Hospital and our maternity services were rated as "excellent" during 2009, by the independent Healthcare Commission in the most comprehensive national study undertaken to date.

The remainder of our re-development will be completed during 2010/11 when our third tower is completed, providing a new women and children's centre and transferring the remainder of our inpatient services to new state of the art facilities.

Newark Hospital

Newark Hospital provides a wide range of general hospital services covering outpatients, diagnostic services and treatment across general medicine, care of the elderly, general surgery (including trauma and orthopaedics), gynaecology, urology, ophthalmics. Services are provided from modernised accommodation, with two operating theatres and 77 inpatient beds.

The Sherwood Centre provides a dedicated women's assessment and treatment centre for antenatal care, gynaecology and breast services. Increasing numbers of patients were seen during the year in our audiology, endoscopy, therapy, CT and radiology departments and more than 25,000 patients were treated in Newark's accident and emergency unit.

We are proud that Newark provides high quality safe care for the people of the surrounding areas, attracting increasing referrals each year and offering a welcoming friendly service within a clean modern environment with waiting times consistently shorter than the national average. It is consistently rated 'excellent' or 'good' by more than 90% of our patients.

During 2009/10, we invested further in services at Newark Hospital, commencing a new hysteroscopy service, and with the support of local Lions groups commenced a new YAG laser service. In June 2009, the Trust received a £1m grant from the Doughty Foundation, and work commenced in early 2010 on the development of new pre-operative assessment and endoscopy units in memory of Mercia Doughty.

During 2009/10, NHS Nottinghamshire County (our commissioners) launched a public consultation on the future provision of healthcare in Newark. The Trust welcomed the opportunity to review the level and range of services provided from Newark Hospital and to re-state its commitment to maintaining this valuable asset as a key part of the Trust's services.

The Trust's Board of Directors, our clinicians, Governors and members supported the view that Newark Hospital should provide 24/7 urgent care services to the local population as well as providing an increasing range of outpatient, planned care and community services. The outcome of the consultation is expected to be decided by our commissioners in June 2010.

Providing Community Services

During 2009/10, we also expanded our services through integrating community paediatrics, Parkinson's and osteoporosis services. In addition we were successful in winning a competitive tender to enable us to provide a diabetes service in the local community.

Our clinicians feel there is much to gain for patients in having truly integrated services across the hospital and community and this forms an integral part of our strategy going forward. The policy for 'Transforming Community Services' provides an ideal opportunity to redesign and integrate care pathways to improve the quality and effectiveness of care:

- Moving care closer to home
- Reducing unnecessary hospital admission
- Improving outcomes and quality of care
- Reducing duplication
- Decreasing the overall cost of care pathways
- Improving patient experience

Our clinicians are keen to work together across the community to raise the standards for the population served, offering clinical leadership, support and our hospital expertise to community services, and vice versa. The sort of patients we feel would particularly benefit include those who use intermediate care and those with Long Term Conditions, such as heart failure, chronic obstructive airways disease, diabetes, epilepsy. In addition we feel children's services should be truly integrated with the right clinical leadership.

Our Vision & Pledges

During 2009/10, we worked with our staff, our members and our Governors to develop and agree our Vision and to develop our pledges for patients and staff.

Our Vision

'To provide the Best Care, with the Best People in the Best Place for our patients and our community and to ensure that our hospitals are a source of pride for our staff, for our patients, stakeholders and community.'

Our Pledges

Pledges to Patients and Carers

We will listen to you
(your individual needs and concerns, and respond to them)

We will work together as a team
(and with you, to give you the best care)

We will show kindness and compassion
each of you with dignity and respect)

We will communicate effectively
(at the right time and in a way that is easy to understand)

We will care for you in a safe and clean environment

Pledges to Staff

We will appreciate you
(showing respect and recognition for what you do)

We will listen to you
(ask your views, working & communicating with you effectively)

We will support you to do the best in your job (treating

We will provide a safe environment

Our progress and performance during 2009/10 in delivering on our vision and in meeting our pledges to patients and staff is highlighted overleaf and is covered in more detail throughout the remainder of this report.

Chief Executive's Report

The Year at a Glance

Every year provides a new set of challenges and 2009/10 was no different. In our third year as a Foundation Trust we have made considerable progress towards achieving our vision to provide the best care, best people and best place. One of the most heartening testimonies to this, and a source of pride, is our results in the nationally run 2009 staff survey. We are rated in the top 20% of Trusts for all the key areas relating to staff satisfaction such as - would you recommend the Trust as a place to work or receive treatment?

The year included some notable landmarks, including the opening in April of the first two of our three 'Towers', the new day case unit in April, the new endoscopy unit in November and the new emergency care centre in August.

The provision of our new accommodation at King's Mill and the hard work of all staff across the Trust enabled us to make a dramatic impact on our MRSA bacteraemia rate, which has been a key priority for the Board of Directors in recent years.

Delivering our Vision & Meeting our Pledges

Work on our new £367m hospital at King's Mill progressed well during 2009/10. With the first two phases now fully operational, we look forward to the completion of the work in 2011.

Our new inpatient accommodation with 50% of patients in single bedrooms - all with en-suite bathroom facilities – remains the best available locally and will help us achieve the highest standards of cleanliness, dignity and privacy.

Moving into our new facilities has given us a tremendous opportunity to maintain improvements to our clinical services, ensuring that our patients receive the best care available, more quickly than ever before.

During 2009/10, we developed our organisational approach to quality improvement, '**A**chieving **B**est **C**are' (ABC). This work will continue to drive our strategy, transforming services and further developing our culture in support of the delivery of our pledges to patients.

We remain on schedule to complete the refurbishment of King's Mill Hospital in 2010/11.

Providing the Best Care – Highlights of 2009/10

1. **Reducing Infections** – We significantly exceeded our reduction targets for both MRSA and Clostridium difficile during the year reflecting the huge amount of work undertaken in recent years to improve our performance. This has consistently been a high priority for the Board of Directors and we are particularly proud of our achievement.

2. **Improving Our Patients Experience** - There has been year on year significant improvement in our national inpatient survey results, increasing the number of domains where we are in the top 20% of Trusts from 7 in 2008 to 23 in 2009. Our patients rated us as 'top 20%' for the cleanliness of wards, toilets and bathrooms, as well as for hand hygiene. With 50% ensuite rooms we are in the top 20% of Trusts for patients not being bothered by the noise of other patients at night, for patients' opinions that there were enough nurses on duty to care appropriately, and for patients feeling that nurse call buttons were answered in a timely way.

3. **Increasing Our Membership, Accountability & Engagement** - At the end of March 2010, we had in excess of 25,000 members in total (including public, staff and affiliate members).

Throughout the year we arranged a number of successful member events, information sessions and held constituency meetings in the community to assist our Governors to meet their members first hand to find out their experiences and views of our services. This feedback and engagement assisted us to develop our vision and strategic objectives for 2010/11 and to develop pledges which truly reflect those things that are most important for our patients and carers.

4. **Listening To Our Patients** – Over 90% of patients from our inpatient wards and outpatient services say we live up to our pledges and over 90% would recommend our services to their family and friends.

5. **Improving our Environment & Investing In New Services** – During the year we progressed towards the completion of our new hospital facilities at King's Mill Hospital and sustained our investment in new hysteroscopy and YAG laser services at Newark Hospital - creating outstanding environments so that our local communities receive health care in the 'Best Place'.

6. **Emergency Preparedness** - The Board of Directors approved additional investment and signed a declaration in September 2009 confirming our preparedness to meet significantly increased demand for our services in response to the anticipated swine flu pandemic.

7. **Attracting & Retaining The Best Staff** – Key to our success is how engaged our staff are in delivering our best care vision and pledges. The 2009 Staff Survey outcomes confirm that we are in the top 20% of Trusts for staff understanding their role and where it fits in; we are better than average in key findings relating to good communication between senior management and staff, and for staff being able to contribute to improvements at work. During the year we recruited many excellent new clinical staff, all of whom see the prospect of helping us develop our new facilities and re-design our services to improve the quality, safety and effectiveness of our services as good reasons for choosing us as their employer. During 2009, we were particularly delighted to be named as one of the Top 100 NHS Employers in the Nursing Times and Health Service Journal Awards.

8. **Technological Innovation** – Once again we were at the leading edge of a number of local and national initiatives in the field of information technology (IMT). The continuing successful implementation of Choose and Book received national recognition from the Department of Health in 2009, and the extended use of our VOCERA communication system and other innovative and imaginative IMT solutions are helping us to improve the work of staff across the Trust were further excellent examples of our continuing success.

9. **External Assurance** - Ensuring that the quality of our services remains the top priority for our Board of Directors. During the year, we were once again rated 'good' for the quality of our services and 'excellent' for our use of resources by the Healthcare Commission. On 16th September 2009, following an unannounced inspection the CQC confirmed that we had fully met all 16 measures relating to the prevention and control of infections. Our pathology department achieved full accreditation with the national accreditation body Clinical Pathology Accreditation (UK) Ltd and during 2009, our maternity services were once again rated as excellent and our caesarean rates were recognised as the best in the country.

Engaging Our Community

Listening to the views of our local community and engaging with our members remains key to achieving our vision and to ensuring increased transparency and openness in all that we do. By the end of March 2010, we had successfully recruited over 19,000 public members, placing us in the top Foundation Trusts nationally – an achievement that we are particularly proud of.

We are grateful for the hard work and enthusiasm of our Governors during the year in assisting us and in working closely with the Board of Directors to influence and shape our services for the future.

Reducing Our Impact on the Environment

We are committed to reducing our impact on the environment and reducing our carbon footprint. During the year, the investment we made during 2008 in our geothermal heat transfer project assisted us to meet this commitment. We were proud that this project, one of the largest in Europe, was shortlisted for a prestigious national Good Corporate Citizen award.

A separate section providing more details on our commitment to sustainability is included in our Operating and Financial Review.

Leading Our Staff

There were a number of personnel changes to our Board of Directors during the year.

Jeffrey Worrall resigned as Chief Executive at the end of November 2009, following nine years leading the Trust. The Board wishes to record its thanks to Jeffrey for his leadership, commitment and significant achievements over the years.

We also welcomed Iain Younger to the Board of Directors as Non-Executive Director in December 2009. Iain replaced Stephen Pearson who stood down at the end of his term of office. The Board also thanks Stephen for his contribution to the success of the Trust over the last four years. David Leah was re-appointed as Non-Executive Director from the 1 December 2009.

Carolyn White
Chief Executive **Date: 3 June 2010**

DIRECTORS' REPORT

Composition of the Board of Directors

The composition of the Board of Director's in the period 1st April 2009 - 31st March 2010 was as follows:

Chairman	Tracy Doucét
Chief Executive	Carolyn White (from 1.12.09) Jeffrey Worrall (to 30. 11.09)

Executive Directors

Executive Director of Strategy & Improvement	Jane Warder
Executive Nurse Director	Carolyn White
Executive Director of Finance	Lee Bond
Executive Director of Human Resources	Karen Fisher
Executive Medical Director	Mike Mowbray

Non-Executive Directors (all considered by the Board to be Independent)

Bonnie Jones	Vice-Chairman
David Heathcote	Senior Independent Director
David Leah	Audit Committee Chair
Stuart Grasar	
Iain Younger (from 1 December 2009)	
Stephen Pearson (to 31 December 2009)	

Summary biographies of Directors who were members of the Board of Directors on the 31 March 2010 are provided on pages 86 to 90.

Operating & Financial Review

During the year we made significant progress towards the achievement of our vision *to provide the best care, with the best people in the best place* for our patients and our community and to ensure that our hospitals are a source of pride for our staff, for our patients, stakeholders and community.

Improving the Quality, Safety & Effectiveness of Our Care

Many of our achievements and investments have made a major contribution towards further improving the quality, safety and effectiveness of our care. Those of significance include:

Continuing to reduce hospital and community acquired infections remained a top priority for both our Board of Directors and Governors and reducing our MRSA bacteraemia by 30% was a key commitment made in our first Quality Report in 2008/9. We made significant improvements during the year reducing MRSA rates by 55% over the 12-month period, our best ever performance exceeding our annual reduction target of 24 by more than 35%.

We also achieved our Clostridium difficile targets throughout the year and succeeded in significantly reducing the number of infections, exceeding our target of 260 by 87% (58 cases in year) making us one of the top performing Trusts in the East Midlands.

These achievements reflect the commitment of staff across the Trust and in particular the tremendous work of members of the Trust's infection prevention and control team, who tirelessly encouraged and supported clinical staff in addressing the causes of infection.

During the year, we increased the number of patients rating our services as 'good' or 'excellent' to more than 90% by March 2010 and continued our progress in achieving significant year on year improvements in our national inpatient survey results. In the 2009 inpatients survey, undertaken by the Picker Institute on behalf of the NHS nationally and published on 12th May 2010, we were rated as being in the top performing Trusts for 23 domains (an increase from 7 in 2008). These include achievement in the top 20% of hospitals for cleanliness of wards, toilets and bathrooms and hand hygiene. With 50% ensuite rooms we are also in the top 20% of Trusts for patients who felt that there were enough nurses on duty to care appropriately and who felt that they were not disturbed by the noise at night and for patients who felt that nurse call buttons were answered in a timely way.

For the second year in a row, the Healthcare Commission rated us 'good' for the quality of our services and 'excellent' for our use of resources.

Treating More Patients, More Quickly Than Ever Before

In addition to these significant improvements in the quality and safety of the care we provide, we continued our commitment to further reducing our waiting times and improving access to treatment.

We invested in significant additional capacity to meet increasing numbers of patients choosing us for their treatment throughout the year. Most notably, 12,000 more patients were seen in our outpatient departments during the year.

During the latter part of the year, referrals in some specialties (most notably trauma and orthopaedics) increased significantly; requiring us to open additional theatre capacity and to increase the number of inpatient beds required to ensure that we were able to safely manage the increase in urgent emergency referrals from primary care during the busy winter months.

Our clinical activity in year when compared to our annual plan is summarised below.

Clinical Activity	***2009/10 Plan***	***2009/10 Actual***
Elective inpatients & Day Cases	38,583	38,462
Non-elective inpatients	35,766	38,265
New Outpatients	76,534	88,757
Accident and Emergency	101,821	99,380

Despite this increased demand for our services, during 2009/10 we treated more patients more quickly than ever before - further reducing waiting times for first outpatient appointments, diagnostic tests and elective surgery. We achieved both the national targets for the numbers of patients treated within the 18 week referral to treatment time throughout the year. For admitted patients, our performance at year end was 94% and for non-admitted 98.7% of patients treated within the 18 week target. The median wait from referral to treatment (admitted) was 10 weeks.

Following performance marginally below target for A&E in the first few months of 2009/10, we significantly improved our performance - achieving our target throughout the remaining months. Despite a busy winter period from January to March, we were proud to end the year as the second best performing Trust in the East Midlands with 98.7% of patients being treated discharged or admitted within 4 hours.

Throughout the year, we continued to face challenges in delivering consistently against the national target of 60 minutes from call to needle for those patients eligible for thrombolysis. Whilst we met the targets for the first six months of the year, our performance during quarter 3 was 66.7% and for quarter 4, 50% against a target of 68%.

Our performance was closely monitored by the Board of Directors throughout the year, however despite significantly improving our own internal door to needle performance, performance by EMAS (East Midlands Ambulance Service) continues to pose significant risks to the ongoing achievement of this target. Our Board has taken a number of actions throughout the year to work with EMAS to assist them to reduce the time taken to transfer patients to the hospital and to improve their performance.

Performance against our cancer target is summarised in the table below.

Target	**Standard**	**Q1**	**Q2**	**Q3**	**Q4**
Cancer 31 days for second or subsequent treatment	98% Drugs	n/a	100%	100%	99%
Cancer 31 days for second or subsequent treatment	94% surgery	n/a	93.3%	100%	93.6%
Cancer 62 days for all referrals to treatment	85% GP	n/a	87.7%	84.7%	84%
Cancer 62 days for all referrals to treatment	90% Screening	n/a	92.5%	87.5%	85.7%
Cancer 2 week wait – all cancers	93%	94.4%	95.1%	95.5%	92.5%
Cancer 2 week wait – breast symptomatic	93%	n/a	n/a	n/a	92.8%
Cancer 31 days from diagnosis to treatment	96%	n/a	100%	99.2%	99.7%

The Trust has faced challenges in consistently delivering all the cancer targets. There has been a substantially higher demand for bowel screening across the county than envisaged when the service was planned and the Trust has needed to double its capacity in year.

Service improvement work has taken place to make patients' journey times even shorter. However there has been a much larger than anticipated number of breaches of these targets (50%) by patients

suspected of cancer who choose to delay their treatment, diagnostic tests or appointments. This was a particular problem in the snowy month of January. One of the actions we are working closely on with the community, particularly GPs, is ensuring patients that are referred into the hospital are encouraged to have each step of their pathway quickly.

The Board throughout the year closely monitored our performance, and service improvement work is ongoing. We have also invited the national Cancer Intensive Support Team into the Trust to do a further assessment of any other aspects we can improve upon.

Demand for Our Services

The demand for our services increased once again during the year with referrals at King's Mill and Newark increasing by 7.5% and 10.6% respectively.

Further assessment of our quarterly performance during the year against our regulatory targets is provided on page 34. Further detailed information on our performance against our key clinical quality, patient safety, clinical effectiveness priorities and external assessment during the year is provided in our Quality Report starting at page 40.

Our Financial Performance

This financial overview summarises our performance for the financial year which ended 31st March 2010. There is no relevant information which has not been brought to the auditor's attention so far as the directors are aware.

In our third year as a Foundation Trust, total income received increased by 7.8% to £235.9m, some £3.3m over plan. At year end our cash, cash equivalents and investments were £33.25m representing deterioration against plan of £0.48m.

Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) was £23.27m against our target of £23.75m and our net surplus (before impairment) was £4.2m, a reduction of almost 50% compared to 2008/9, reflecting the significantly increased costs of our new hospital and poor performance in delivering our planned income generation targets and reducing our costs (£3.40m against planned savings of £7.24m)

We achieved a financial risk rating of 4 at year end (a score of 1 being 'high-risk' and 5 'low' risk) comprising achievement of targets as summarised in the table below.

Metric	**Actual**	**Monitor rating**
EBITDA margin*	9.9%	4
Achievement of EBITDA plan	98%	4
Return on assets	11.4%	5
I & E surplus margin	1.8%	3
Liquidity	16.9	3
Weighted average		**4**

* EBITDA is earnings before interest, tax, depreciation and amortisation.

Improved Efficiency & Value for Money

Our total operating expenses (excluding depreciation) rose during the year to £212.1m, exceeding plan by £3.77m. Of this £145.7m (68%) was spent on staffing, ensuring we continued to attract and retain 489 medical and dental staff, 1222 registered nurses and midwives, 387 scientific, technical and therapeutic staff and 889 other health professionals and clinical staff.

Over 11% of our total operating expenses (excluding depreciation) was spent on drugs and clinical supplies helping to ensure that our patients continue to be able to access the latest treatments.

The £4.183m surplus was achieved by delivering over £3.4m in efficiency savings across a range of cost reduction and efficiency schemes.

Capital Investment

The Trust continued to invest in improving facilities and infrastructure. During 2009/10 capital spending totalled £11.6m, including £3.8m spent on upgrading or buying new equipment essential for the day to day operations of the Trust, £0.8m on improvements in IT and £7m on building works and new service developments.

Financial Disclosures

Commercial income and private patient CAP

In accordance with our terms of authorisation, private patient income is capped at 0.2% of our total NHS clinical revenue. We have remained compliant with this for 2009/10 with private patient income of 0.1%.

Our Key Partners

In delivering our key services we have a number of material contracts with the Department of Health and organisations including NHS Nottinghamshire County, our local primary care Trust (PCT) and main commissioner, local Practice Based Commissioners (PBCs), Nottingham Community Health, Central Nottinghamshire Clinical Services (the local Out of Hours service) and Nottingham University Hospitals Trust, for which the Department of Health is the parent body.

In addition, the Trust continued to work with Central Nottinghamshire Hospitals plc and its sub-contractors, and received tremendous support from the Trust's many volunteers and charitable organisations including the League of Friends, Daffodils, Newark Hospital Volunteers, Lions and the Doughty Foundation.

Prudential Borrowing Limit

Monitor, the Foundation Trust regulator, sets an annual prudential borrowing limit by reference to a number of key financial ratios. This is the maximum amount we can borrow. Throughout 2009/10, we remained within our £377.9m prudential borrowing limit. Monitor also authorised the Trust to have a £15m working capital facility in 2009/10, however, the Trust did not exercise this option.

Going Concern

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

External Audit Services

The Board of Governors approved the appointment of KPMG as the Trust's external auditors from 1 November 2007 for a period of three years. We incurred £66,000 in audit service fees in relation to the statutory audit of our accounts for the twelve month period to 31 March 2010, and the audit of the restatement of our accounts to IFRS standards. No other audit services were required during the accounting period.

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps required, in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Non-audit Services Provided by the External Auditor

We did not commission any non-audit services from KPMG during 2009/10.

Countering Fraud & Corruption

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 and the police as necessary.

We continue to work hard 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. A number of staff received counter fraud awareness training. A total of 545 staff received face to face training, including 497 staff who received a fraud awareness session as part of their induction training on joining the Trust and 53 staff completed a Counter Fraud e-learning module, which was only made available in mid-March 2010, giving a total of 598 staff who received training during the year.

Accounting Policies for Pensions and Other Retirement Benefits

Our accounting policies for pensions and other retirement benefits are set out in note 3 (page 120) to the accounts and details of senior employees' remuneration can be found in the annual accounts.

Looking Forward

Trading Environment & Financial Risks

Whilst we continued to deliver a healthy financial performance for the year ending 2009/10, there have been significant challenges over the last twelve months in the national economic and political environment, and in our commissioner's projected financial position, which have significantly impacted on our plans for 2010/11 and beyond.

Nationally, and internationally, the effects of the global banking crisis and the economic slowdown will have a detrimental and long term impact on the health of the public finances. Given the scale of economic challenge, despite the commitment to fund real term increases in NHS spending by the new coalition government, the NHS continues to face the prospect of a significant and sustained reduction in overall funding in the medium term.

In addition to these national factors there have been significant changes locally in our commissioner's financial position and in the pricing structure for our patient treatment income. These changes have increased the financial risk for both our commissioners and ourselves.
During 2010/11, the introduction of new contract penalties and CQUINs will increase the risk to our contracted income and future financial performance.

During 2009/10, we have sought to establish robust risk management processes to mitigate this risk and enable us to manage the impact of reduced income on our services and long term viability. Accordingly, our future projections in respect of growth, tariff inflation, price inflation, interest rates and efficiency requirements have all been revised to take account of this.

Having agreed contracts with all our main commissioners by the end of 2010/11, our key risks for next year link directly to our commissioners ability to reduce demand for our services and our own ability to more robustly control our cost base and to flex and reduce our capacity as demand management schemes are implemented.

Our Board of Directors has considered 3 year financial plans based on our 'best', 'likely' and 'worst' assessment and have identified the financial challenge required under each of the three scenarios. We will continue to regularly and robustly review our assumptions, ensuring that we identify and take the actions required under each.

Our Staff

Staff Engagement

In partnership with staff, during 2009 we developed and published pledges for both our staff and patients. These 'pledges' set the standards which form the basis of our relationships with staff and patients and upon which we will measure and communicate our progress:

Our Pledges to Staff

We will appreciate you
(showing respect and recognition for what you do)

We will listen to you
(ask your views, working and communicating with you effectively)

We will support you to do the best in your job

We will provide a safe environment

We have a number of formal and informal mechanisms in place to support the pledge to our staff of - "*We will listen to you*". The Joint Staff Partnership Forum is the forum for consultation and negotiation, which meets on a monthly basis to discuss and explore the key strategic issues. A new Workforce Change Group has recently been established to support and oversee consistency of approach to changes affecting our staff. This group has been established as a direct result of feedback from staff side colleagues regarding their need to fully understand and support workforce changes.

During the latter part of the year, the Board of Directors and Executive Team commenced the development of our corporate turnaround strategy focused on clearly communicating the actions required during 2010/11 to ensure that we have a sustainable financial future - protecting our cash, reducing our costs and increasing our profitability, whilst continuing to further improve our efficiency.

The successful delivery of our 'Meeting the Challenge Strategy' will depend upon our ability to call our staff to action, to communicate and engage with them and to ensure that all our staff are clear about the role they play in assisting us to deliver our plans and maintain a relentless focus on quality. During the early part of 2010, we have held a number of forums to brief staff on the challenges and priorities contained within "Meeting the Challenge" which sets out our vision and strategy for the coming years. This mechanism has already assisted us to improve our engagement with staff and to identify potential service improvement solutions for the future. Some 400+ suggestions were received from staff regarding opportunities for improvement. A group has been established to review the suggestions made and provide responses either on themes (such as sickness absence) or an individual basis.

We are committed to delivering our pledges and to working in partnership with staff and their representatives. During the year we have listened to the views of staff in relation to our internal communications. As a result of feedback, we have recently introduced our Chief Executive's ''blog'', reviewed our 'team' brief and used internal surveys to improve our communications with staff.

We also recognised the achievements of our staff at our annual staff excellence awards presentation ceremony in September 2009 and introduced a Star of The Month scheme to recognise the contributions of individuals

Throughout the year, we worked closely with our staff Governors: obtaining their views on our forward plans, discussing our operational and financial performance, engaging them as Governors in improving the quality and safety of our services and assisting them to engage with our staff members. We are grateful to them for their significant contribution.

Our priority for 2010/11 will be the continued implementation of our new staff engagement strategy: improving staff communications, continuing our initiatives to enhance team working and the

development of a new training, education and development strategy. These improvements are critical to our Achieving Best Care (our ABC) approach that will help ensure we deliver our pledges to staff and support cultural change within the organisation.

2009 Staff Survey

The Trust participates in the National Staff Survey on an annual basis in which 850 randomly sampled staff are surveyed.
An analysis of the response rate and top and bottom four ranking scores from the 2009 survey is shown below:

Response Rate:

Response Rate 2008		Response Rate 2009		Improvement / Deterioration
Trust	*National Average*	*Trust*	*National Average*	
52%	52%	50%	50%	Our response rate decreased by 2% but remained in line with the national average

Top 4 Ranking Scores:

	2008		2009		Improvement/Deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Percentage of staff experiencing harassment, bullying or abuse from patients/relatives in last 12 months					
	21%	22%	16%	21%	2009 Trust lowest (best) 20% Decreased by 5% points (positive)
Percentage of staff suffering work-related injury in last 12 months					
	13%	17%	13%	17%	2009 Trust lowest (best) 20% No change in % points
Percentage of staff experiencing discrimination at work in last 12 months					
	4%	---	4%	7%	2009 Trust lowest (best) 20% No change in % points
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months					
	18%	19%	14%	18%	2009 Trust lowest (best) 20% Decreased by 4% points (positive)

Bottom 4 Ranking Scores:

	2008		2009		Improvement/ Deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Percentage of staff having equality and diversity training in last 12 months					
	26%	27%	26%	35%	No change in % points. 2009 Trust below average
Percentage of staff receiving health and safety training in last 12 months					
	76%	76%	75%	78%	Decrease by 1 % points (negative). 2009 Trust below average
Percentage of staff reporting errors, near misses or incidents witnessed in the last month					
	90%	95%	94%	95%	Increase by 4 % points (positive). 2009 Trust below average
Percentage of staff experiencing physical violence from patients/relatives in last 12 months					
	14%	12%	11%	11%	Decrease by 3 % points (positive). 2009 Trust at national average

Note: *National Average figures given represent those for Acute Trusts*

The 2008 staff survey outcomes suggested the need to improve our approach to staff appraisal, violence and aggression, flexible working and incident reporting. During the year significant work was completed to ensure all staff received an appraisal together with an associated personal development plan (PDP). We are pleased to note improvements in responses for 2009 regarding staff appraisal, staff having a well structured appraisal and staff appraised with a PDP, all of which ranked highly when compared to other Trusts.

We have also completed a review of our violence and aggression policy and introduced personal security devices for vulnerable staff, again we are pleased to note improved responses in relation to the perceptions of us as an employer towards violence and harassment. We will continue to focus our attention on the reporting of errors and near misses which remains an area for improvement.

The 2009 staff survey outcomes identify many positive responses - we performed average or above in 37 out of the 40 key finding areas – see below.

The survey responses show an improvement in 10 key finding areas, no change in 25, 1 area which has worsened and 4 new key finding areas which were previously unreported and therefore have no comparable data.

40 key findings

	2008	**2009**
Best 20%	11 Areas	18 Areas
Better than Average	10 Areas	12 Areas
Average	9 Areas	7 Areas
Worse than Average	1 Area	3 Areas
Worse 20%	5 Areas	0 Areas

Whilst we are pleased with the survey outcomes there remain a number of areas which require improvement. Our action plan for 2010/11 will focus on:-

- Reviewing incident reporting processes regarding errors, near misses or incidents
- Developing and implementing a programme of Equality and Diversity training
- Developing and implementing new approaches to increase the uptake of health and safety training
- Developing and implementing new approaches to deliver job related training

Detailed action plans have been developed for these priority areas and will be led by identified Managers. Delivery of the action plans will be overseen by the Workforce Committee.

Equality, Diversity & Inclusivity

Diversity and inclusivity is fundamental to all we do, both in the way we provide services to our community and the way in which we manage our staff. We have committed within our pledges to treating our patients and staff with dignity and respect.

Embracing diversity will ensure that we are providing services which meet the needs of our community and achieve excellent employment practices which allow all employees to progress and develop and achieve their full potential.

Diversity and Inclusivity Leads

Our approach to diversity and inclusivity is led by the Executive Director of Human Resources. There is also a nominated Non Executive Director lead for diversity and inclusivity and the nominated staff side lead ensures a partnership approach to all aspects of the diversity and inclusivity agenda.

How Performance is monitored

We monitor diversity and inclusivity data on an ongoing basis via the Diversity and Inclusivity Committee. This committee is led at executive level, meets bi-monthly and reports to the Executive Management Board. The purpose of the Diversity and Inclusivity Committee is to support activities within the Trust to ensure that we meet our statutory Board responsibilities and obligations under law relating to equality and diversity.

The Committee has two work steams; Workforce and Mental Capacity Act/Vulnerable Adults. These work streams support the development of activities within the Trust, ensuring that it operates as an equal opportunities employer, which recognises and utilises the skills within its diverse workforce and meets the future needs of the community it serves. They also work to ensure that patients and users of our services are treated with dignity and respect ensuring equal access to services provided.

The Committee provides an annual report to the Board of Directors which agrees our priorities and activities to be delivered providing assurance to directors that we continue to promote equality of access for the users of our services and equality of employment for staff.

Publication Duties

We have developed and published our Single Equality Scheme 2008-2010 on the Trust's Website to demonstrate how we intend to meet the diversity and inclusivity agenda and current processes and practice across the Trust.

We have a specific Employment Duty to monitor our workforce and to publish the results of this monitoring. As a result we produce an employment process data report via the electronic staff record (ESR) and NHS Jobs relating to all six equality strands and publish results on the Trust Website on a six monthly basis. The report outlines the statistics for the following categories;

- Applications received;
- Short listed applications;
- Appointed applicants;
- Case work (ethnicity and gender only);
- Staff promotions;
- Leavers.

The Trust's Intranet and Website incorporate key documents relating to:-

- Annual Workforce Report
- Annual Diversity and Inclusivity Report

- Annual report on training activity (ethnic origin and gender)
- A report is produced on a six monthly basis on Equality Impact Assessment results & any areas relevant to the six equality strands (as stated in the Race Relations Act (Amendment) 2000).
- Equality Impact Assessment Process
- Religion and Belief – A practical guide for the NHS
- The Secretary of State report on disability equality
- Sexual Orientation – A practical guide for the NHS
- The Gender and Access to Health Services Study
- Trans – A practical guide for the NHS
- Transgender Experiences – Information and Support.

Current and Future Priorities

An action plan has been developed by the Diversity and Inclusivity Committee to ensure the agreed priorities are delivered, this action plan is monitored by the committee and work is carried out by the workstreams. The following objectives have been agreed for the coming year:

Action	Progress	Timeframe
Review of Single Equality Scheme and Action plan.	The Single Equality Scheme is being revised to incorporate the proposed Equality Bill and an action plan is being developed using the results of Equality Impact Assessments. Following Consultation the new Single Equality Scheme will be implemented and published on 1st January 2011	1st January 2011
Ensure commitment to Equality Impact Assessment roll-out across the Trust and to monitor the mapping and priority assessments for the next 12 month, this work will inform the work of the committee, identifying areas of concern and necessary actions.	A new Equality Impact Assessment toolkit has been implemented to allow systematic recording and monitoring of Equality Impact Assessments. An Equality Impact Assessment process is in place within Corporate functions and is currently being rolled out across the Trust. The Trust Board has agreed that no new or revised policies will be ratified without an Equality Impact Assessment.	July 2010
Undertake further analysis of data for patients, workforce and training to establish underlying trends and issues and take action where necessary.	Analysis is ongoing and updates have been provided to the Diversity and Inclusivity Committee. Further continued analysis is required to establish underlying trends and required actions.	December 2010
Develop the work of the Committee to ensure Human Rights issues are considered across the Trust both in service delivery and workforce.	Further work is required to ensure Human Rights issues are considered.	December 2010
Develop a system for collecting data via the equality strands for patients attending the Trust.	Systems and staff training have been implemented to collect ethnicity and gender data of patients attending the Trust. Work is being carried out to improve the quality of the data collected. Further work to develop systems to collect data relating to the other equality strands will then ensue.	December 2010
Evaluate the effectiveness of the current integrated approach to equality in all training.	Currently for the nursing workforce there is Equality & Diversity Training on a module titled Transcultural Healthcare which relates to the care of patients from different ethnic backgrounds. The Training Manager and Chaplain Manager are delivering Religious & Cultural Awareness training which is commencing in April 2010 this relates to Privacy & Dignity. The Training Education and Development (TED) Quality Group will be undertaking an exercise to ensure that Diversity & Inclusivity are appropriately embedded within training courses	December 2010

Workforce Information

An analysis of the workforce by the diversity strands is shown below:

GROUP	Category	Workforce Headcount Apr 08 – Mar 09	Workforce Headcount Apr 08 – Mar 09 (%)	Workforce Headcount Apr 09 - Mar 10	Workforce Headcount Apr 09 - Mar 10 (%)
AGE	Under 20	33	0.74%	27	0.58%
	20-24	295	6.60%	308	6.66%
	25-29	455	10.18%	485	10.49%
	30-34	513	11.48%	514	11.12%
	35-39	543	12.15%	566	12.24%
	40-44	718	16.06%	707	15.29%
	45-49	727	16.26%	768	16.61%
	50-54	567	12.68%	590	12.76%
	55-59	392	8.77%	427	9.24%
	60-64	176	3.94%	180	3.89%
	65+	51	1.14%	51	1.10%
GENDER	Male	924	20.67%	999	21.61%
	Female	3546	79.33%	3624	78.39%
	Undisclosed	0	0.00%	0	0.00%
ETHNICITY	White - British	4024	90.02%	4099	88.67%
	White - Irish	12	0.27%	14	0.30%
	White- Any other white background	40	0.89%	46	1.00%
	White Northern Irish	4	0.09%	3	0.06%
	White Unspecified		0.00%	1	0.02%
	White English	9	0.20%	9	0.19%
	White Scottish	1	0.02%	1	0.02%
	Asian or Asian British -Indian	117	2.62%	147	3.18%
	Asian or Asian British - Pakistani	49	1.10%	57	1.23%
	Asian or Asian British - Bangladeshi	7	0.16%	10	0.22%
	Asian or Asian British – Any other Asian Background	25	0.56%	30	0.65%
	Asian Sri Lankan	2	0.04%	1	0.02%
	Asian British	2	0.04%	2	0.04%
	Asian Carribean	1	0.02%	1	0.02%
	Asian Unspecified	0	0.00%	1	0.02%
	Mixed – White & Black Caribbean	11	0.25%	16	0.35%
	Mixed White & Black African	6	0.13%	6	0.13%
	Mixed – White & Asian	6	0.13%	7	0.15%
	Mixed – any other mixed background	4	0.09%	6	0.13%
	Mixed - Black & Asian	1	0.02%	1	0.02%
	Mixed - Other/Unspecified	0	0.00%	1	0.02%
	Black or Black British Caribbean	19	0.43%	20	0.43%
	Black or Black British - African	40	0.89%	45	0.97%
	Black or Black British – Any other black background	3	0.07%	2	0.04%
	Black Nigerian	0	0.00%	1	0.02%
	Black British	1	0.02%	1	0.02%
	Other Ethnic Group - Chinese	18	0.40%	30	0.65%
	Other Ethnic Group – Any other ethnic group	31	0.69%	25	0.54%
	Undisclosed	37	0.83%	40	0.87%
DISABILITY	Yes	23	0.51%	37	0.80%
	No	268	6.00%	490	10.60%
	Undisclosed	4179	93.49%	4096	88.60%

Age

In 2009/10 age data continues to be stable when compared with the previous year, with the average age being 41.78 years. The highest populated age group continues to be 40-44 and 45 – 49. This is important to note to ensure adequate succession planning commences to prepare for the effects of the individuals in this group moving to the next age bands and subsequent retirement.

For the current period there is a slight decrease in people aged 20 and under, but on the whole the age demographics continue to remain static, with a typical distribution across the age ranges.

Gender

In 2009/10 the majority of the workforce continues to be female, 78.39%. Male employees account for 21.61% of the workforce population. Due to growth in the overall workforce the number of females has increased by 2.20% from the previous year and male headcount has grown by 8.12% Although there has been a slight increase in the number of males compared with the previous year, the position continues to remain relatively static. This profile is consistent nationally with the NHS, where 80% of the workforce composition are female.

Ethnicity

In 2009/10 the ethnicity composition continues to remain stable when compared with the previous year. The majority of the workforce is White British (88.67%), which is 10.03% less than the population profile where 98.7% are White.

Disability

Last year the data indicated a large number of individuals (93.49%) who did not wish to disclose their disability status, and this was identified as an area to improve and encourage people to be comfortable enough to share this information. Although there continues to be a large number of people who do not wish to disclose this information, positively the number of people stating that they do or do not have a disability has increased, and employee's non disclosure has reduced to 88.60%.

Sustainability & Climate Change - Our Impact on the Environment

The impact on the environment of all large organisations continued to be a key national concern and our Board of Directors remains committed to reducing our impact on the environment and improving our sustainability.

Previous annual reports described the installation of a state of the art heat transfer scheme at King's Mill Hospital which we progressed in partnership with CNH plc. The benefits from this investment are now starting to be realised in reduced energy consumption. The Trust also commissioned a specialist company to undertake preliminary work to extract coalmine methane from below the King's Mill Hospital campus as an additional energy resource.

In addition to the work already underway during 2009/10, the NHS Sustainable Development Unit produced the NHS Carbon Reduction Strategy and updated it in early 2010. The strategy outlines key commitments and time frames in relation to carbon reductions for NHS organisations. The Trust, through the development of a Sustainable Development Committee, will establish a Board approved Sustainable Development Plan.

Monthly performance reports provided under the PFI contract by Project co include the monthly utility usage. This allows for the management and reporting to the Board of sustainability performance.

Summary Performance

The following table records the actual consumption of resources used over the last two financial years.

There has been an increase in both waste and some of the finite resources, due to the expansion of the King's Mill Hospital site. It takes into account dual running during the commissioning period. A reduction in the amount of gas used between the two years is reflective of effectiveness of the Geo Thermal unit.

Area		**Non-financial data (applicable metric)**	**Non-financial data (applicable metric)**		**Financial Data (£k)**	**Financial Data (£k)**
		2008/9	***2009/10***		***2008/9***	***2009/10***
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	Domestic 388 Clinical 428 tonnes	Domestic 429 Clinical 569 tonnes	Expenditure on waste disposal	254	309
Finite Resources	Water	154,084	181,297	Water	293	302
	Electricity	14,005,756	24,322,745	Electricity	1,765	1,812
	Gas	853,291	978,938	Gas	205	237
	Coal	2,797	1,789	Coal	355	246

The Trust is currently registered on the European Union Emissions Trading Scheme. This process is managed by Skanska Facilities Services (SFS) under the PFI project agreement. Trading has not yet commenced.

Future Priorities and Targets

The Trust is preparing to register as part of the Carbon Reduction Commitment, which must be completed by the end of September 2010. Energy usage during 2010/2011 will be used as the base year prior to trading commencing from April 2011.
In order to achieve the key commitments in relation to the Carbon Reduction Strategy and hence sustainability the following actions are required:

- *Establishment of Sustainable Development Committee by the end of April 2010.*

The remit of this group is to cover the development of the Sustainable Development Management Plan and to manage Carbon Reduction Commitment and the EU Emissions Trading Scheme. It is proposed that this Committee is chaired by the Director of Operations, Corporate Development and includes representatives from CNH Plc, SFS and the Operational Divisions, Finance, Human Resources. The Management Plan will establish clear measurable milestones to measure, monitor and reduce direct carbon emissions (First meeting 27th April 2010)

- *Identification of workstreams to reduce energy and carbon usage, including procurement, travel and transport*

- *Participate in locate partnerships and networks in relation to the Carbon Strategy and Carbon Reduction*

- *Complete the Good Corporate Citizenship Assessment Model (the Trust has registered for this scheme)*

- *Provide regular Board level updates of performance in energy efficiency and carbon reduction (Quarterly, with annual reports to staff, public and other stakeholders).*
  This will be based initially on ERIC data, however as other measures are developed in relation to carbon emissions, these will be included

- *Increase the knowledge base of key staff in order to ensure the Trust meets the requirements of the Carbon Reduction Strategy*

Regulatory Ratings

Compliance with our Terms of Authorisation

Each year Monitor, the FT regulator, publishes an Annual Compliance Framework that is used to measure, monitor and regulate individual Foundation Trust's compliance with performance against key national priority targets and with the terms of its authorisation.

Our Board and regulator assess the information provided in the annual plan and in-year submissions from Foundation Trusts and assign a planned risk rating for three areas – finance, governance and mandatory services.

The finance risk rating is derived from a number of indicators and is described as a numeric rating from 1 to 5, with 5 being the highest rating possible.

For 2009/10, the governance rating is derived from a number of indicators, including service performance and 3rd party reports and is described in a 'traffic light' rating of Green, Amber, Red, where Green indicates full compliance.

The Mandatory services rating is derived from a number of indicators relating to the provision by the Trust of its mandatory services declared at authorisation.

A summary of our regulatory performance comparing both our planned and actual performance during 2008/9 and 2009/10 is provided below.

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial risk rating	**5**	5	5	5	5
Governance risk rating	**A**	A	A	R	A
Mandatory services	**G**	G	G	G	G

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	**4**	3	3	3	4
Governance risk rating	**A**	G	A	A	R
Mandatory services	**G**	G	G	G	G

At the end of 2009/10, the Trust's governance rating was red as a result of its performance against a number of service performance targets, particularly cancer access targets and thrombolysis.

The main reasons for this position have been described earlier in the Annual Report, and for cancer targets included a substantially higher demand for bowel screening across the county than was envisaged when the service was planned, patient choice, and adverse weather conditions in January 2010.

The Board of Directors has recognised that there remains a risk associated with achievement of the 62 day cancer wait target and with thrombolysis for the first quarter of 2010/11 and is taking action to

address these risks, including close monitoring of performance and inviting the national Cancer Intensive Support Team to assist the Trust with its performance.

Sickness Absence

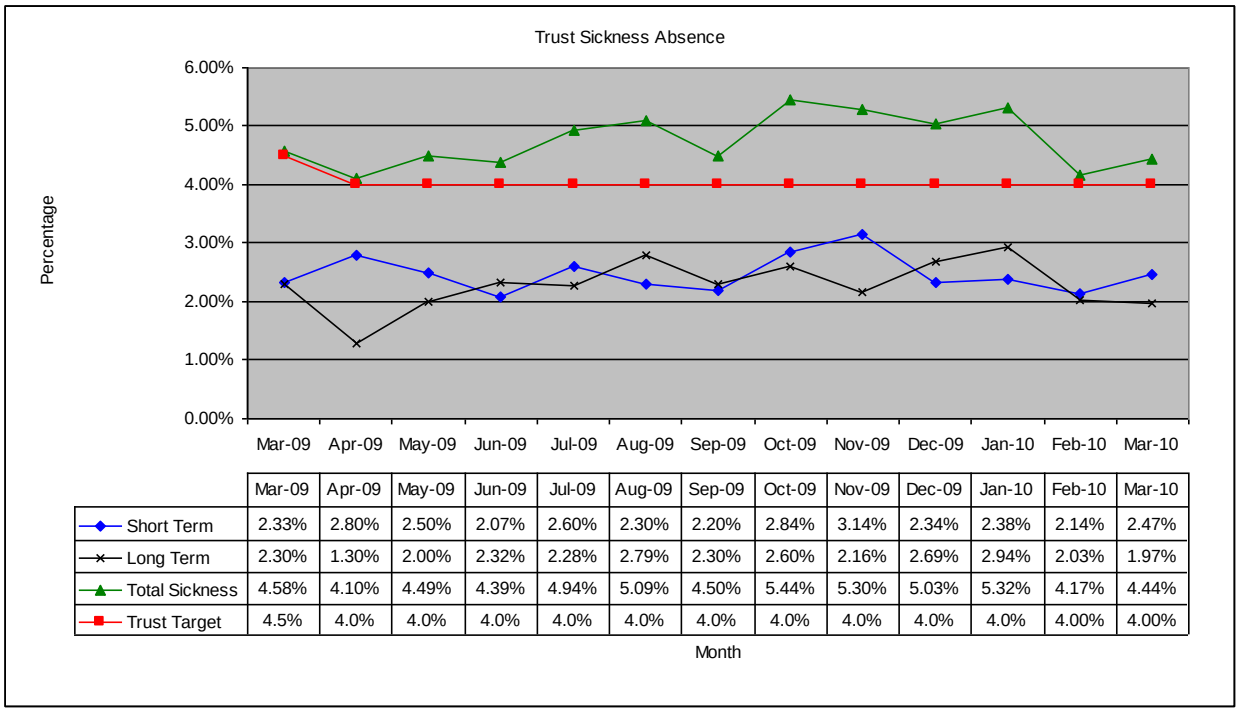
Our target for sickness absence was set at 4% for 2009/10 but despite a continued focus on managing sickness absence in year we were not successful in achieving this target.

The rolling 12 months sickness absence rate from April 2009 to March 2010 was 4.77% which is a static position compared to the previous 12 months.

Through the launch of the new absence policy and the creation of a new role of Sickness Absence Co-ordinator, coupled with closer monitoring, measurement and management of absence we are seeking to significantly reduce our sickness absence rate for 2010/11 as part of our efficiency challenge and a target of 3.5% has been set.

Our Board of Directors receive data on sickness absence on a monthly basis which includes both the Trust's position, divisional performance and on a quarterly basis statistics regarding reasons for sickness absence and data relating to Occupational Health provision.

The table below shows our sickness absence rates for 2009/10.



	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Short Term	2.33%	2.80%	2.50%	2.07%	2.60%	2.30%	2.20%	2.84%	3.14%	2.34%	2.38%	2.14%	2.47%
Long Term	2.30%	1.30%	2.00%	2.32%	2.28%	2.79%	2.30%	2.60%	2.16%	2.69%	2.94%	2.03%	1.97%
Total Sickness	4.58%	4.10%	4.49%	4.39%	4.94%	5.09%	4.50%	5.44%	5.30%	5.03%	5.32%	4.17%	4.44%
Trust Target	4.5%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.00%	4.00%

Health and Safety

The Health and Safety function within the Trust is led by an appropriately qualified and experienced Health and Safety Manager. The Board of Directors receive a detailed Health and Safety Report on an annual basis, together with monthly updates on specific issues.

Detailed below are a number of key Health and Safety indicators captured and reported within the Trust.

Staff Health and Safety Incidents by Type 2009/10

Health & Safety Staff Incidents 2009/10		
1.	Abusive, violent, disruptive or self harming behaviour	138
2.	Accident of some other type or cause	72
3.	Collapse of a structure or fitting	14
4.	Collision with an object	37
5.	Contact with a very hot or very cold surface	17
6.	Exposure to a biological hazard	11
7.	Fall from height	4
8.	Fall on level ground	26
9.	Hazardous and avoidable exposure to infection	1
10.	Hazardous exposure to electricity or electric shock	1
11.	Injured whilst restraining a patient	1
12.	Injury from clean sharps	16
13.	Injury from dirty sharps	83
14.	Lifting in the course of moving a load	8
15.	Lifting or moving a patient or other person	27
16.	Lifting or moving an object other than a load	4
17.	Person struck by a projectile	5
18.	Road traffic accident	3
19.	Sharps or needles found	7
20.	Slips on ice or snow	29
21.	Stress related illness	1
22.	Stretching or bending injury other than lifting	13
23.	Suspected Fall	2
24.	Trapped in lift, locked in a room, other traps	13
25.	Tripped over an object	20
26.	Unintended exposure to radiation	1
27.	Work related upper limb disorder syndrome	2
	Total	**556**

The Datix Clinical Coding Scheme (CCS) was introduced from December 2008. The switch to Datix CCS codes also means that fewer incidents are being recorded as “staff accidents” and are instead being correctly coded to the type of incident they relate to e.g slip on ice or snow or tripped over an object. The new form also helps encourage the reporting of incidents through improved ease of use. However, this switch also means that direct comparisons with previous years figures are difficult across the range of codes in the above table.

The overall level of reported staff health and safety incidents has decreased slightly from 577 in 2008/9 to 556 in 2009/10. One important area to see a welcome improvement was staff health and safety incidents resulting from violent or abusive behaviour. These have fallen from 160 in 2008/9 to 138 in 2009/10.

The number of staff accidents reported to the Health and Safety Executive under the Reporting of Injuries and Dangerous Occurrences Regulations (RIDDOR) 1995 increased from 22 to 29. The increase was due, in part, to the slip accidents resulting from the bad weather in December and January. This resulted in 6 specific RIDDOR reports being made when usually the Trust makes 3 or 4 RIDDOR reports due to slips per year. The Trust also saw an increase in the number of RIDDOR reports made in relation to moving and handling.

RIDDOR Reports by Year

RIDDOR Reports by Year			
Year	**Number of Employee RIDDOR Reports**	**Number of RIDDOR Reports re Members of the public**	**Total**
2009/10	29	10	39
2008/9	22	8	30
2007/8	20	25*	45
2006/7	24	27	51
2005/6	20	13	33

* Although 25 RIDDOR reports were made in 2007/8 regarding members of the public on closer examination only 7 of these reports met the reporting requirements of RIDDOR.

Staff RIDDOR reports by Type and Year

Staff RIDDOR reports by Type and Year					
Type	**2009/10**	**2008/9**	**2007/8**	**2006/7**	**2005/6**
Moving and handling patient	11	5	6	6	7
Manual handling object	5	3	2	3	2
Violence and aggression from a patient	2	1	1	4	3
Burn from hot food or beverage	1	2	1	1	1
Slip	7	1	4	5	2
Trip	1	5	2	0	2
Hit by moving or falling object	0	4	1	3	1
Hit a stationary object	1	0	0	0	1
Contact with a hazardous substance	0	0	2	2	
Other	1	1	1		1
TOTAL	**29**	**22**	**20**	**24**	**20**

Patient RIDDOR reports by Type and Year

Patient RIDDOR reports by Type and Year					
Type	**2009/10**	**2008/9**	**2007/8**	**2006/7**	**2005/6**
Unobserved fall	5	2	8	8	7
Fell from chair/toilet commode	0	1	4	4	1
Fell from bed/trolley	2	0	2	4	1
Walking to toilet unassisted	1	0	6	5	1
Mobilising without assistance	2	2	2	4	1
Slip	0	1	1	0	1
Trip	0	2		1	
Patient transfer	0	0	1	0	1
Other	0	0	1	1	
TOTAL	**10**	**8**	**25**	**27**	**13**

Annual Staff Survey – Comparison with other Trusts			
Question	**Change Since 2008 Survey**	**Ranking, compared with all acute Trusts in 2009**	**Ranking, compared with all acute Trusts in 2008**
% Staff receiving health and safety training in last 12 months	• No change	! Below (worse than) Average	• Average
% Staff suffering work-related injury in last 12 months	• No change	√ Lowest (best) 20%	√ Lowest (best) 20%
% Staff suffering work-related stress in last 12 months	• No change	√ Below (better than) average	• Average
% Staff witnessing potentially harmful errors, near misses or incidents in last month	• No change	√ Lowest (best) 20%	√ Below (better than) average
% Staff reporting errors, near misses or incidents witnessed in the last month	• No change	! Below (worse than) Average	! Lowest (worst) 20%
Fairness and effectiveness of procedures for reporting errors, near misses or incidents	√ Increase (better than 08)	√ Above better than average	• Average
%Staff experiencing physical violence from patients / relatives in last 12 months	• No change	• Average	! Lowest (worst) 20%
% Staff experiencing physical violence from staff in last 12 months	• No change	• Average	• Average
% Staff experiencing harassment, bullying or abuse from patients / relatives in last 12 months	• No change	√ Lowest (best) 20%	√ Below (better than) average
% Staff experiencing harassment, bullying or abuse from staff in last 12 months	• No change	√ Lowest (best) 20%	Average
Perceptions of effective action from employer towards violence and harassment	√ Increase (better than 08)	√ Above (better than) average	√ Above (better than) average
Impact of health and wellbeing on ability to perform work or daily activities	-	√ Below (better than) average	-
%feeling pressure in last 3 months to attend work when feeling unwell	-	• Average	-

The annual NHS staff survey provides the Trust with valuable feedback on staff's perception of the Trust's performance on a range of measures relating to health, well being and safety. Of the 13 measures provided, the Trust has improved its score to a statistically significant level in two areas, remained unchanged in 9 and two scores are new. The Trust is in the best 20% of Trusts in 4 areas, better than average in 4, average in 3 and below average in only two areas. The Trust has developed action plans to address these two areas of weakness during 2010/11.

Occupational Health

The Trust has an in-house Occupational Health (OH) Department that provides services to Sherwood Forest Hospitals, other organisations both NHS organisations and private sector.

- Contacts to the OH service have increased by 89% between 2003/4 and 2009/10 (this does not include any of the swine flu vaccines given by OH nurses to healthcare workers in 09/10). Workload increase has been managed through changing ways of working within the service and increasing efficiency.

- Sherwood Forest Hospitals NHS Foundation Trust vaccinated 57% of staff who have patient contact against **swine** flu during 09/10 – this is the second highest rate when compared to all the other NHS Trusts within the East Midlands.

- Sherwood Forest Hospitals NHS Foundation Trust vaccinated 45.2% of staff who have patient contact against **seasonal** flu during 09/10 – this is the highest rate when compared to all the other NHS Trusts within the East Midlands.

- Audit work undertaken by OH shows that 31% of Manager referrals to the service in 09/10 were because of stress/anxiety/depression. OH worked with the clinical psychology team to devise a stress awareness education programme to assist the Trust in helping to address stress issues in staff. The programme will recommence fully in June 2010. The Boorman Review recommendations clearly support the development of such initiatives.

- Audit work undertaken by OH shows that 33% of Manager referrals to the service in 09/10 were because of musculo-skeletal problems. OH provides a musculo-skeletal pain service for staff that experience any type of musculoskeletal problems. Staff are able to access dedicated assessment and treatment appointments with a specialist nurse in pain management, an extended scope practitioner physiotherapist, and a moving and handling co-ordinator. All staff who are referred to the Occupational Health Department and who have musculoskeletal problems are automatically offered an appointment for this service. Again the Boorman Review recommendations support the development of such initiatives.

- In 2009/10 OH nurse workload activity breaks down as follows: 48% occupational vaccinations, 34% advice (includes sharps/needlestick injury advice, listening service and general health and well being advice), 9% pre employment health assessment, 8% blood tests and 1% health surveillance.

Data Confidentiality

The Trust reported one serious untoward incident relating to a breach in confidentiality in 2009/10. Full details are included in the statement on internal control (SIC).

QUALITY REPORT 2009/10

Foreword

Quality is at the heart of everything we do, we believe it is our focus on quality that will make us stand out from other providers of health care, make our services even more efficient and inspire our staff to become more innovative and embrace new ways of working

During the last two years we have embedded our vision of Best Care Best People Best Place this vision is guiding us to provide ever improving quality services for our patients and carers. Achievements this year have included significant reduction in healthcare acquired infections, our A&E waiting times and accreditation of key elements of our service including all our laboratory services, stroke and acute cardiac syndrome care and cancer care

Staff are key to influencing the quality of care and have helped with patients and carers, Governors and members to produce a set of pledges to assist in achieving our shared vision. I was delighted this year to receive our excellent staff survey results which reflect the enthusiasm and commitment our staff have to helping us to achieve our ambitions

During 2010/11 we will again focus on key priority areas within the domains of patient safety, clinical effectiveness and patient experience, ensuring that we have a balanced set of objectives which influence those things which make the most difference to our patients

This report looks forward to the coming year which we know will be challenging for us and with this in mind it is even more important that we continue to drive up our quality standards. The report also reflects on our progress last year and high lights our achievements as well as those areas where we know we still have room to improve.

I believe this is an honest, transparent and accurate account of our journey towards Best Care Best People Best Place and I would like to thank all the people who have contributed to this report.

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

Carolyn White
Chief Executive

Progress Against 2009/10 Priorities

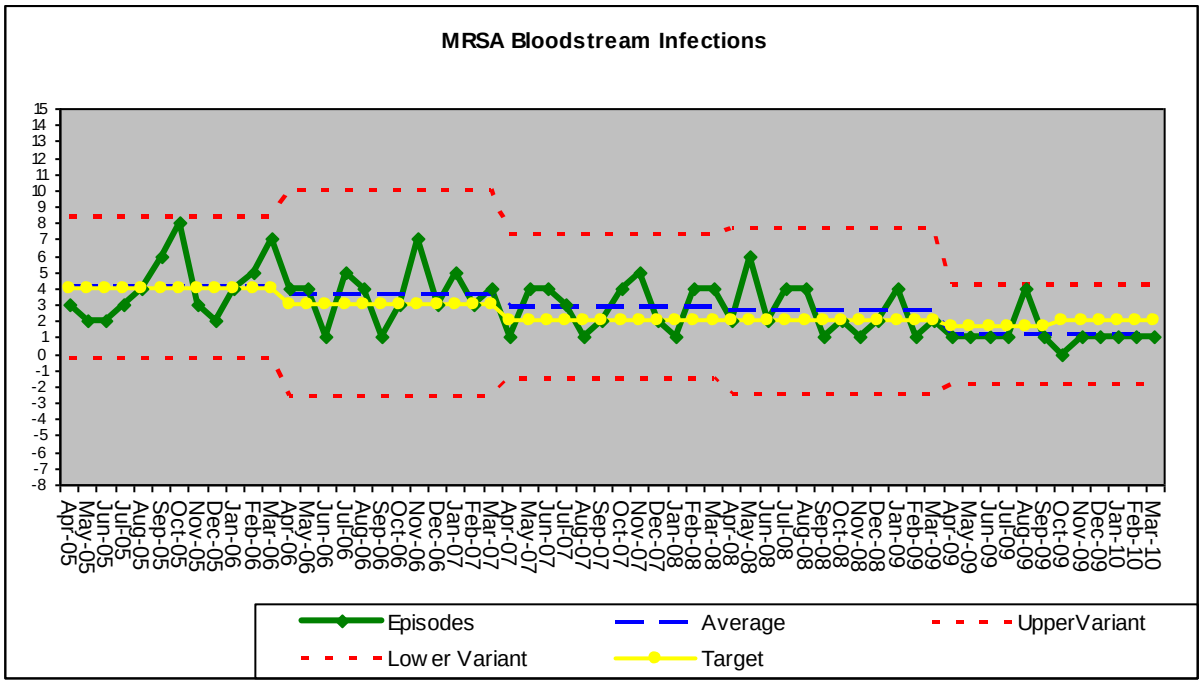
The three main priorities for 2009/10 and progress are discussed below.

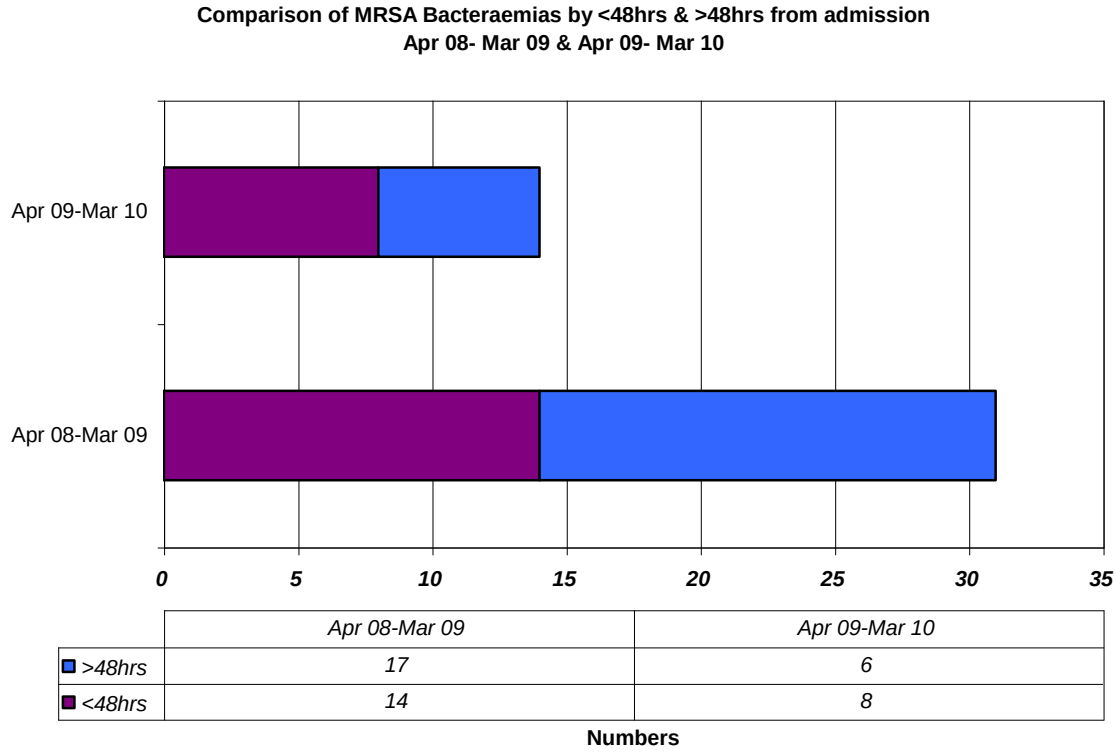
1. Patient Safety. Reduce incidence of health care acquired infections (HCAI), in particular reducing the number of MRSA bacteraemia by a further 30% during 2009/10.

Progress

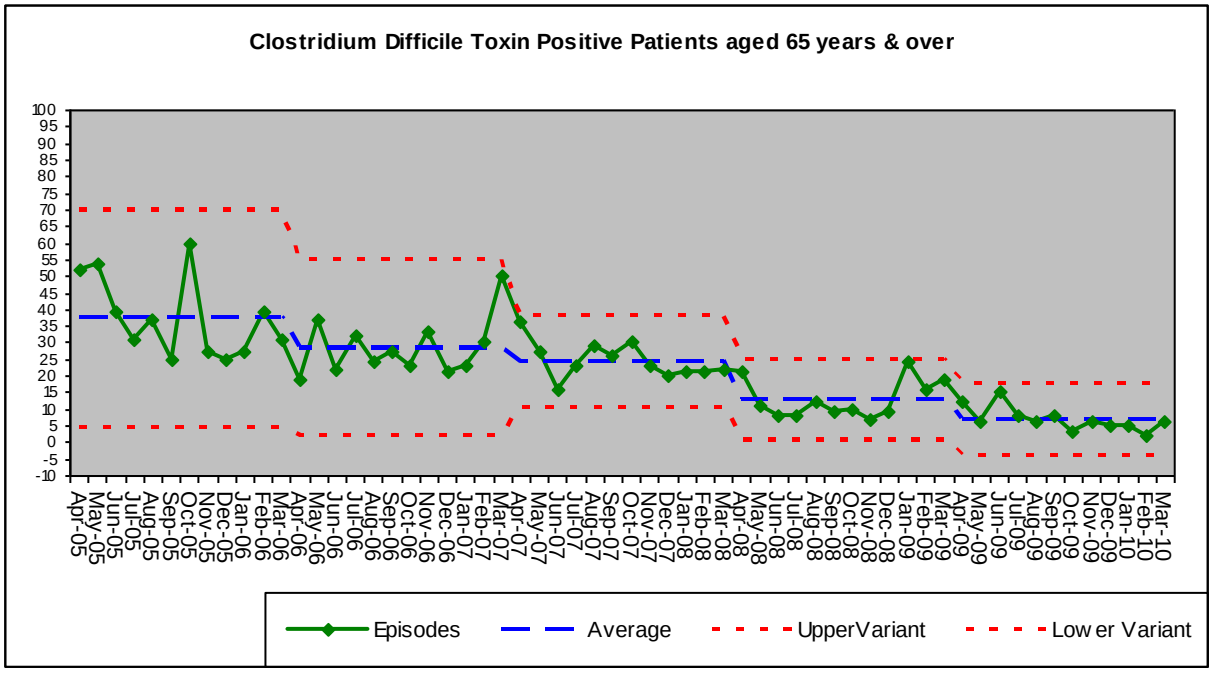
We have worked extremely hard to reduce the cases of MRSA bacteraemia and have reduced cases by 55% from 08/09 to 09/10. We have systematically improved the compliance with best practice and have seen a reduction in the cases of MRSA. Each case receives a thorough root cause analysis and lessons are learnt and improvements sustained. Further training has been given to staff throughout the year to assist with reducing the number of cases. We have also seen a month on month reduction in the number of *Clostridium difficile* toxin positive patients. The graphs below are a visual representation of our results.

We ended the year with the third lowest MRSA rate in the region; we are the lowest in the region by a significant margin for our C-Difficile rate.





The above graph describes the significant reductions in MRSA bacteraemias achieved in 2009/10 when compared to the previous year. The blue bars in the graph highlight the number of post – 48 hour MRSA bacteraemias recorded – these are the cases that the Trust can control more effectively.



Specific initiatives implemented during 2009/10

- We have introduced a zero tolerance regime rooting out non compliant behaviour.
- We have rolled out a screening programme for all admissions with active surveillance and follow up of positive patients in the community.
- We now have improved isolation facilities with 50% single rooms at the King's Mill site.
- We have improved the contact precautions for any patients known to have an infection or to be colonised.
- There has been cultural change throughout the organisation through positive leadership and engagement at executive and senior management level.
- Numerous local audits have taken place for local action this ensures ownership of issues and improvements.
- There has been a policy written and followed regarding reducing and improved monitoring of antibiotics.

2. Clinical Effectiveness. Further improve the way we monitor and care for acutely ill in-patients through the use of an early warning score tool, in line with National Institute for Clinical Excellence (NICE) guidance

Patient Observations

As part of the Trust wide Commission for Quality and Innovation (CQUIN) project, audits have been carried out to measure Trust-wide compliance with NICE (2007) guidelines for care of the acutely ill adult. Guidelines identified the following standards:

- All six mandatory vital signs (respiratory rate, heart rate, blood pressure, oxygen saturation, temperature and level of consciousness) should be monitored every time the observations are measured.
- With a minimum frequency of 12 hourly observations for all patients.
- Where vital signs exist, frequency of monitoring must be increased.
- All patients must be assessed using a physiological track and trigger score to identify those at risk of further deterioration. At Sherwood Forest Hospitals, the Augmented Care Assessment Tool (ACAT) is the trigger tool in use.

Audit Methodology

Ten patients were regularly randomly selected from each ward for audit and review. The last set of observations recorded on each patient's chart were reviewed to identify compliance with the standards listed above. The project lead has now carried out four cycles of the audit, and trends in compliance are illustrated in Table 1 below.

Significant achievements have been made Trust-wide with regard to improvement in the recording of patient vital signs. Overall compliance percentage with documentation of the six mandatory vital signs has been maintained above 90%:

Table 1. Compliance with all elements of the audit.

	KMH Site (%)	NWK site (%)	Trust wide (%)
June 2009	88	99	91
August 2009	95	100	96
November 2009	91	91	91
February 2010	93	98	94

It is key to note however that audits of vital signs were in progress prior to the outset of the CQUIN project and results presented here do not truly demonstrate the full extent of our achievements. In 2006 the project lead highlighted the significance of vital signs recording in response to the National Confidential Enquiries (NCEPOD 2005) report. This national audit highlighted that respiratory rates were routinely not recorded. Local findings in February 2006 showed similar. In a three-day audit of all patients across the Trust, compliance with respiratory rate monitoring varied significantly in all ward areas, but ranged from only 40-60%. Compliance with respiratory rate monitoring in February 2010 was 100% across the Trust.

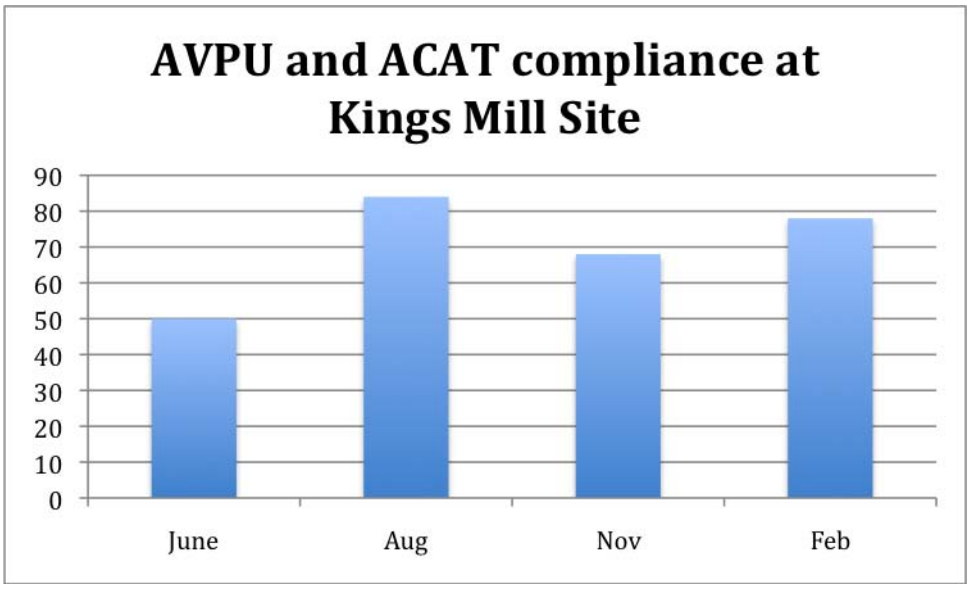
Table 2. Compliance with AVPU and ACAT monitoring across the Trust.

	June 2009		August 2009		November 2009		Feb 2010	
	Nwk	KMH	Nwk	KMH	Nwk	KMH	Nwk	KMH
AVPU	100	50	100	84	63	68	100	78
ACAT	93	54	100	84	66	68	100	78

Key areas for future focussed improvement include documentation of the AVPU (a measure of level of consciousness) and the local Track and Trigger score (ACAT). Compliance with these two vital assessments remains variable. The drop in compliance with both these elements and overall compliance in November 2009, shown in Table 2, may be explained by the implementation of a Trust policy that prohibited Healthcare Support Workers from assessing and recording the AVPU or ACAT.

This is now the role of the registered nurse alone. With consistent reinforcement of these issues by the project lead, compliance improved by February this year, with Newark wards all achieving 100% compliance. Small ACAT cards, that can be carried behind identity badges, have now been distributed throughout the Trust to all healthcare professionals and act as a constant reminder of the scoring system in use.

Compliance with AVPU and ACAT monitoring at the Kings Mill Site



Education and training

The in-house critical care skills for ward nurses course has been reviewed. Sixteen places have been secured on a local AIMS course for the oncoming year. In addition, the in-house critical care skills course has been re-designed to incorporate an assessment element to bring it in line with the acute illness management (AIMS) course delivery. All nurses new to the Trust attend this training on induction. All doctors new to the Trust will have completed AIMS training during the acute programme in medical school.

Learning from experience will facilitate education in practice. A Consultant Anaesthetist and the Consultant Nurse from Critical Care are leading a project to retrospectively review cases from which multi-professional teams can learn. Currently in its infancy, two cases have already been reviewed by way of a pilot. The review team will progress further over the oncoming year with a goal to review one case per month as a minimum.

Communication

SBAR is a communication tool that aims to enhance patient handovers. The requirement for its use has been disseminated widely across the Trust.

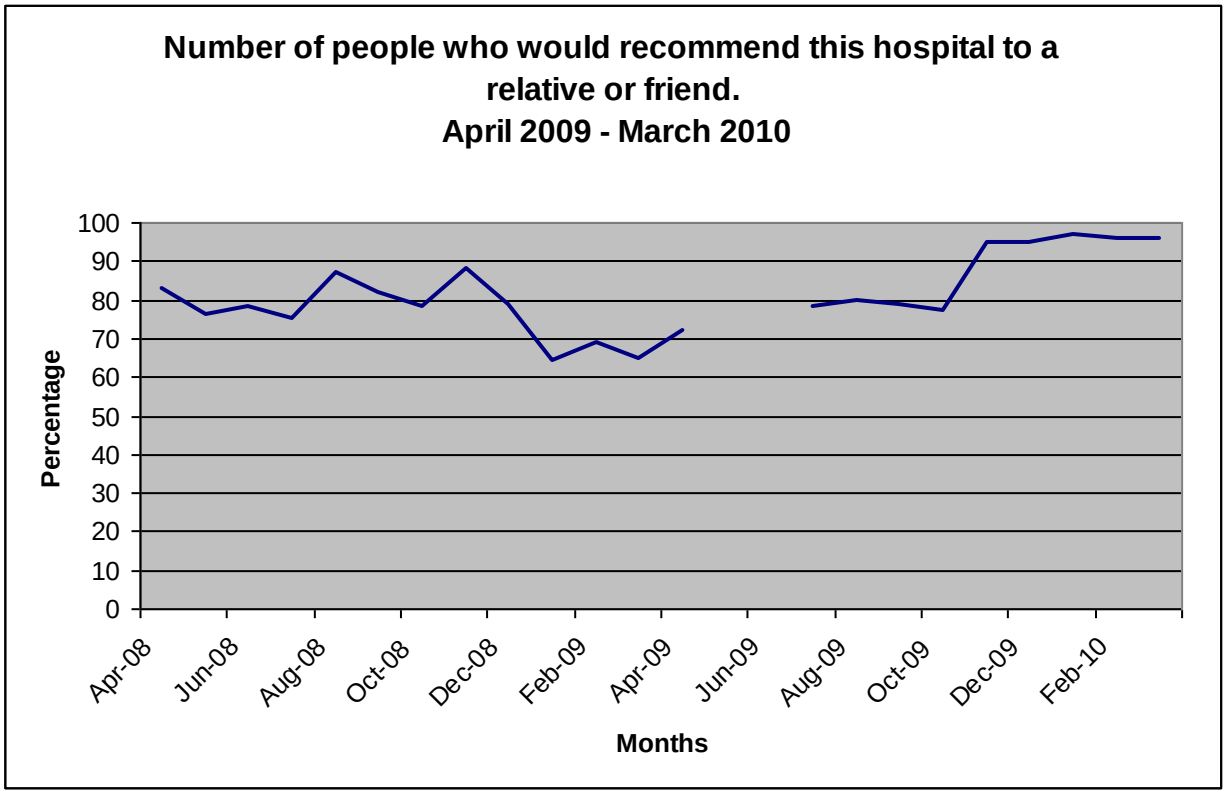
S – situation (explain where you are and what the problem is)
B – background (to the patient's situation – past medical history)
A – assessment (structured holistically to cover airway, breathing, circulation, disability and exposure)
R – recommendations – (what the reporter thinks should happen next)

Trust-wide communication has identified that SBAR is the Trust's communication tool of choice. Links to a ten-minute education tool have been disseminated to all staff Trust-wide and anecdotal evidence

suggests that some clinical staff are now using the tool. Nursing documentation and staff are currently being consulted about newly-designed SBAR documentation. Subsequent CQUINS audits will include a measure of compliance with this key quality element.

3. Patient Experience. Increase the number of people who would recommend our hospital/s to a friend or family member.

The number of people who would recommend the hospitals has increased during the third and fourth quarter of 09/10. The reasons for this could be due to the new environment at the King's Mill site and the introduction and roll out of patient and carer pledges.
The data collection has been taken using Dr Foster intelligence patient experience trackers and is a mixture of in patients and out patients.
(There were no Dr Foster patient experience surveys conducted in June and July 09)



During 2009/10 the Trust has fed back all the results to the relevant departmental managers to inform their service development plans. Specific areas were identified for improvements in particular in relation to the environment. These areas have now improved. It has been decided that the question relating to whether patients would recommend this hospital is not being asked regularly during 2010/11 due to the high positive percentages received during the last year.

The Trust successfully recruited a further 50 volunteers to compliment service provision within our hospitals to further enhance our customer experience. The Trust now has over 650 volunteers supporting our service teams to deliver our patient and carer pledges.

Other Priorities Set 2009/10

Patient Safety

During 2009/10 the Trust has also been working on the following chosen metrics:

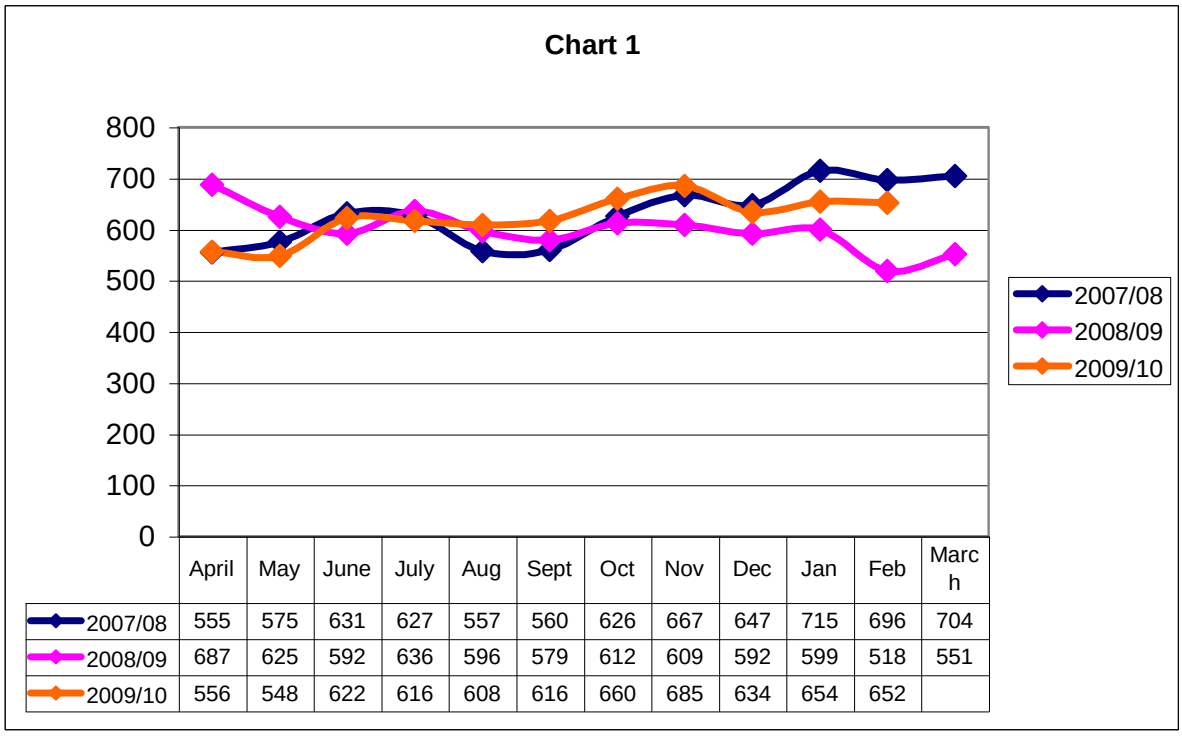
Clinical Incident Reporting

Clinical Incident reporting underpins our patient safety strategy as it provides key indicators for review and improvement. National consensus is that a Trust with high reporting levels of clinical incidents has a positive patient safety culture and 'more reporting is better'. The Trust has developed an electronic reporting system and has invested in a system administrator to provide timely reports to clinical teams to inform them of key safety issues. The Trust uploads its clinical incidents to the National Reporting and Learning System (NRLS) co coordinated by the National Patient Safety Agency (NPSA). This Trust is deemed to be an average reporting Trust, when benchmarked against similar sized Trusts. In the last reporting period by the National Patient Safety Agency April 09 to September 09 there were between 250 and 600 incidents uploaded per month, which shows that the Trust is working towards a more systematic process for uploading into the national database.

The median figure for the Trust uploading into the national database over the reporting periods September 2008-March 2009 was 6 incidents per 100 admissions, and over the reporting period April 2009 to September 2009 was 5 incidents per 100 admissions which has increased to the national average.

Below is a table of the data which is reported by month over the previous three years.

The average Incidents reported per month:



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2007/08	555	575	631	627	557	560	626	667	647	715	696	704
2008/09	687	625	592	636	596	579	612	609	592	599	518	551
2009/10	556	548	622	616	608	616	660	685	634	654	652	

The timeliness of Sherwood Forest Hospitals reports being uploaded into the NRLS is now approximately 30 days while the median number of days for the cluster group is 51 days between an incident occurring and the incident being reported demonstrating a high level of compliance by Sherwood Forest Hospitals.

Never Events

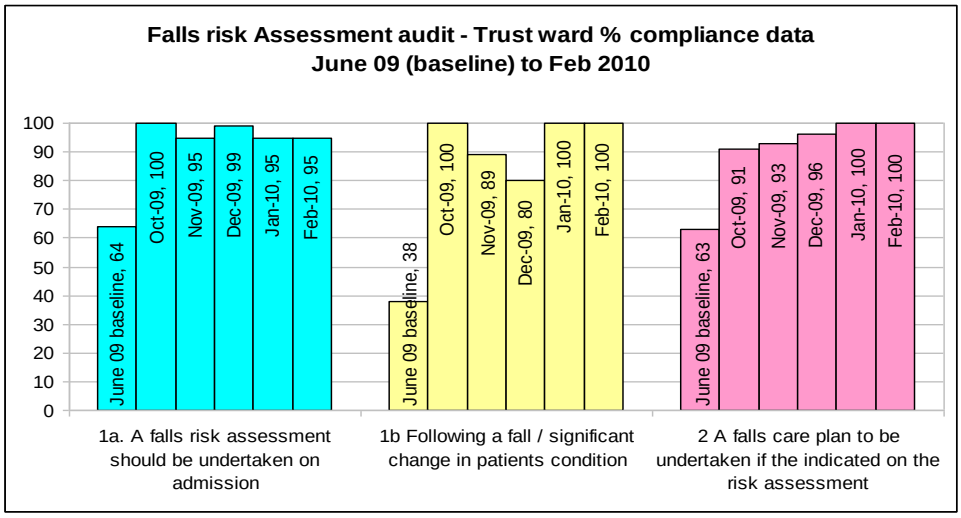
Never Events are very serious clinical incidents which should 'never' occur if appropriate safety checks are built into healthcare practice. Examples of 'never events' might include wrong side amputation or inappropriate injection of a chemotherapy agent.

There have been no reported 'never events' reported for this Trust in the last year. Never events including nil returns are reported in summary form to the Board of Directors on a quarterly basis.

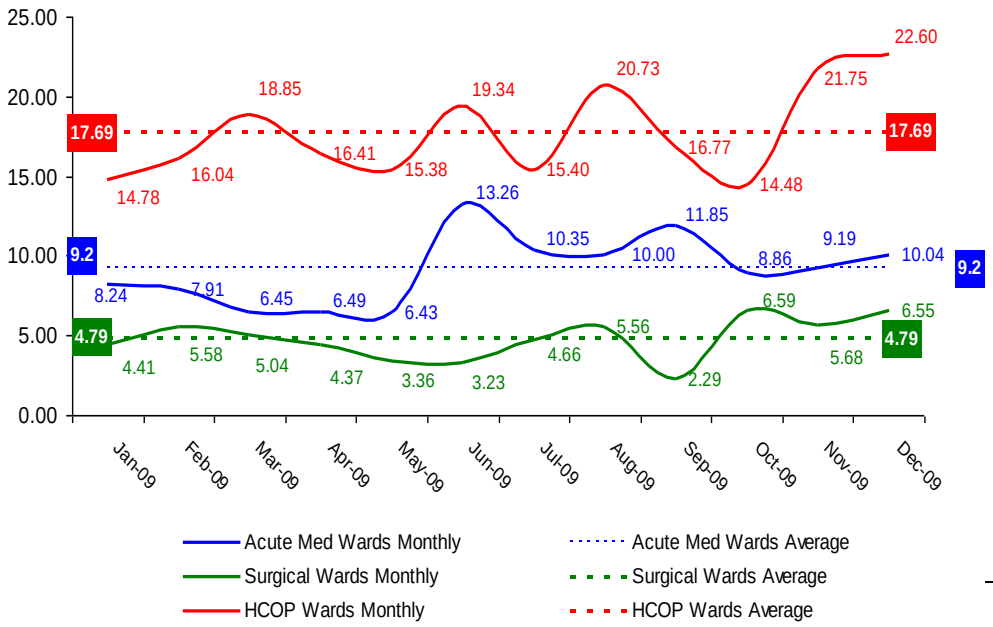
Slips Trips and Falls

Elderly vulnerable patients are at greater risk of falling and slipping when cared for in unfamiliar surroundings which disorientate them especially if they are suffering from confusion already. The risk assessment and careful management of patients at risk is therefore of utmost importance.

During 2009/10 the Trust has completed an initial cross Trust observational audit on the use of risk assessment tools and care plans. This audit has led to monthly audits of falls risk assessments and care plans across all wards. Compliance with use of the documentation has risen dramatically since this:



There is ongoing analysis of clinical incident data to identify any trends and then responding accordingly. The clinical system for reporting falls is being updated to include more detail in 2010 to make for more detailed analysis for trends in terms of the geography of the wards and multiple events happening to the same individual.



The graph above shows the number of falls per 1000 occupied bed days using the raw number of incidents reported. By way of benchmark, in 2007, the National Patient Safety Authority (NPSA) confirmed that the national average number of falls per 1000 occupied bed days for Acute Trusts was 4.8, with an average of 18 per 1000 occupied bed days for Wards with more vulnerable patients.

- We have implemented an ongoing training programme for both nurses and medical staff to raise awareness and understanding of falls

- We identified the need for key equipment to reduce patients' risk of falling – we now have lowering beds freely available for at risk patients.

- We are promoting falls as a quality indicator for the care we deliver in Sherwood Forest Hospitals and reduce the risks. We aim to improve NHSLA risk assessment from level 1 to level 2 and will be focussing on this in 2010.

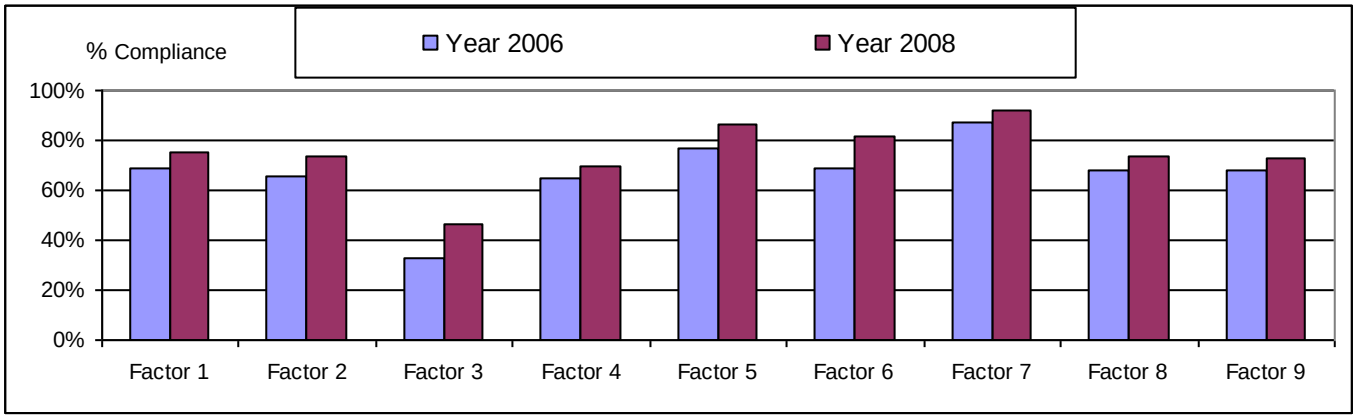
Tissue viability

Development of tissue damage is a key indicator of nursing care. The nurses and tissue viability team strive to reduce the incidence of pressure ulcers. The team provide continuing education and audit. Pressure ulcer point prevalence is recorded 4 times a year and all grade 2, 3 and 4 pressure ulcers are reported as a clinical incident via the Trusts clinical incident procedure (Datix). We react to these audits/incidents by examining the issues and create management plans to address them. For example, we provide mandatory training and specific teaching in clinical areas where deficits have been identified and provide individual plans of care for patients at risk of or with existing pressure damage. Audit of pressure relieving equipment occurs on an ongoing basis and findings are actioned accordingly.

The pressure area management policy has been launched this year along with a new pressure ulcer prevention leaflet for patients and carers.

The Trust has a regular audit programme as part of Essence of Care (a national programme). The baseline audit for the pressure ulcer benchmark was undertaken in 2006 with an overall 73% compliance with benchmark; re-audited in 2008 [overall 81%] with the next re-audit planned within the programme for 2010.
Where a factor does not achieve 70% [minimum agreed by Essence of Care Steering Group: Sherwood Forest Hospitals] the factor[s] are highlighted to indicate that a Trust action plan will be implemented to enable improvement or compliance with the factor. The following are the benchmark factors with the findings from 2006 and 2008

Factor 1	Screening and assessment
Factor 2	Who undertakes assessment?
Factor 3	Information patients and or carers [prevention & treatment]
Factor 4	Individualised plan for prevention and treatment of pressure ulcers
Factor 5	Pressure ulcer prevention – re-positioning
Factor 6	Pressure ulcer prevention – redistributing support surfaces
Factor 7	Pressure ulcer prevention – availability of resources and equipment
Factor 8	Implementation of individualised plan
Factor 9	Evaluation of interventions by a registered practitioner



There is an overall improvement from 2006 to 2008; a Trust-wide action plan has been presented to the Steering Group for approval and implementation.

Nutrition

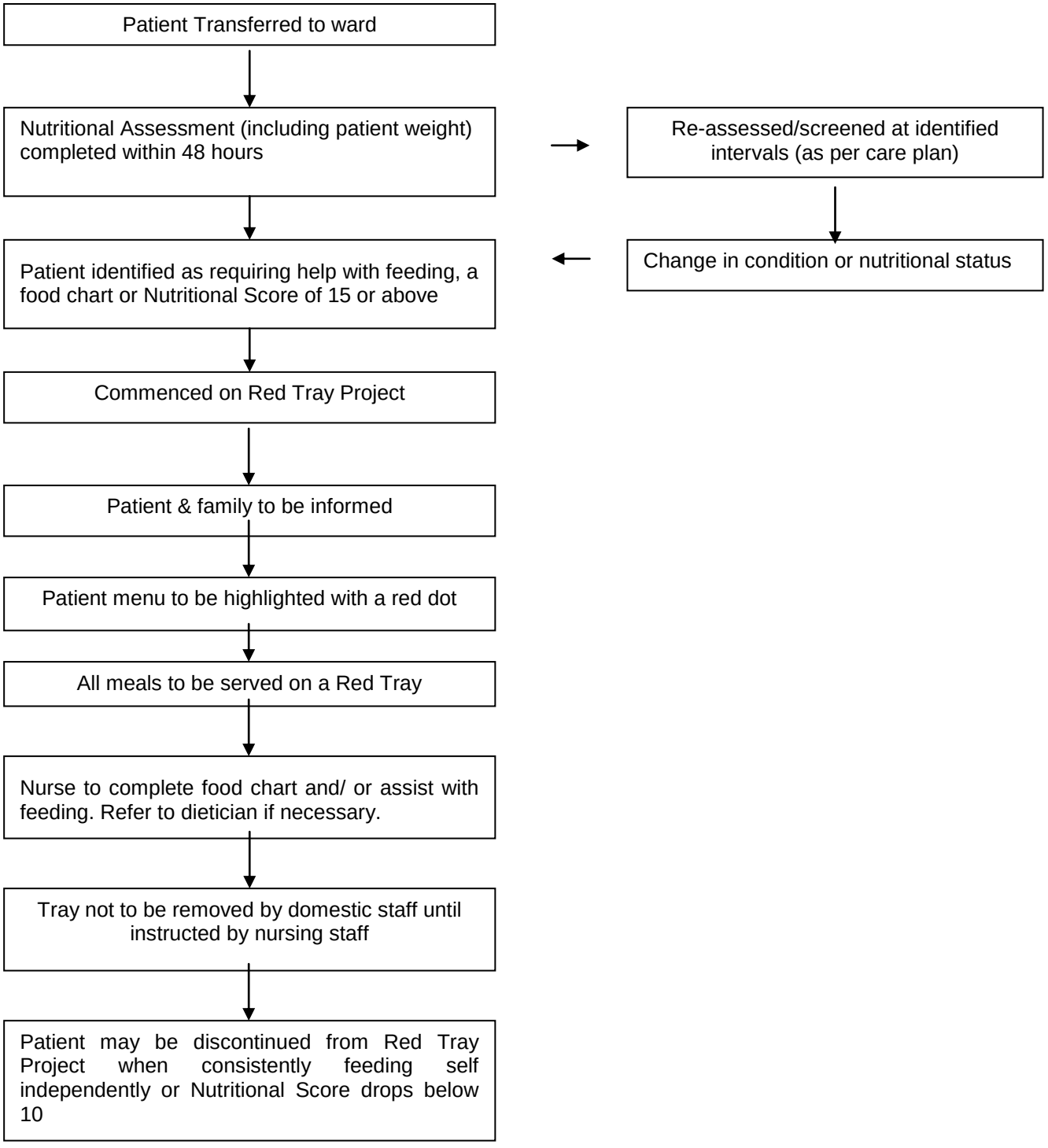
Patient nutrition is key to a healthy recovery. The Trust has well established Nutrition Board Committee and sub group meetings.

Nutrition is now included in new Dr's training and Registered Nurse training and we have developed the role of the volunteer mealtime assistants who are assisting with nutritional needs on the health care of the older persons wards.

A training programme has been developed for ward based staff.

Red tray guidance has been developed to improve patient nutritional status in compliance with Essence of Care. The flow chart highlights patients who need help with feeding or who are on food charts

Red Tray Flow Chart



For the coming year:

- Essence of care benchmarking to be repeated in June.
- Annual study days for link nurses.
- Protected mealtime policy to be completed and implemented.
- Ward based training on Nutritional screening to continue.

Maternity

The Trust has an excellent reputation for low rates of interventional deliveries (these are any deliveries which require further medical support) this is supported by an increasing ratio of midwifes to birth rate. Currently Midwife to birth ratio is 1:30 but will be 1:28 when latest recruited Midwives are in post. We are experiencing a positive response to recent recruitment campaigns adding experienced and newly qualified midwives to the team. The Trust has delivered against Maternity Matters with the exception of developing the 'one number' (a single access phone number) across Nottinghamshire to access maternity care. A county wide solution is nearly in place with plans to operationalise at local level. Patients who attend this Trust are given the mobile phone number of their midwife.
The Trust has participated in the Nottinghamshire maternity and newborn service review engagement is now completed.

There has been a development of an Internet page which is updated by senior midwife to support information access and choice agenda's. A practice development midwife has been funded by deanery ensuring robust induction for new starters. A lay representative has been identified for Local Supervising Authority (LSA) audit and other activities.

Statistics 2009 :-Total Births 3106

	Sherwood Forest Hospitals	National Picture
Normal Births	74%	70%
Vaginal Births	85%	75%
Caesarians	15%	25%
Home Births	6%	2-3%

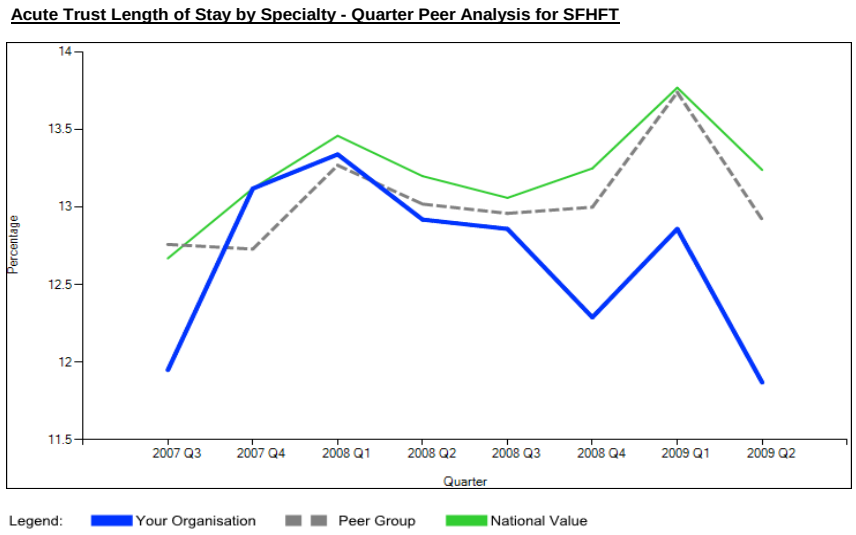
Clinical Effectiveness

Emergency Re-Admissions (14 Day)

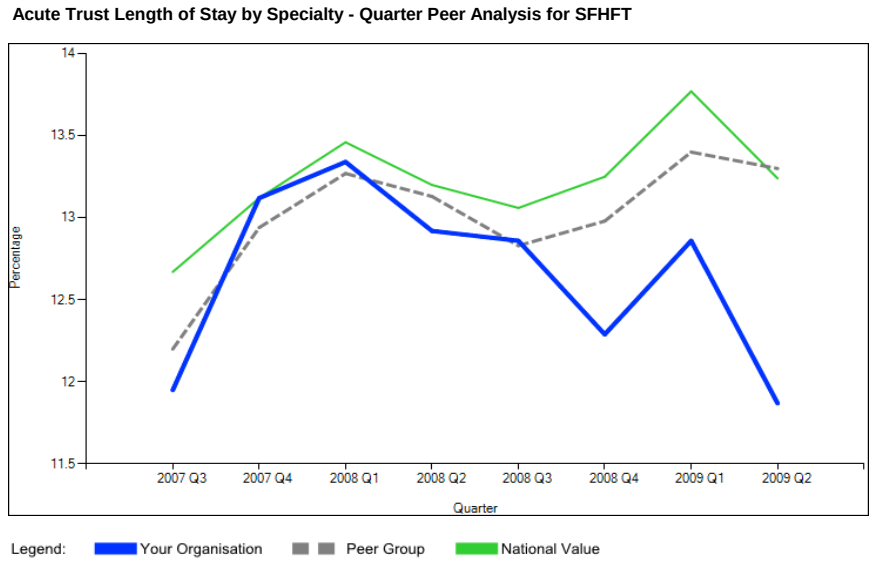
Trust performance has been consistently better than both the 'medium hospitals' and NHS East Midlands averages since the start point of the NHS Institute for Innovation and Improvement (NHSII) benchmarking trend analysis in Q2 2007. Our current ranking is 60th / 167, however over the past 8 quarters we have been ranked in the top 30 Trusts on four occasions. The re-admission trend across Q1-Q3 in 2009/10 has remained at similar levels despite our continued improvement in reducing average length of stay

NHSII Average Length of Stay Benchmarking Trend Analysis
Q3 2007 – Q2 2009: All Specialties

Peer Group – Medium Hospitals Average



Peer Group – East Midlands SHA



Cancer

Cancer Waiting Times performance continues to be a priority for the Trust. Due to the lower number of referrals to the Trust and lower number of cancers treated, meeting the new national standards using the 18 week adjustment model continues to be a challenge. In particular performance has been significantly impacted by patient choice to defer diagnostics and/or treatments. This was most noticeable within December and January with the Christmas/New Year holidays and the severe weather experienced over the winter months. Several service improvement initiatives however are underway supported by our Cancer Management Team and local Mid Trent Cancer Network, Service Improvement Team.

Fractured neck of femur

The National Hip Fracture Database (NHFD) is a joint venture of the British Geriatrics Society (BGS) and the British Orthopaedic Association (BOA), and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. It allows care to be audited against the six evidence-based standards set out in the BOA/BGS 'Blue Book' on the care of patients with fragility fracture and enables local health economies to benchmark their performance in hip fracture care against national data.

The NHFD is intended to focus attention on hip fracture both locally and nationally, benchmark its care across the country, and use continuous comparative data to create a drive for sustained improvements in clinical standards and cost effectiveness and to improve both the acute hip fracture pathway of care and subsequent falls prevention and bone health management: with direct benefits to patient care and outcomes, and eventual reductions in fracture incidence.

The data below (based on data submitted since September 2009) shows that the Trust's average time to theatre and average length of stay are better than regional or national averages. Performance on other indicators is also favourable. The following has been taken from the NHFD website.

KMH – Latest data up to March 2010 (from September 2009)

Bluebook Times Last 12 months	Sherwood Forest Hospitals	SHA	National
Avg Time to ward (hrs)	8.24	8.33	9.87
Avg Time to Theatre (hrs)	32.75	47.44	43.31
Avg length of stay (days)	14.91	18.43	21.34

Bluebook Indicators Last 12 months	Sherwood Forest Hospitals Count	Sherwood Forest Hospitals %	SHA %	National %
Preoperative Assessment	136	91.28	46.41	58.43
Bone Protection Medication	149	100.00	54.19	57.87
Specialist Falls Assessment	130	87.25	36.84	56.07

Sentinel Audit

King's Mill Hospital has gained accreditation as a Primary Stroke Centre, with excellent comments on our service, team and facilities from peer review.

Work is ongoing to further improve the service, using a structured stroke service improvement programme, including specific work streams for TIA (mini strokes), pathways and cross county partnership working.

The following table shows the progress made by the Trust with regard to the ongoing measurements against the 9 Sentinel Audit key performance Indicators. The Trust's performance has continued to improve in relation to access to CT scan, physiotherapy assessment within 72 hours of admission, OT assessment within 4 working days of admission and patient mood assessed. The percentage of patients whose care achieves all 9 indicators has improved from 4% in February to 20% in March 2010. (It is important to note that even specialist centres reported 0% of patients achieving all 9 indicators when the baseline was assessed)

		National quartiles						
		25% of sites score below	median score	25% of sites score above	**Baseline - Sentinel Audit October 2008**	**November 2009 24 patients**	**February 2010 23 pts**	**March 2010 45 pts**
Indicator 1	Patients spend at least 90% of stay on a stroke unit	44%	56%	69%	66%	88%	74%	78%
Indicator 2	Screening for swallowing disorders <24 hours after admission	58%	73%	88%	74%	67%	83%	73%
Indicator 3	Brain scan within 24 hours of stroke	44%	57%	70%	41%	71%	83%	84%
Indicator 4	Aspirin or clopidogrel by 48 hours after stroke	77%	88%	96%	87%	67%	61%	73%
Indicator 5	Physiotherapist assessment within 72 hours of admission	74%	88%	94%	78%	83%	83%	91%
Indicator 6	OT assessment within 4 working days of admission	43%	69%	85%	15%	67%	70%	78%
Indicator 7	Patient weighed during admission	61%	76%	87%	83%	96%	83%	91%
Indicator 8	Patient mood assessed by discharge	43%	68%	87%	72%	67%	65%	71%
Indicator 9	Rehabilitation goals agreed by the multidisciplinary team	80%	92%	97%	78%	100%	91%	98%
% patients who achieve all 9 indicators						4%	4%	20%

Secondary Prevention

The information below is taken from MINAP (Myocardial Ischaemia National Audit Project) data. Period 01/07/09 to 31/12/09. Data includes patients discharged alive with a discharge diagnosis of myocardial infarction (heart attack).

July –September 2009

	KMH	NEWARK	NATIONAL
ASPIRIN	96.8%	90%	98.1%
B BLOCKER	92.9%	75%	94.3%
ACE	88.3%	80%	92.4%
CLOPIDOGREL	98.4%	70%	
STATIN All admissions	94%	80%	96.6%
Number of patients	67	4	

October – December 2009

	KMH	NEWARK	NATIONAL
ASPRIN	96.0%	100%	98.1%
B BLOCKER	95.0%	80%	94.3%
ACE	84.8%	88.9%	92.4%
CLOPIDOGREL	98.7%	88.9%	
STATIN All admissions	96.0%	100%	96.6%
Number of patients	142	10	

Hospital Standardised Mortality Ratios (HSMR)

HSMR is an analysis of data drawn from Secondary Users Service (SUS, hospital figures), by the Dr Foster unit at Imperial College. The data uses the diagnostic code for cause of death and standardises by adjusting for a number of factors including age, sex, co morbidity, deprivation and method of admission. Monthly analysis of the data is made by the Dr Foster unit and any outliers are notified to respective Trusts for investigation.

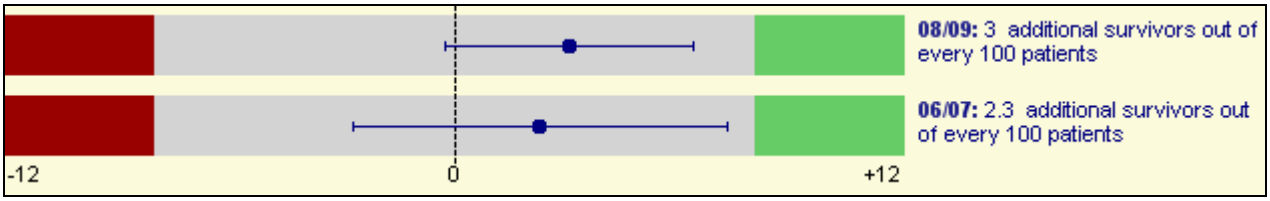
All alerts related to Dr Foster data were investigated by the Trust and there were no causes for concern last year.

Case note reviews did not identify any individual or systematic issues with quality of care with regard pneumothorax, cardiac failure or visceral atherosclerosis. Other variables such as definitions, data quality, patient case-mix, and chance may play a role.

Overall mortality reported by Dr Foster for 1 year is 96.16 compared to the national average of 100. Therefore the Trust is displaying lower than the national average for mortality.

Trauma audit

The Trust collects and summarises data to the UK Trauma Audit and Research Network (TARN) The chart below shows the results for the audit showing the Trust as a Trauma Unit is performing better than average in the survival rates for patients admitted with severe injuries, with upper quartile outcomes for most areas of trauma care including head injuries and fractures.



Patient Reported Outcome Measures (PROMs)

PROMs were introduced in April 2009 and require assessment of patient's quality of life pre and post operatively. Data is analysed independently by nationally commissioned agencies.

The Trust has received the first set of results on participation rates for pre-op questionnaires, but to date no patient outcome reports.

Our participation rate for Hip replacements is 45%, Knee replacements 41%; Varicose veins 26.3% and hernias 33.5%

Within the East Midlands we are 4th out of 8 Trusts for veins and hernias, and 5th for orthopaedic procedures for response rates. The best responses are around 80%, and the worst are at 1%

An action plan has been implemented to improve participation rates, as the expected rate of return was expected to be 80% nationally, although this was before the process had been tried on this scale.

Discharge information

We are one of a few local Trust's perform electronic same day discharge summaries for Emergency Care and in-patients. This is in response to GP's suggestions to improve care.
The Trust is working with NHS Nottinghamshire County, NHIS (Notts Health Informatics service) and a panel of local GPs to improve the quality of the Trust's discharge summaries. A questionnaire was sent to all of the local GP practices in November 2009 and the results showed that the majority of respondents felt that they received timely discharge summaries and that the content is good and well laid out. The survey did highlight that the consistency of information did vary across the Trust and also highlighted specific areas for improvement. The results were discussed with the GP panel and a suggestion to incorporate a 'GP to action' box is currently being implemented by NHIS. The GP panel also highlighted some technical problems surrounding the electronic discharges, and five GP surgery visits have been conducted to understand how the Trust's system interacts with the different systems being used in our local primary care communities.

An audit focusing on the quality of the information within the discharge summary is currently being planned. The audit will be conducted in the first quarter of 2010-11 and the findings will be used as a training tool to continually improve the quality of the summaries further.

18 weeks from referral to treatment

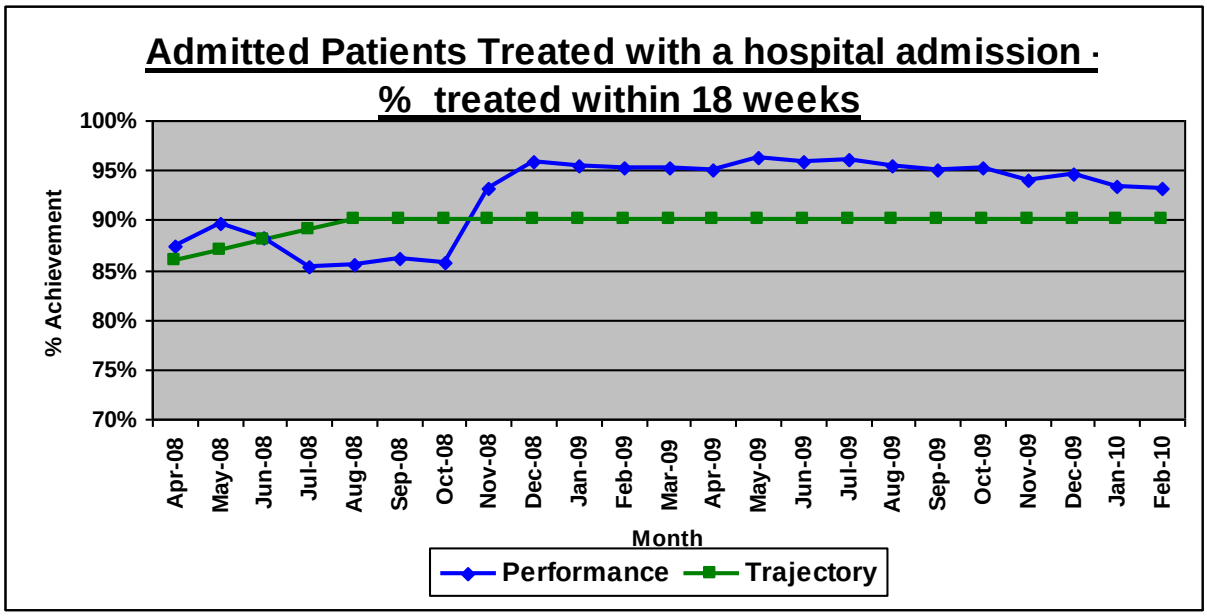
18 Weeks is about delivering the right care, at the right time and of the right quality without unnecessary delays.

18 Weeks measures the whole patient pathway from referral to the start of treatment, including all tests and out-patient consultations up to the start of treatment.

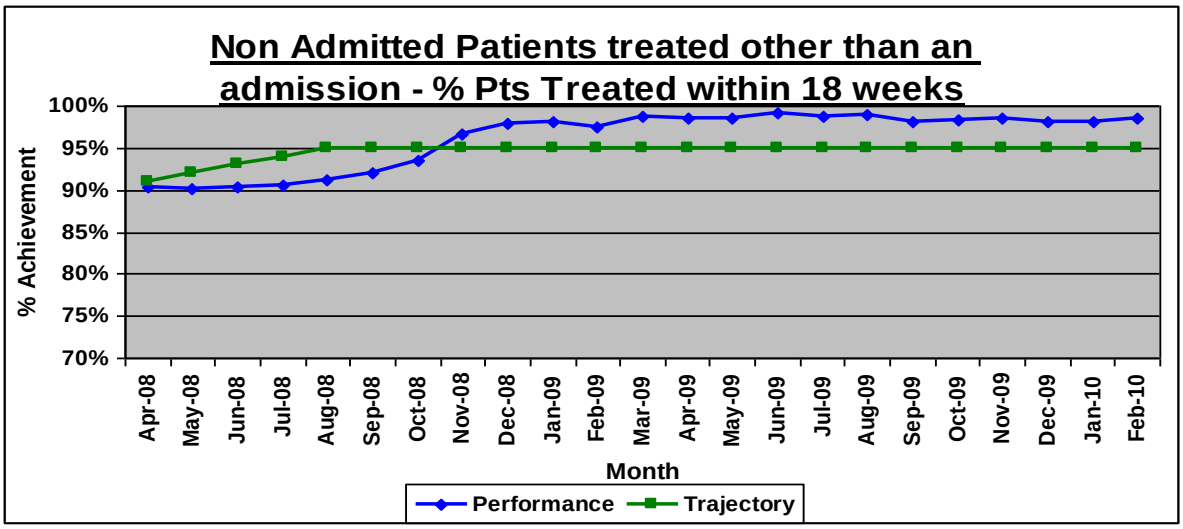
National Target from December 2008
90% of patients treated on an 'admitted' (where treatment is often an operation or procedure) pathway; and
95% of patients treated on a 'non-admitted' pathway are treated within 18 weeks.

At the end of March 2010 the average (median) wait for admitted patients waiting for surgery was 10 weeks and non admitted patients was 4-5 weeks.

Performance
Monthly Summary – Admitted



Monthly Summary - Non Admitted



The Trust is consistently achieving in all specialties with the exception of trauma and orthopedics, where there is an action plan to address this.

The data for the last quarter is still to be validated.

End of Life Care

The Trust has implemented an End of Life Action Plan & Pathway. The national End of Life Care Strategy quality markers for Acute Hospitals consist of 14 identified measures. The Trust's General Palliative and End of Life Care Group have base-lined against these measures and can demonstrate full compliance with 3 measures. The work plan for the coming year is to work towards full compliance in all standards.

Compliance with 3 measures:

1. Hospital based Specialist Palliative Care MDT
2. Full implementation of LCP (Liverpool Care Pathway) across all Wards within the Trust
3. Quiet spaces in wards for relatives and carers.

Work being progressed throughout the year:

1. End of Life Care action plan.
2. Accessing the needs of carers and relatives.
3. Effective communication with GP's and health care professionals within Primary Care.
4. Auditing of End of Life Care data
5. Effective mechanism for identifying those who are approaching end of life.
6. Accessing and recording needs and preferences.
7. Identifying patients preferred place of care.
8. Development of a locally wide register.

Patient experience

Pledges

Throughout the year real time data collection has been captured. In-patients and outpatients have been surveyed on a daily basis and the information gained used to make service improvements.

The graphs below show a visual representation of the results from the real time data collection of adult in-patients During November 2009-March 2010. The questions are based on the patient and carer pledges, which have been developed with patients, carers, staff, members and Governors and are:-

Patient and carer pledges

• We will listen to you
(Your individual needs and concerns, and respond to them)

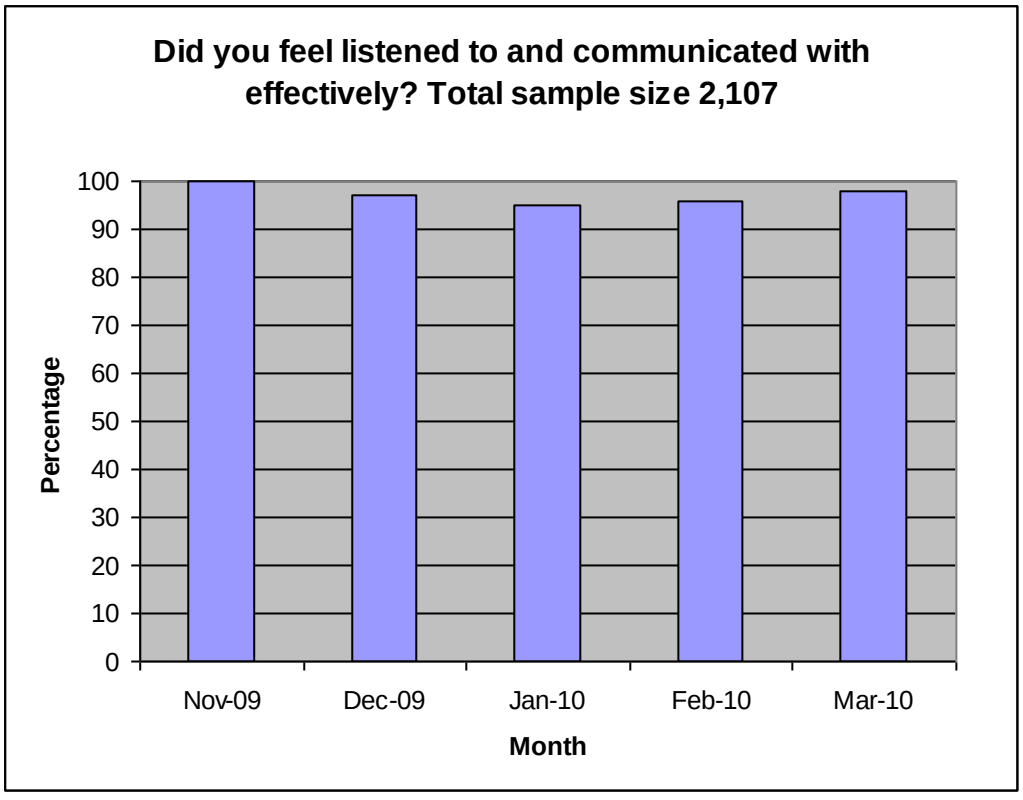
• We will work together as a team
(and with you, to give you the best care)

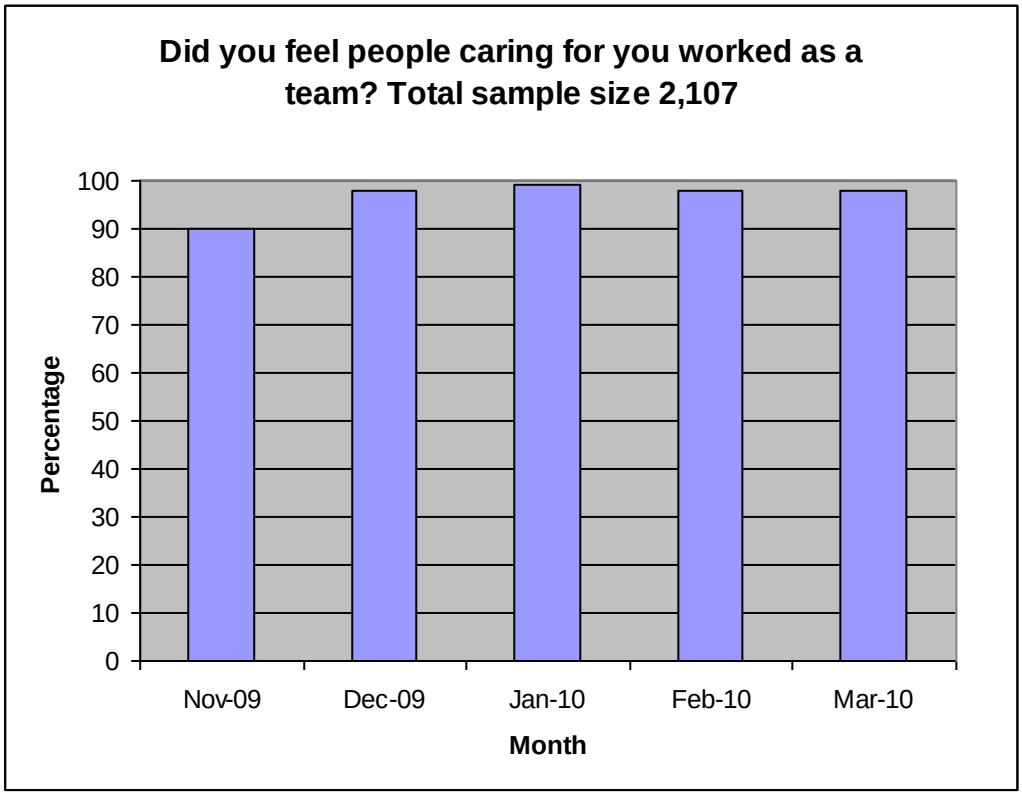
• We will show kindness and compassion
(treating each of you with dignity and respect)

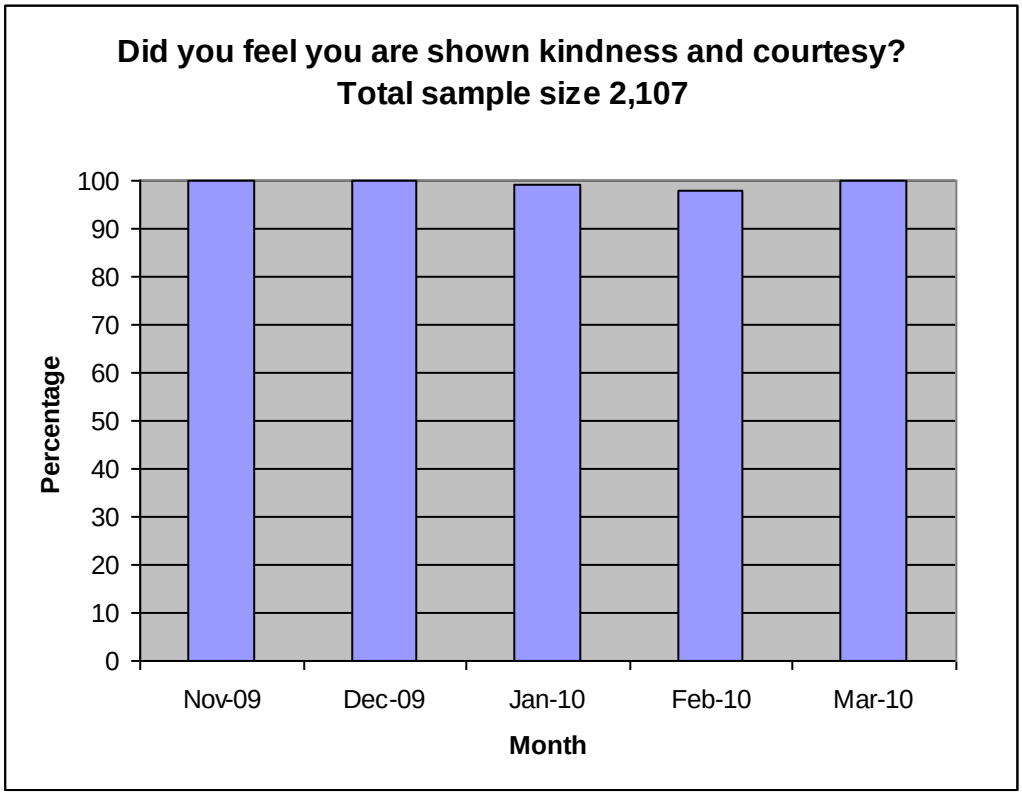
• We will communicate effectively
(at the right time and in a way that is easy to understand)

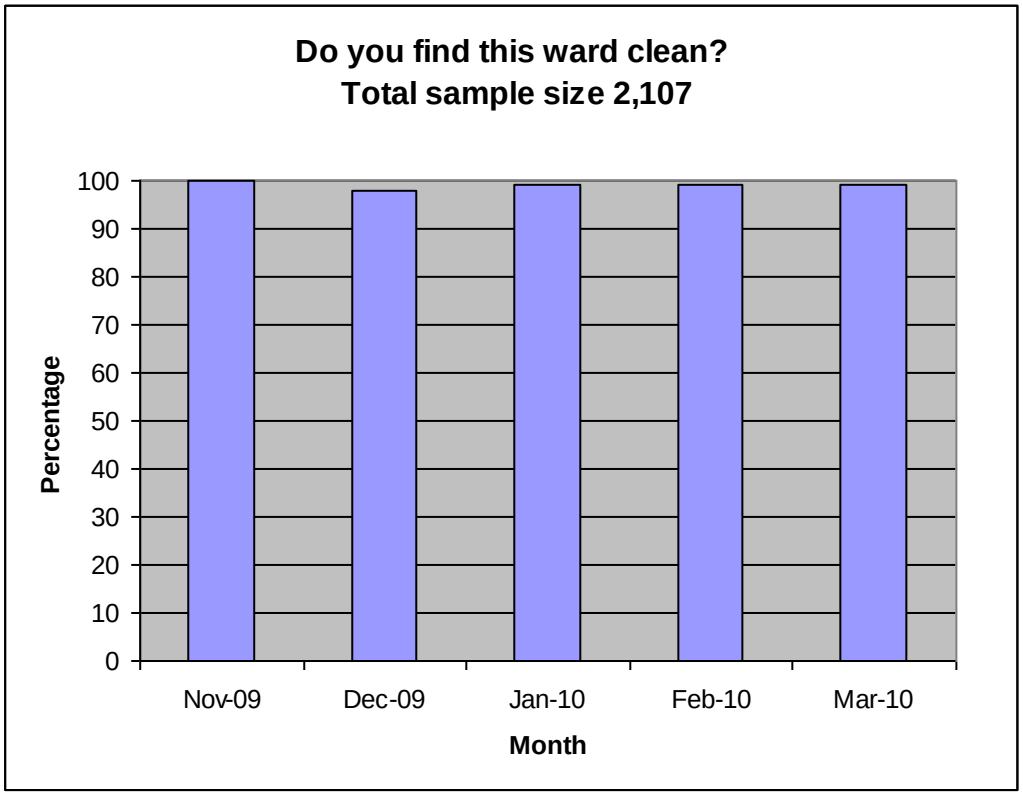
• We will care for you in a safe and clean environment

The graphs below show the percentage of people who answered yes.




Did you feel people caring for you worked as a team? Total sample size 2,107
Percentage
100
90
80
70
60
50
40
30
20
10
0
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Month


Did you feel you are shown kindness and courtesy? Total sample size 2,107
Percentage
100
90
80
70
60
50
40
30
20
10
0
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Month



Complaints

Following the introduction of revised National Complaints Regulations on 1 April 2009, more emphasis has been placed on involving complainants in how their complaint is handled. The Complaints team is committed to strengthening communication links with patients, carers and relatives.

The Trust received 485 complaints in 2009/10, compared with 499 in 2008/09.

The national target for acknowledging complaints is three working days and this was achieved in 96% of cases. There is no national target for responding to complaints and the emphasis is placed on agreeing an appropriate timescale for investigation with each individual complainant. To assist in monitoring purposes, the Trust uses a red, amber green rating system. Complaints graded red are the most complex and can take up to a maximum of six months; amber complaints 30 working days, and green complaints 20 working days. 81% of complaints were answered within the initially agreed response period and 19% of complaints were answered within an extended period.

The Trust continues to use complaints positively in order to make improvements to services and examples of actions implemented are provided in our quarterly board reports.

Patient Advice and Liaison Service (PALS)

The PALS team continue to support our patients, carers and visitors through their NHS journey. During 2009/10 the team handled 6,903 contacts and the common themes were communication, waiting times, appointment cancellations and environmental issues. Monthly reports containing all patient experience data including PALS referrals are shared with service management teams identifying possible service improvements, training needs and sharing patient compliments.

Cleanliness / PEAT Assessment results 2009.

The Patient Environment Action team (PEAT) was established in 2000 to assess NHS hospitals.

Under the programme every hospital providing inpatient and outpatient care has to undertake as assessment of its patient environments, cleanliness and food. Assessments can be either using internal / external teams. Results are validated for internal audits with the inclusion of a patient

representative and / or a Patient Governor. Performance may also be assessed by an external representative participating either on the day or post validation visit – both would be unannounced.

In 2009 Sherwood Forest Hospitals undertook an internal audit involving two patient representatives.

Improvement was noted in the environment and privacy and dignity categories with a move from acceptable to good. Food services retained its good rating.

At Newark Hospital the improvement was noted in the environment and food with a move from acceptable to good. Privacy and dignity retained its rating.

Comparison of 2008 performance to 2009 performance

Year 2008	Site Name	Environment Score	Food Score	Privacy and Dignity Score
	King's Mill Hospital	Acceptable	Good	Acceptable
	Newark Hospital	Acceptable	Acceptable	Good
Year 2009	King's Mill Hospital	Good	Good	Good
	Newark Hospital	Good	Good	Good

During the last year we have continued to work closely with our service providers to continually improve. The audit for 2010 was undertaken during February and was supported by an external validator. Although official scores will not be available until June, initial findings were excellent. The team found that standards across both sites were consistent in both new and old estate with only a few minor issues being identified.

Steamplicity

The Trust has worked closely with our service providers to introduce a new meal service system, Steamplicity to all the wards in the new hospital. This was rolled out during September 2009. Steamplicity is a meal cooking system that steams food in four to six minutes. Each meal is individually plated and steamed in packaging that contains a steam-release valve – like a mini pressure cooker – which regulates the temperature throughout the cooking process, keeping the food in the best possible condition. The valuable nutrients are retained and food keeps its colour and texture.

There are 24 choices of main meals on the current menu all offered at lunch and suppertime, from roast chicken to cod Provencal, macaroni cheese to beef casserole. There are choices of salads and sandwiches as well as 15 desserts to choose from. Special diets are also catered for including diabetic, high energy, vegetarian, gluten free, low salt. The menu can be provided in any language, including braille.

Steamplicity meals are free from artificial additives and preservatives, created using quality ingredients and analysed by nutritionists to meet the latest Government and NHS guidelines.

Introducing the new system was a huge challenge to both the Trust and Medirest; the new Ward Hostesses role was introduced at the same time, to separate the cleaning and catering functions at ward level.

Whilst the Trust and Medirest were pleased with the introduction of the new service, the real test of course is how the patients responded. These are a few of the many positive comments we have received:

“Much to my surprise I really look forward to ordering meals, I never thought I would see the day whereby hospital food tasted so nice” (retired GP)

“I am due to go home go home after three weeks in hospital and am upset to be leaving as the new food is marvellous”

“I love the food, the best I had ever had at any hospital and I have been to a lot of hospitals.”

“As a diabetic I liked the wide range of choice and symbols showing the healthy options.”

Steamplicity was introduced onto the children’s surgical ward during December 2009 and this has significantly improved the children’s experience too.

The contract management team have continued to monitor the food service delivery at ward level and the standard of service being delivered continues to be very high.
PEAT 2010 demonstrated positive feed back on all elements of food service, whether delivered via the Steamplicity or conventional cook chill method. There was plenty of choice and variety on the day of the audit, and the quality and presentation of the food achieved an “excellent “rating on both sites.
Steamplicity will be introduced onto the remaining wards as they move into the third tower of the new hospital in 2010.
The Trust are also considering the roll out at Newark Hospital in the future.

Privacy and Dignity-Same Sex Accommodation

National Standard;
Deliver substantial and meaningful improvements which will virtually eliminate mixed sex accommodation (MSA), including shared sleeping accommodation and sanitary facilities.

The Trust is committed to:

- Ensuring that all patients receiving care within its hospitals feel that they are treated with respect and that their right to privacy and dignity is upheld and actively promoted.

- There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including when the patient’s admission is unplanned.

- High standards involve a presumption that men and women do not have to sleep in the same room nor use mixed bathing and toilet facilities, unless there is a compelling clinical need.

- To protect patients from unwanted exposure, including casual overlooking and overhearing the Trust will aim to ensure that all patients admitted to or transferred to another area within its hospitals have access to the right bed, in the right place at the right time.

A full review of the Trust’s estate at both Newark and King’s Mill Hospitals was undertaken in late Spring 2009, and over £692,000 was spent to enhance accommodation.

A proposal to improve elements of the estate was developed and approved by the Executive Management Board and schemes of work agreed.

A very positive peer review was undertaken by representatives from the Department of Health, NHS East Midlands and NHS Nottinghamshire County

Specific initiatives during 2009/10 included:

- Transfer of adult medical and surgical wards at King's Mill Hospital to new wards with 50% single occupancy rooms and en-suites and multi occupancy bays with en-suites.

- Provision of en suite WCs to the majority of bays and some single occupancy rooms at Newark Hospital.

- Provision of additional shower and bathrooms at Newark Hospital

- Provision of additional assisted WCs including within the minor ops suite at Newark Hospital.

- Refurbishment of Wards 8 & 9 in preparation of opening the Emergency Assessment Unit, including the provision of additional bathrooms and the creation of solid partitions to all multi occupancy bays

- Creation of a second trolley recovery area on the Day Surgery Unit enabling patients of the opposite sex to recover in separate areas.

- Provision of a second assisted WC in the new Endoscopy dept to enable patients of the opposite sex to be cared for in separate recovery areas.

- Erection of full height solid partitions to some bed spaces in the Intensive Care Unit to reduce overlooking and overhearing.

- Revision and launch of the Trusts Privacy & Dignity Policy with an individual copy to every member of Trust staff.

- Participation in two public awareness campaigns, including a manned stand during Dignity and Same Sex Accommodation Awareness Week

Ongoing Improvement Work

The Trust will have undertaken a self assessment and published a public declaration of compliance with virtually eliminating mixed sex accommodation by 31st March 2010.

A monitoring and reporting procedure for any mixed sex occurrences will be implemented from 1st April 2010.

The written information provided to patients regarding same sex accommodation will be reviewed

Staff training requirements in relation to privacy and dignity will be reviewed with a view to ensuring that all staff groups within the Trust receive training on their roles and responsibilities and the behaviours expected by the Trust.

We are continuing to ask patients real time questions relating to same sex accommodation and report these findings back to the Board of Directors on a quarterly basis as well as the lead nurse on a monthly basis.

Accreditation

Pathology

All of the departments within Pathology at Sherwood Forest Hospitals have been awarded full accreditation by Clinical Pathology Accreditation (UK) Ltd, the recognised accreditation body for medical laboratory services in the United Kingdom.
The process of accreditation involves the external assessment of a medical laboratory to assess conformance with ' Standards for the Medical Laboratory' incorporating ISO 15189:2003 to ensure that the laboratory provides a service that meets the agreed needs and requirements of its users.
Cellular Pathology were the first department within Pathology to be awarded full accreditation status in March 2008 followed by Haematology and Clinical Chemistry in June 2009. Microbiology were the last department to be fully accredited in November 2009. The staff in Pathology are committed to maintaining the standards required to remain fully accredited after future inspections in order to support the Trust in continually improving the quality of care that is delivered to its patients.

Cancer

The Trust has 8 Cancer multidisciplinary teams (teams made up of various health care workers) who all take part in the new annual self-assessment Peer Review Programme. In addition cross-cutting services will join the programme as and when the national standards are released. The Trust plans to participate in the national cancer patient survey programme and will use the results to feed into local service provision and cancer MDT teams. The Trust was one of the first in the East Midlands to do a rigorous self assessment for peer review. In addition the Trust's skin and upper gastrointestinal teams were externally reviewed in Jan 2010 with Gynaecology and Lung scheduled for an external review in Jan 2011.

We have (noted by the Mid Trent Cancer Network Peer Review Group) a robust internal validation process and plan to review all teams annually after their self-assessments. Any issues are raised with the relevant divisions and monitored by the local Cancer Unit Board via a risk register.

Stroke

A set of criteria have been developed for organisations accepting stroke patients.

Comprehensive Level 1 provides 24 hour a day direct admission to an acute stroke unit with access to neurological and neuro-radiological service in addition to a foundation of stroke care
Primary Level 2 provides direct admission to an acute stroke unit for a restricted number of hours per day (up to 24 hour) in addition to a foundation of high quality stroke care
Local Level 3 A centre providing a foundation of high quality stroke care

Under the new proposals, people will be taken by ambulance directly to the nearest hospital with a specialist stroke centre rather than the closest hospital.

The NHS East Midlands Acute Stroke Services Project set out minimum criteria each level must achieve within 3 years in order to be accredited. This includes having appropriately trained staff who can offer urgent care including brain scans. There will be 24-hour cover to ensure patients can access specialist care at any time of the day or night.

King's Mill Hospital was successfully accredited as a Primary (level 2) stroke centre and Nottingham University Hospitals has been accredited as a comprehensive (level 1) stroke centre, following a rigorous assessment process.

Primary Percutaneous Coronary Intervention (PPCI) (heart attack treatment)

In order to deliver a comprehensive reperfusion therapy (treatment for heart attacks) service it is proposed that three levels of service provision provided within the East Midlands for heart attack patient who need reperfusion therapy.

- Level 1: 24/7 Primary Percutaneous Coronary Intervention (PPCI);
- Level 2: PPCI (Restricted hours) with an out-of-hours regional PPCI service;
- Level 3: Gold standard Acute Coronary Syndrome Management.

To ascertain the level of service provision:

- It is mandatory that each centre meets the minimum standard of a Level 3 provider. This will mean clear, robust, sustainable protocols for management of these services, working with partner organisations, e.g., ambulance services other level providers.
- All centres comply with current and future British Cardiovascular Intervention Society (BCIS) requirements.
- Interventional cardiologists will be required to form part of the rota for 24/7 PPCI care, to ensure a sustainable reperfusion therapy service for the region.
- Thrombolytic therapy (clot busting drugs) will be available within protocols for the region.

King’s Mill Hospital was successfully accredited at level 3

Our Priorities for 2010/11

The three main priorities for the 2010/11 quality report will be linked to the domains of patient safety, clinical effectiveness and patient experience. Other priorities will also be identified for 2010/11. The priorities will stretch the organisation further in its vision of providing *Best Care Best People Best Place.*

Why have they been chosen?

These priorities have been chosen after consultation with staff and the Board of Governors who represent the views of the public. A development day was held in January 2010 and various board of Governors sub committees have taken place throughout the year namely, performance and strategy, membership and engagement and patient quality and experience.

How will progress be monitored and measured?

Progress will be monitored via monthly and quarterly quality report's which are presented to the Board of Directors, the PCT at the monthly Quality Scrutiny Panel, through the Clinical Governance Committee, to the Patient Quality and Experience sub committee of the Board of Governors and monthly and quarterly reports to the Board of Directors.

Priorities for 2010/11

The three top priorities for 2010/11 are listed below.

1. Patient safety

Further reduce incidents of slips trips and falls

2. Clinical effectiveness

Reduce avoidable death, disability and chronic ill health from VTE (venous thromboembolism)

3. Patient experience

Improve privacy and dignity of patients including Same Sex Accommodation

Other Quality Priorities for 2010/11

Patient safety

- Reduce cases of healthcare acquired infections (specifically urinary tract infections and MSSA bacteraemia).
- Maintain a zero tolerance on hospital acquired pressure ulcers
- Implement national best practice standards within the patient safety first campaign, to include specific focus on reducing slips, trips and falls
- Implementation of the world health organisation (WHO) theatre check list
- Maintain improvement in caesarean section rates to be within the top quartile of peer comparator Trusts

Clinical effectiveness

- Continue to improve monitoring of acutely ill patients
- Further participation in national clinical audits
- Monthly review of hospital standard mortality rates
- Improve patient's dignity in theatre with more effective theatre gowns
- Reduce the number of infections associated with indwelling urinary catheters
- Improvement in the number of procedures listed in the BADS handbook (day case procedures)
- To reduce the number of under 17 year old accident and emergency attendees who are admitted
- Reduction in the mean medical emergency length of stay

- Reduction in emergency readmissions for people with long term conditions
- Improvement in post stroke death and dependency rate
- Improvements in national sentinel process of care audit scores

Patient Experience

- Improve patient meals service, specifically meals for patients with compromised nutrition
- Improvement on ambulance turn around times
- Improvement against the five national indicator measures
    1. Were you involved as much as you wanted to be in decisions about your care and treatment?
    2. Did you find someone on the hospital staff to talk to about your worries and fears?
    3. Were you given enough privacy when discussing your condition or treatment?
    4. Did a member of staff tell you about medication side effects to watch out for when you went home?
    5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Participation and development of action plans in relation to the East Midlands patient experience project
- Continue to use real time data to improve the customer experience and identify themes and trends for service improvement
- Continue to develop the role of volunteers in enhancing the customer experience

Our Assurance

Review of services

During 2009/10, the Trust provided 50 clinical services.

The Board of Directors has reviewed data made available to it in relation to the quality of care of these services.

The income from clinical services represented 79% of the total income generated from the provision of services by the Trust for 2009/10.

Audit and research

During 2009/10 17 national clinical audits and 6 national confidential enquiries covered NHS services that Sherwood Forest Hospitals provides

During 2009/10 Sherwood Forest Hospitals participated in 88% of national clinical audits, and 100 % (6/6) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals was eligible to participate in during 2009/10 are as follows:-

National Confidential Enquiries (NCEPOD)

Title of national audit / patient outcome project	Participated
Parental Nutrition (Jan 09-Dec 09)	Yes
Elective & Emergency Surgery in the Elderly (Oct 08-Dec 09)	Yes
Surgery in Children (Apr 08 –Mar 10)	Yes
Peri-operative Care (Mar 2010)	Yes

Confidential Enquiries into Maternal and Child Health (CEMACH)

Title of national audit / patient outcome project	Participated
Obesity in pregnancy (March 09 –April 09)	Yes
Head injuries in Children (Sept 09 – Feb 10)	Yes

National Clinical Audits (as defined by the HQIP 2009/2010 schedule but with N/A projects removed e.g. paediatric cardiac surgery / not done at Sherwood Forest Hospitals)

Title of national audit / patient outcome project	Participated
Bowel cancer (NBOCAP)	Yes
National lung cancer audit (NLCA)	Yes
Oesophago-gastric (stomach) cancer	Yes
Mastectomy and breast reconstruction	Yes
British Association of Urological Surgeons. (BAUS)	No. Audit will commence 2010/11
National Neonatal Audit (NNAP)	Yes
National Audit of Cardiac Rehab.	Yes
Heart Failure	Yes
Heart rhythm management	Yes

Myocardial ischaemia (MINAP)	Yes
National Diabetes Audit	No
National Joint Registry (NJR)	Yes
RCP Continence audit 3rd round 2009	Yes
Carotid Interventions / NVD	Yes
Hip Fracture Database	Yes (from Sept 09)
TARN	Yes
Intensive Care National Audit and Research Centre (ICNARC)	Yes

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals participated in, and for which data collection was complete during 2009/10, are listed below alongside the number of cases submitted to each audit enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

Clinical audits and national confidential enquiries	**Number of cases**	**Percent submitted**
Parental Nutrition	19	58%
Elective and Emergency Surgery in the Elderly	16	63%
Surgery in Children	Still in 'cases ascertainment' stage – NCEPOD will inform the Trust by mid July of the total number of cases expected – case submission will commence after that.	TBC by June/ July 2010 NCEPOD to confirm sample size following national case ascertainment stage
Peri-operative Care	101 cases submitted from theatres against 216 actual in-patient procedures	41%
Obesity in pregnancy	54	100%
Head injuries in Children	31	100%
Bowel cancer (NBOCAP)	On-going	100%
National lung cancer audit (NLCA)	On-going	100%
Oesophago-gastric (stomach) cancer	114	100%
Mastectomy and breast reconstruction	183	100%
National Neonatal Audit (NNAP)	337	100%
National Audit of Cardiac Rehab.	831	100%
Heart failure	242	100%
Heart rhythm management (pacing/implantable defibrillators)	223	100%
Myocardial ischaemia (MINAP)	661	100%

National Joint Registry (NJR)	884	100%
RCP Continence audit 3rd round 2009	80	100%
Carotid Interventions / National Vascular Database	58	28%
Hip Fracture Database	191	100%
TARN	144	64%
ICNARC	684	100%

The reports of 1 National Clinical Audit were reviewed by the provider in 2009/10 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided

1. National Falls and Bone Health Audit – Organisational audit only – undertaken in 2008 but reported and reviewed in 2009
Conclusions:
The Trust was not fully compliant with all areas of the national falls guidance although significant improvements have been made to the service. The action plan below has contributed to further improvements in service.

	Actions planned	Date to implement by	Date implemented
1	Instigate multidisciplinary, consultant led, fully integrated Falls Clinic.	May 2009	May 2009
2	Follow up of >65yrs, fallers who attend A&E with Multi-factorial falls risk assessment form	April 2009	April 2009
3	Data – The Falls group will review in patient falls data against inpatient activity (occupied bed days)	June 2009	Process commenced April 09
4	Audit – the Falls group will discuss audit requirements for 09/10 including potential audit of the use of the falls risk assessment form.	Sept / Oct 2009	Oct 2009
5	Undertake a Patient Satisfaction Survey of falls clinic	Dec 2009 / Jan 2010	Underway Jan 2010
6	Community osteoporosis protocol to be made available on the Trust intranet.	Oct 2009	Oct 2009
7	Nursing core plan to include Day case patients as well as inpatients	Feb 2009	Feb 2009
8	Pre-operative medical assessment and treatment on the orthopaedic ward by a senior physician with relevant training	Jan 2011	Process commenced Jan 2010

The reports of 31 Local Clinical Audits were reviewed by the provider in 2009/10 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided.

Audit	Question	Outcome
1	Are we compliant with procedures for requesting, consenting obtaining and sending bone donations following Total Hip Replacements at King's Mill Hospital? Audit reported 19th April 2009	Findings sent to relevant group's pre-op nurses, theatre nurse, and Orthopaedic surgeons. Refresher/ Update Courses under taken. Posters and information leaflet for patients explaining process devised. Blood collection on admission completed.
2	Eye casualty review appointments Audit standard: All review appointments for eye casualty	A repeat prospective audit to address the issue of appropriateness of referrals. All non-A & E referrals to be referred directly to OP clinic. Reserve a specific number of OP clinic slots for

	patients should be arranged in the time-frame stated by the casualty officer 100% Local target Results: Only compliant in 59% of cases audited. Audit reported 23rd April 2009	such patients. Triage of patients seen in A & E over weekend, to allocate an appropriate review date. This is being re audited in 2010 to complete the audit loop.
3	Diabetic Ketoacidosis protocol (DKA) - is it being followed for the immediate management of patients? Audit reported 5th May 2009	Presentation of audit results at the Medicine Grand Round March 2010 Availability of printed protocol on the wards
4	Treatment and documentation around treatment variance for causes of gonorrhoea in GU Med Audit reported 6th May 2009	Highlight guidelines to all staff Present findings Plan re-audit in April 2010
5	Clinical care of under 16 year olds in GU medicine Audit reported 28th May 2009	New proforma for notes of under 16's developed and staff trained in its use
6	Secondary prevention and osteoporosis at King's Mill Hospital- are non-hip fractures managed according to current nice guidelines? Audit reported 12th June 2009	Flow diagrams used in fracture clinic to guide fragility fracture management Osteoporosis link nurse identified to facilitate referrals and treatment.
7	MINAP verification audit 2008: Medications on discharge - are we compliant with the NSF for CHD Audit reported 18th June 2009	Form designed to aid data collection. We are compliant see further information in this quality report.
8	Liverpool Care Pathway (LCP) for the care of people in the last days of life Audit reported 30/06/2009	Formal audits of care for dying patients will begin again in 2010/11. Quality reports are submitted on a quarterly basis to the Trust board regarding the end of life pathway.
9	Aetiological investigations done for congenital deafness Audit reported 13/07/2009	Findings shared with relevant groups Diagnostic and investigatory form designed Plan joint paediatric deafness clinics between ENT and Paediatrics Consent discussed with Clinical Geneticist.
10	GP referrals to skin cancer target wait clinics Audit reported 14/07/2009	Information shared with GPs regarding target wait.
11	Paediatric Forearm fractures / pain management in A&E Audit reported 22/07/2009	On-going education regarding documenting pain score implemented.
12	Paediatric efficiency and effectiveness of sedation in children undergoing radiological imaging - are we adhering to Trust guidelines? Audit reported 27/07/2009	Agreed actions Revise patient info sheet to show that IV sedation not given. Update care pathway to show patient info given. Completed
13	2 week wait Urgent referrals to	Any inappropriate referrals to be highlighted to the

	King's Mill Hospital Maxillofacial department for investigation of oral white patches Audit reported 31/07/2009	referring clinicians regarding future referrals. Completed
14	Falls risk assessment documentation on admission to hospital Audit reported 13/8/09	Old care plans destroyed Ward level audit reports and action plans to submitted to falls group on a monthly basis Findings presented to clinical governance Mandatory training completed
15	Secondary prevention of osteoporotic fragility fractures at King's Mill Hospital Audit reported 04/09/2009	Findings shared with relevant group's Group discussion between senior surgeons and formulation of an action plan
16	Patient Identification (Wristband) Audit July 2009 Combined report for planned care and surgery and emergency care and medicine Audit reported 29/09/2009	Staff have been reminded that when a patient's wristband has been removed for an invasive procedure, it must be replaced immediately. Audit results to be reported to the Division Clinical Governance Meeting. This annual audit will be on the Trust's forward clinical audit plan for 2010/11 which takes place during the summer.
17	Central Venous Catheter (CVC)securing Audit reported 30/09/2009	CVC checklist introduced June 2009
18	Prevention of inadvertent hypothermia related to operations Audit reported 03/11/2009	Staff education completed Guidelines reviewed Request review of stocks and availability of warming machines. Patient outcomes improved? Yes, reducing the risk of peri-operative hypothermia reduces the risk of surgical site infection and improves healing.
19	Observations and subsequent interventions carried out on the wards during the 24 hours preceding sudden death, unexpected ICU admission or cardiac arrest, as recommended in current guidelines? Audit reported 3/11/09	Key areas where problems may occur were highlighted by this audit. It is anticipated that dissemination of the findings of this audit might generate network-wide discussions around the formulation of a care bundle to enhance the care of the acutely ill adult. Documentation of mandatory vital signs and TTS is essential to any future improvement.
20	CNST: Standards for Maternity care 2008 Audit reported 18/11/2009	Training: Greater emphasis on attending training for senior house officers and provision of adequate number of training sessions to account for people on nights etc. Possibility of incorporating more training into induction session. Encourage specialist registrars and staff grade doctors to frequently refresh training, for example by including emergency training as part of the RITA assessment. Documentation: To accentuate emphasis on proper documentation, so as to provide an accurate environment with which to assess performance.
21	Thromboprophylaxis risk	Improve the rate of completion of the initial

	assessment compliance in Planned Care & Surgery Division 2009 Audit reported 26th Nov 2009	thromboprophylaxis risk assessment in accordance with DoH guidance. Improve the prescribing practices according to the level of calculated risk. Consolidate improvement in relation to completion of thromboprophylaxis risk assessments and prescribing practices Undertake weekly rapid cycle clinical audit Weekly audits on completion of forms are in place There have been 10 weekly audits to date (stated 12th Feb 10) Compliance for all adult in-patients having a VTE risk assessment undertaken on admission has improved from 21% (12th Feb 2010) to 42% (16th April 2010)
22	Haematology admissions with suspected neutropenic sepsis Audit reported 1st Dec 2009	The neutropenic sepsis policy has been re-written and was launched in May 2010. Re-audit in late 2011.
23	Nephrectomy operations - laparoscopic and open - audit of length of stay and operative times Audit reported 22nd Dec 2009	At present, practice at Kings Mill is fulfilling the audit criteria / good practice demonstrated. No changes to practice are necessary. Recommendations for further audit: It is recommended these criteria should be re-audited in 3 years (allowing a larger sample size) to ensure standards are being maintained and to measure any improvement as further experience is gained by surgeons new to the procedure.
24	NHSLA Consent: Chemotherapy, Clinical haematology Audit reported 4th Jan 2010	Ensure Trust consent form completed for all planned (oral and IV) chemotherapy - Nov 2009. completed and implemented Write a local information leaflet for CTD and MPT chemo - implemented Nov 2009 Re-audit annually Nov 2010
25	Are nutritional core care plans A&B being implemented and followed correctly? Audit reported 5th Jan 2010	The findings of the audit will be disseminated to: The Nutrition Board, Heads of Nursing, Ward Leaders, Nutrition Link Nurses by 31st March 2010 Audit findings and summary to be included in new ward information pack and ward briefings. To be included in Nutrition Link Nurse training. By 31st March 2010 Anticipated outcomes: It is anticipated that a higher percentage of patients will be screened within 24 hours of admission to hospital, and that they will be placed on the correct care plan and monitored and reassessed appropriately in accordance with the care plans.
26	Cytology smear and results 2008 GUM Audit reported 20th Jan 2010	Good compliance with standards demonstrated Highlight to staff need for letter contact Highlight to staff need to complete register for each cytology sample

		ongoing quality audit feedback to individual consultants Diary system implemented
27	Paediatric DKA guidelines Audit reported 20th Jan 2010	Develop standardised protocol for the young adult age group (15 – 20yrs), balancing fluid requirements of individual versus risks of cerebral oedema Detailed review of current literature regarding development of cerebral oedema in this age group
28	Paediatric Surfactant 2008 (AUDIT Cycle 3) Audit reported 16th Jan 2010	As a result of the audit we plan to change our current guidelines for use of rescue surfactant (increased dose). The next step is to look at cost of using higher dose vs. two smaller doses.
29	Carotid Doppler for stroke patients at Newark Audit reported 25th Feb. 2010	Audit has demonstrated / confirmed that we are not yet achieving national standards. The 2 week target is difficult to achieve. Better coordination between stroke team, cardio respiratory team and vascular department is required to reduce and minimise delay. Following presentation of audit findings and discussions with network various steps have been taken and a noticeable improvement noted- re-audit recommended in 1 year.
30	Haematology Clinic Letters 2009 Audit reported 17th March 2010	Dictated clinic letters within 2 days of clinic - by 1st April 2010 - all consultants Type clinic letters within 2 days of completion of tape by 1st April - all secretaries Sign / post completed letters within 1 day by 1st April all staff. Improvements / Impact as a result of audit: These actions should ensure that we improve communication with primary care colleagues and ensure that secondary care colleagues have access to up to date information in the case notes.
31	Care of the acutely ill patient a baseline audit of the NICE guidelines (2007) Audit reported 27/07/2009	Quarterly audits have demonstrated incremental improvements across all clinical areas

Clinical research

The number of patients receiving NHS services provided by Sherwood Forest Hospitals that were recruited during 2009/10 to participate in research approved by a research ethics committee was 830 in NHS portfolio studies. This is lower than average due to vacancies in posts during 2009/10.

Commission for Quality and Innovation (CQUIN)

A proportion of Sherwood Forest Hospitals income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals and NHS Nottingham County through the Commissioning for Quality and Innovation payment framework. All of these quality payments were achieved. In addition the Trust received an incentive payment for a stretch target for C Difficile rates, which it has also achieved. Further details of the agreed goals for 2009/10 and for the following twelve month period are available on request from the Chief Executives office.

The monetary total for the amount of income conditional upon achieving the quality improvement and innovation goals for 2009/10 was £837,500 and £150,000 for achieving C Difficile targets; the total amount achieved was £987,500

Care Quality Commission (CQC)

Sherwood Forest Hospitals is required to register with the Care Quality Commission. The Trust's registration was subject to two conditions based upon the CQC assessment of breaches to regulation 10 'Assessing and monitoring the quality of service provision'

The conditions are as follows:

Condition 1

The Trust must ensure that effective systems to assess and monitor the quality and safety of service provision are in place across all services by 31 July 2010. Evidence must be available to demonstrate this from 31 July 2010.

Condition 2

The Trust must ensure that the Integrated Critical Care Unit has in place a system of clinical governance that supports continual improvement and clinical excellence by 31 May 2010. Evidence must be available to demonstrate this from 31 May 2010.

Sherwood Forest Hospitals has agreed actions plans to ensure that concerns identified by the CQC are resolved by the end of July 2010.

- Specifically to improve clinical governance systems in ICCU to support continual improvement and clinical excellence by the end of May 2010.
- To ensure effective and improved systems to assess and monitor the quality and safety of service provision are in place across all services by July 2010.

The Care Quality Commission has not taken enforcement against Sherwood Forest Hospitals during 2009/10

Sherwood Forest Hospitals was subject to periodic review by the Care Quality Commission and the last review was on 16th September 2009. The review was in relation to the prevention and control of infections. The CQC assessment of Sherwood Forest Hospitals following the review was:

CQC overall judgement

"On inspection, we found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risk of a healthcare associated infection"

Sherwood Forest Hospitals has participated in a review/ investigations by the CQC following a referral from the National Clinical Assessment Service (NCAS) in relation to care on our ICCU during 2007.

Data Quality

Sherwood Forest Hospitals submitted records during 2009/10 to the secondary users service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

-Which include the patient's valid NHS number was 99.8% for admitted patient care; 99.9% for outpatient care; 97.3% for accident and emergency care.

-Which includes the patients valid GP registration code was 100% for admitted patient care; 100% for outpatient care; and 99.8% for accident and emergency care

Information Governance (IG)

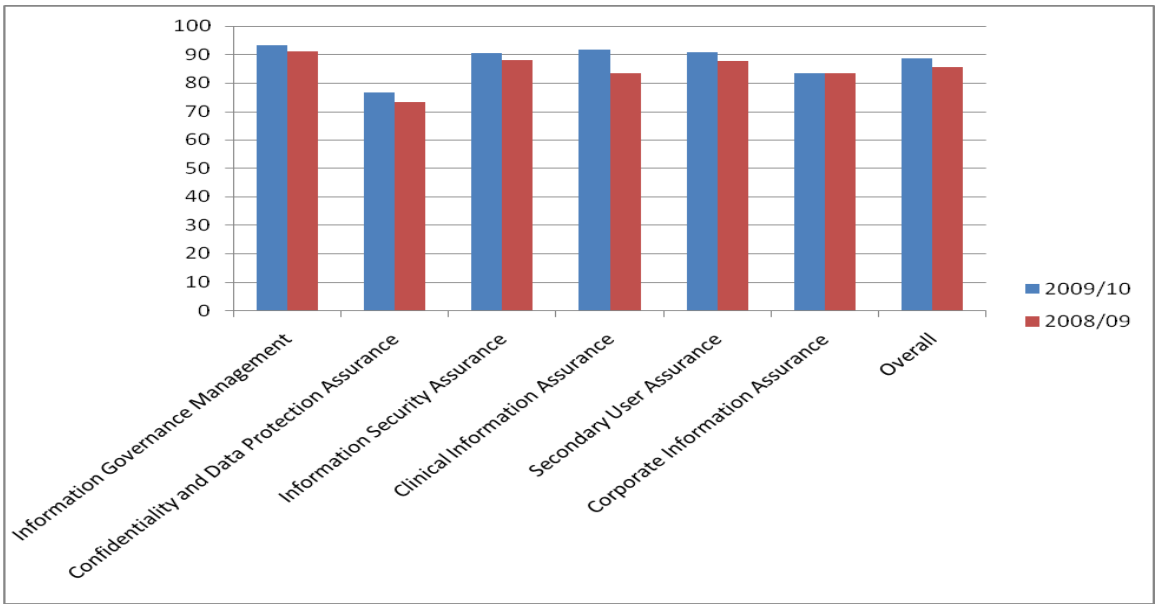
Sherwood Forest Hospitals score for 2009/10 for Information Quality and Records management assessed using the Information Governance Toolkit was 88.7%. Sherwood Forest Hospitals has demonstrated year on year improvement in relation to information governance and is pleased to report further improvement in 2009/10.

Improvement

Overall improvement has been made across the IG Toolkit, which is outlined in the table below which compares the ratios of scores for 2009/10 against 2008/09:

	2008/09	**2009/10**
Level 0	0	0
Level 1	0	0
Level 2	27	21
Level 3	35	41
Total	**62**	**62**
Percentage (%)	**85.5**	**88.7**

This has resulted in an overall improvement to the total score, which has increased from 85.5% in 2008/09 to 88.7% for this year's submission. This ensures that the Trust will maintain its excellent Green rating.



Audit

The information governance toolkit scores were audited on the 10th, 11th and 12th of February 2010, by an independent assessor. 30 out of the 62 standards were reviewed and the Auditor agreed with the attainment levels put forward by the IG department for 27 of these standards. The remaining 3 standards have been reviewed by the IG department and will form part of the 10/11 work plans.

Payment by results

Sherwood Forest Hospitals has been subject to two Payment by Results Data Assurance Framework audits in the year. These audits are carried out by the Audit Commission and covered:

- Outpatient data quality
- Admitted patient care clinical coding

The main conclusions of the Outpatient audit were that the Trust's data quality arrangements were good in the three areas tested, only meeting minimum requirements in one area, that being that corporate objectives and targets for data quality are not clearly defined.
The audit found good standards of Outpatient data recording with an overall error rate of 1.2% from the sample tested.

With regards to the admitted patient care audit, the Audit Commission concluded that the Trust's performance was excellent compared to the overall performance of Trusts in 2008/09.

The Trust's HRG error rate of 5.0% compares favourably with the national average of 8.1% and 8.5% of the local Strategic Health Authority. In monetary terms, the audit identified a 1.4% error on the sample tested.

The audit concluded that coding arrangements are good, which is leading to a marked improvement in diagnosis coding accuracy. Procedure coding accuracy was identified as an area where improvement could be made.

The results should not be extrapolated further than the actual sample audited.

Other Information

Health Care Commission (HCC) investigation

In March 2009 the HCC investigated Mid Staffordshire NHS Foundation Trust. Following publication of the report Sherwood Forest Hospitals undertook a gap analysis of the key issues raised within the Mid Staffs report and sought evidence from clinical services that provided board assurance that similar circumstances could not occur within our own Trust. Where evidence could not be produced or was deemed insufficient specific reviews/audits were commissioned and progress monitored throughout the Executive and Board of Directors.

NHSLA-CNST Risk management

During 2009/10 the Trust has undergone assessment for CNST level 1 for both general hospital and maternity care. The general hospital assessment scored the unusually high score of 50/50 and maternity scored 46/50.

Clinical Audit

Clinical Audit processes at Sherwood Forest Hospitals are governed by our policy and strategy documents. These documents have been written to conform to nationally agreed "Best Practice" for clinical audit and have been implemented via the Trust's clinical governance mechanisms. The implementation and success of the clinical audit strategy's aims and objectives will be measured by the clinical audit operational plan and reported to the Clinical Audit and Clinical Governance Committee.

These aims and objective are:
To deliver an effective clinical audit plan that contributes to the continuous improvement of patient care and health outcomes.
By:

- Aligning clinical audit activity with national and local health priorities as agreed by the Trust, local health communities, Divisions and Service Lines
- Ensuring that the rationale for undertaking clinical audit relates to improvements in health care delivery.
- Providing training, support and advice for Sherwood Forest Hospitals staff in relation to clinical audit.
- Monitoring the governance arrangements through which the quality of clinical audit activity and outputs will be monitored

Clinical Governance

Clinical Governance is the process by which NHS organisations assure themselves and others that services are safe, effective and improving. This takes a great deal of work and a lot of commitment from all our staff. All our services take clinical governance seriously and along with a large number of single issue quality committee's work timelessly to improve the care our patient's experience.

The Clinical Governance Committee reviews performance across the Trust, ensures national guidance is followed and seeks to maximise quality improvements each year.

Clinical Governance processes are reviewed by the Audit Committee and ultimately by the Trust Board. A large number of external bodies such as CQC, Dr Foster, Royal Colleges and laboratory accreditation also monitor our performance and Sherwood Forest Hospitals works with them to learn of any new opportunities for improvement.

The Trust believes we have a sound system for Clinical Governance, population by relevant information such as quality indicators. Clinical staff are trained to understand our systems and have faith in them. Crucially we encourage a "no blame" culture and suspect all members of staff to do a good job, but also to actively find ways to do their job better.

An overview of measures

Patient Safety Metrics

	2009-2010	2008-2009	2007-08
The Trust has fully met the HCC core standards and national targets	**23/23**	24/24	24/24
Clostridium difficile year on year reduction	**96**	177	324
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half of the 2003/04 level	**14**	31	36
Never events that occurred within the Trust	**0**	0	0
Essence of Care Benchmark (EoC)Outcomes :	**Due 2011**	2008-09	Programme 1
Pressure Ulcers	**Due 2011**	81%	73%
Record Keeping	**Due 2011**	81%	75%
Effective Communication	**Due 2011**	84%	77%

Notes

The Trust EoC programme has a 18-month to 2-year cycle and the benchmarks mentioned within the grid[s] are due to be re-audited during 2010-2011 with benchmark leads currently in the planning stages to review their specific audit tool ready for Programme 3. The migration of the wards also had an impact on the time-table for the re-audit programme and the introduction of the new benchmarks.

Patient Experience Metrics

	2009	2008	2007	National average
National PEAT scores (0-5, 5 being excellent):				
*Environment King's Mill Hospital	**4**	3	4	4
*Environment Newark Hospital	**4**	3	4	4
*Food KMH	**4**	4	4	5
*Food NH	**4**	3	3	5
Essence of Care Benchmark Outcomes:	**Due**			
Privacy and dignity	**2010/11**	82%	80%	
Food and Nutrition	**2010/11**	81%	77%	
Selected Inpatient Survey Results:				Highest scoring 20% of Trusts
Did you have confidence in the doctors treating you?	**89%**	90%	87%	91%
Did you have confidence in the nurses treating you?	**88%**	88%	85%	89%
Were you given enough privacy when being examined or treated?	**96%**	95%	91%	95%
Did you find someone on the hospital staff to talk to about your worries and fears?	**61%**	65%	58%	64%
% of patients who would recommend hospital to a relative/friend	**87%**	80%		

NotesThe Trust Essence of Care programme has a 18-month to 2-year cycle and the benchmarks mentioned within the grid[s] are due to be re-audited during 2010_2011 with benchmark leads currently in the planning stages to review their specific audit tool ready for Programme 3. *The migration of the wards also had an impact on the time-table for the re-audit programme and the introduction of the new benchmarks*.
The PEAT scores are the results of a PEAT mini audit the actual PEAT results will be available in June 2010

Clinical effectiveness and National Targets and Regulatory Requirements	2009-10	2008-09	2007-08	2009-10 Target
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	**98.8%**	99.3%	99.8%	96%
Maximum waiting time of 31 days from decision to treat to start of treatment - subsequent surgical and drug-based treatments	**Drug 99.7%** **Surgery 94.3%**	N/A	N/A	Drug 98% Surgery 94%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	**84.5%**	94.6%	N/A	85%
Maximum waiting time of 62 day from screening to 1st definitive treatment	**90.5%**	N/A	N/A	90%
18-week maximum wait from point of referral to treatment (admitted patients)	**94% (March 10)**	95% (March 09)	86% (March 08)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	**98.7% (March 10)**	99% (March 09)	90% (March 08)	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	**98.7%**	98%	98%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	**63%**	60%	78%	68%
Screening all elective inpatients for MRSA	**100%**			100%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**94.4%**	99.8%	99.7%	93%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all GP referrals – Breast Symptomatic*	**92.8%**	N/A	N/A	93%

* Please note that the new Breast Symptomatic target applied for January – March 2010. The target was achieved for February and March, but was missed in January and therefore for the quarter, due to patients exercising choice in the snowy weather.

Annex

Assurance

Commentary from Nottinghamshire County LINk

Nottinghamshire County LINk
Unit E2, Southglade Business Park
Cowairs
Nottingham
NG5 9RA

T 0115 9734647
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www.strongerlocalvoice.com
info@strongerlocalvoice.com

Your Stronger Local Voice

Ref: LT

Mike Tasker
Companies Secretary
Sherwood Forest Hospitals NHS Foundation Trust

Date: 1st June 2010

Dear Mike

Re: Nottinghamshire County LINk Response to the Quality Report of Sherwood Forest Hospitals NHS Foundation Trust

The Nottinghamshire County LINk is delighted to enclose our comments on the Sherwood Forest Hospitals NHS Foundation Trust Quality Report.

We are happy with the improvements that the Trust has made to date, and are pleased and encouraged by the planned future developments. At this point, we have no negative comments to make about the content of the Quality Report.

The Nottinghamshire County LINk would finally like to thank you for giving us the opportunity to provide feedback, and hope that our comments are a valuable contribution.

Yours sincerely,

Jane Stubbings – Nottinghamshire County LINk Chair

Commentary from NHS Nottinghamshire County

The Commissioning PCT has reviewed the Quality Account. The PCT recognises the key areas of improvement and the priorities for 2010/11. Quality goals have been agreed with the PCT and are embedded within the contract.

The commissioning PCT monitors quality and performance at the Trust throughout the year. There are monthly quality and performance review meetings and there is frequent ongoing dialogue as issues arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year. It is noteworthy that the Essence of Care pressure ulcer audits were not undertaken during the reporting period. However, these are undertaken on an 18-24 month cycle and the next audit is planned for 2010.

The Trust is working with the PCT to ensure that the Care Quality Commission registration conditions are met. The Trust has shared its action plan and a number of improvement actions have already been taken. There are some ongoing challenges in relation to data quality and robustness of investigations. However, the Trust is working constructively to address these issues.
The independent investigation into allegations on the Integrated Critical Care Unit is welcomed.

The Trust has demonstrated a high level of commitment to improving patient experiences. The patient experience local surveys provide a high level of assurance in areas where they are conducted. The Trust openly shares this information with commissioners.

The PCT has an appointed governor at the Trust. This enables the commissioning organisation to better understand the views and concerns of public and staff Governors. It also assists with information exchange between the Trust, commissioners and public representatives and helps to provide additional assurance to corroborate the information within this Quality Account.

Commentary from the local Overview and Scrutiny Committee (OSC)

A presentation was given to the Overview and Scrutiny Committee on the 9 March 2010. The OSC has confirmed that it does not wish to comment on this year's Quality Report.

GOVERNANCE - ACCOUNTABILITY & TRANSPARENCY

Effective corporate governance is a fundamental cornerstone for the success of every NHS Foundation Trust. As a Foundation Trust, our Board of Directors has increased autonomy to make financial and strategic decisions for the benefit of our community. Our Board of Directors have a framework of democratic local accountability through our members and our Board of Governors, replacing central control from the Secretary of State for Health.

Our Board of Directors direct the business of our Trust having ultimate and collective responsibility for:

- *Determining our strategic direction and objectives, taking into account the views of our Governors, members and other stakeholders*
- *Ensuring the delivery and achievement of national and local contractual performance targets.*
- *Ensuring the quality, safety and effectiveness of healthcare services, research, development, training and education*
- *Ensuring good governance, adequate systems of control and robust management of risk*
- *Ensuring our ongoing compliance with the terms of our authorisation, our constitution, legislation, mandatory guidance and other obligations*

Composition of the Board of Directors

The composition of the Board of Director's in the period 1st April 2009 - 31st March 2010 was as follows:

Chairman	Tracy Doucét
Chief Executive	Carolyn White (from 1.12.09) Jeffrey Worrall (to 30. 11.09)

Executive Directors

Executive Director of Strategy & Improvement	Jane Warder
Executive Nurse Director	Carolyn White
Executive Director of Finance	Lee Bond
Executive Director of Human Resources	Karen Fisher
Executive Medical Director	Mike Mowbray

Non-Executive Directors (all considered by the Board to be Independent)

Bonnie Jones	Vice-chairman
David Heathcote	Senior Independent Director
David Leah	Audit Committee Chair
Stuart Grasar	
Iain Younger (from 1 December 2009)	
Stephen Pearson (to 31 December 2009)	

Summary biographies of Directors who were members of the Board of Directors on the 31 March 2010 are provided overleaf.

Directors' Profiles

Tracy Doucét, Chairman

Tracy was appointed Chairman of the Trust and Board of Directors from the 2 April 2008.

She chairs the Board of Directors Remuneration, Nomination and Investments committees and the Board of Governors Nomination Committee.

Tracy joined the Board as a Non Executive Director when we were granted our Foundation Trust licence on the 1 February 2007, bringing a range of commercial and financial experience.

Tracy is managing partner of a management consultancy practice with extensive experience at executive and non-executive director level across both public and private sectors. She was formerly an Executive Director with Greater Nottingham TEC, prior to which she worked with HSBC and is a qualified Chartered Banker.

Tracy has assisted a number of FTSE 100 companies and public sector organisations to develop and implement ambitious and strategic plans, improving communication, governance, customer focus, leadership and performance.

Tracy's work on corporate communication strategies, stakeholder engagement, effective governance, partnership working and leadership development, has been published widely.

Tracy's other commitments include roles as a Director and equity Investor in a small number of companies. There have been no changes reported.

Carolyn White, Chief Executive

Carolyn joined the Trust as Executive Nurse Director in July 2001, having previously worked for 12 years at the Hull and East Yorkshire Hospitals NHS Trust in a variety of senior nursing and management roles.

Carolyn trained as a registered children's nurse and state registered nurse in Liverpool and qualified in 1982, and worked for most of her clinical career in paediatric intensive care.

Following her appointment as Executive Nurse Director, Carolyn significantly raised the profile of nursing services within the Trust, and her professional drive improved recruitment, retention and training of nurses and other clinical staff.

She has highly developed leadership skills and change management experience which were demonstrated most recently in leading the improvement to the Trust's infection control performance in 2009/10.

Carolyn was appointed Executive Nurse Director of the Foundation Trust on 1 February 2007 and was subsequently appointed Interim Chief Executive on the 1 December 2009 and Chief Executive on the 1 February 2010 for 12 months.

Jane Warder, Executive Director of Strategy and Improvement

Jane joined the board of directors in June 2007.

Her responsibilities include strategy, operations, improvement, business development and communications.

Passionate about improving patient experience Jane is the Trust lead for this aspect of quality

Initially trained as a nurse, Jane has had numerous roles to support organisations in improvement, including working cross organisationally, nationally, with boards, clinical teams and individuals. Jane has worked in the NHS for 25 years and has masters degrees in both organisational consulting and counselling practice.

Jane is influenced by a desire to really understand and appreciate what works well for patients and staff, to build on strengths as well as addressing areas for improvement.

Jane was appointed Chief Operating Officer from the 1 February 2010.

Lee Bond, Executive Director of Finance

Lee joined the Board of Directors in August 2007, and also leads the Trust's information, procurement and corporate development functions, the latter being responsible for the delivery and commissioning of the new hospital development.

Lee was previously Executive Director of Finance at Sheffield Children's Hospital NHS Foundation Trust and has worked in the NHS since 1993.

Lee is qualified with the chartered institute of management accountants (CIMA) and acts as the Trust's principal advisor on all financial matters.

Mike Mowbray, Executive Medical Director

Mike has been a Consultant Anaesthetist at King's Mill Hospital since July 1991 and was appointed Executive Medical Director to the Sherwood Forest Hospitals NHS Trust in June 2002.

He was subsequently appointed as Executive Medical Director of the Foundation Trust on 1 February 2007.

Since 2000, Mike has been a college advisor for the Royal College of Anaesthetists with a PASK certificate from the Association of Anaesthetists.

Mike has redesigned our consultant appointments process to ensure that we get the best candidates. He oversees job planning so that doctors work safely and productively. As Chair of the Clinical

Governance Committee he drives continuous improvement of clinical services and assures the Board on clinical quality.

While continuing to provide clinical care, the Executive Medical Director's role is to provide dynamic leadership of the Trust's medical profession, play a key part in developing policies and strategies, and offer a medical perspective on all matters to the Board of Directors.

Karen Fisher, Executive Director of Human Resources

Karen joined the Board of Directors as Executive Director of Human Resources on 14 April 2008.

Karen has worked in the NHS for almost 30 years and has significant experience in Human Resources, partnership working and change management. She held senior management positions at both Regional Health Authority and the acute sector.

Karen is a member of the Chartered Institute of Personnel and Development and holds an MSc in Leadership through Change HR Management.

Stuart Grasar, Non Executive Director

Stuart, who is a resident of Sutton-in-Ashfield joined the Board of Directors on 10 November 2008 and is a member of the Remuneration Committee.

Stuart is a Chartered Fellow of the Institute of Personnel and Development and was previously head of the Public Services Department at North Nottinghamshire College in Worksop.

He has also held board room appointments since 1984 with the Ilkeston Consumer Co-operative Society becoming chairman of the whole group from 2003 until 2006. His achievements include the development and motivation of people to move onto successful careers and his commercial experience has contributed to successful business trading.

Bonnie Jones, Non Executive Director

Bonnie joined the Board of Directors on the 1 February 2008 and was appointed Vice-Chairman in January 2009.

Bonnie is a member of the Audit Committee, the Remuneration Committee, Nominations Committee, the Investments Committee and chairs the Organ Donation Committee. She is the Non-Executive Director representative on the Trust's Infection Control Committee, and the lead safeguarding NED.

Bonnie was formerly an investigator with HM Customs & Excise specialising in common agricultural policy fraud. She represented the National Childbirth Trust at North Nottinghamshire Health Authority's Maternity Services Liaison Committee, and went on to be the lay member of Newark and Sherwood Primary Care Group.

Bonnie was subsequently appointed chair of Newark and Sherwood primary care Trust in 2000, where she spent six years. During this time the Trust developed as a lead commissioning organisation in Trent, working closely with the Trust.

Bonnie is currently an Executive Committee member of Newark and Sherwood Community and Voluntary Services (CVS) and a Non-Executive Director with the Nottinghamshire Probation Trust.

David Heathcote, Non Executive Director

David joined the Board of Directors on the 1 February 2008 and was appointed Senior Independent Director in November 2008.

David is a member of the Audit Committee, the Investments Committee and the Nominations Committee. He is also the Whistle blowing, and the equality and diversity lead Non-Executive Director.

David is a Chartered Certified Accountant and has worked as Chief Executive at a number of UK based companies. More recently David has concentrated his time working largely with Nottingham based companies, in the roles of Board Advisor and Non-Executive Director.

His achievements include the successful turnaround of companies and helping to develop and motivate people into roles carrying greater challenges and responsibilities.

David Leah, Non Executive Director
David joined the Sherwood Forest Hospitals NHS Trust on 1 November 2005, and was appointed to the Foundation Trust Board of Directors on 1 February 2007. David was subsequently reappointed for a further 3 year term on 1 November 2009. David is the Chair of the Audit Committee.

David is a Chartered Certified Accountant by profession and has worked for a variety of companies and industries. He was previously group Finance Director of one of the country's leading interior contracting groups, and his extensive commercial knowledge has enabled him to contribute to the establishment of successful business strategies.

David is now a director of a business support consultancy with a small portfolio of SME clients.

Iain Younger, Non Executive Director
Iain joined the Board of Directors on the 1 December 2009 and is a member of the Audit Committee and the Investments Committee. Iain is a member of the Institute of Directors, a former member of the Chartered Institute of Personnel Management, and a former Fellow of the Institute of Leadership and Management, of which he was a founding member.

From an initial background in Human Resources, Iain has been a board member of a number of FTSE Companies and Charitable organisations, and has wide experience in the development of strategic and business plans, including mergers and acquisitions, for a number of large private and public sector concerns. Iain also brings considerable experience as a Non-Executive Director, having held appointments within the business, education, and voluntary sectors.

Composition of the Board of Directors

The Board of Directors met monthly (except for August) during the year with an additional public Board meeting each quarter. Extra-ordinary meetings were held in June 2009, October 2009 and in March 2010.

Attendance at Board of Director meetings during 2009/10 was as follows:

Director	30/4	28/5	05/6 Extra	25/6	30/7	24/9	29/10 Extra	05/11	26/11	17/12	28/01	25/02	16/03 Extra	25/03
Tracy Doucét	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
David Leah	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Stephen Pearson (to 31/12/10)	Y	Y	Y	Y	N	Y	N	N	Y	Y	N/A	N/A	N/A	N/A
Bonnie Jones	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
David Heathcote	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Stuart Grasar	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Iain Younger (from 1/12/09)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y	Y	N	Y
Jeffrey Worrall (to 30/11/09)	Y	Y	N	Y	Y	Y	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A
Lee Bond	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Carolyn White	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mike Mowbray	Y	N	N	Y	N	Y	N	Y	Y	Y	Y	Y	N	Y
Jane Warder	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Karen Fisher	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

The four sub-committees of the Board of Directors during the year were:

- Audit Committee
- Remuneration Committee
- Nominations Committee
- Investments Committee

The membership and role of each of these committees at the 31st March 2010 is summarised below.

Audit Committee Membership

David Leah – Chairman, Non Executive Director
David Heathcote - Non Executive Director
Bonnie Jones - Non Executive Director
Iain Younger - Non Executive Director

Role & Responsibilities of the Audit Committee

The Audit Committee is a committee of the Board of Directors and supports the Board of Directors in ensuring that effective internal control arrangements are in place across the Trust. The Audit Committee is also the governance committee.

The Audit Committee comprises of four independent Non-Executive Directors and provides an independent check on the executive arm of the Board of Directors. The Audit Committee provides assurance to the Board of Directors on a wide spectrum of control issues, and in recent years has

widened its scope to include other areas of governance, in addition to financial controls. The Audit Committee reviewed its terms of reference during the year to ensure that the systems of control for clinical governance and information governance in particular were robust.

The Audit Committee receives reports on all systems of control including operational management issues and risks. It also considers the controls and assurances that underpin the Statement of Internal Control (SIC) included in the annual report and accounts and the declaration of compliance with the Healthcare Commission's standards for better health. It also reviews the adequacy of the Trust's assurance framework.

The Audit Committee met on five occasions during 2009/10 and focused on specific items identified in its annual work plan. The Non-Executive Directors met in private with the Trust's auditors in January 2010. An assessment of the Audit Committee's effectiveness in 2009/10 was carried out and a work plan to address any issues identified was agreed.

Members' attendance at Audit Committee meetings during 2009/10 was as follows

Member	**21/04/09**	**05/06/09**	**21/07/09**	**20/10/09**	**21/01/10**
David Leah	Y	Y	Y	Y	Y
David Heathcote	N	Y	Y	Y	Y
Bonnie Jones	N/A	N/A	N/A	Y	Y
Iain Younger	N/A	N/A	N/A	N/A	Y

Remuneration committee

Tracy Doucét - Chairman
Bonnie Jones - Non Executive Director
Stuart Grasar - Non Executive Director

Role & Responsibilities of the Remuneration Committee

The primary role of the remuneration committee is to establish a formal and transparent procedure for setting remuneration and contractual terms and conditions for all Executive Directors, this includes pension rights, termination of employment, arrangements for termination of employment and other non-contractual terms.

The Remuneration Committee met five times in 2009/10. The principal focus of the Remuneration Committee is the agreement of remuneration for Executive Directors. The Remuneration Committee membership consists of Non-Executive Directors.

Member	**9/07/09**	**15/10/09**	**26/11/09**	**17/12/09**	**14/01/10**
Tracy Doucét	Y	Y	Y	Y	Y
Stuart Grasar	Y	Y	Y	Y	Y
Bonnie Jones	N	Y	Y	Y	Y

Nominations Committee Membership

Tracy Doucét - Chairman
David Heathcote – Non Executive Director
Bonnie Jones – Non Executive Director
Carolyn White – Chief Executive

Role & Responsibility of the Nominations Committee

The Nomination Committee acts on behalf of the Board of Directors to ensure that there is a formal, rigorous and transparent procedure for the appointment of new members to the Foundation Trust Board of Directors and ensure that systems and processes are in place for the development of existing members.

Specifically the Nominations Committee:

- Leads the process for nominations of Executive Directors.
- Regularly reviews the structure, size, and composition of the Board of Directors and makes recommendations regarding the skills, knowledge and experience of directors.
- Leads succession planning/talent management activities at Board of Director level.
- Advises the Board of Governors on the appointment of Non-Executive Directors and the Chairman.
- Ensures that appropriate appraisal mechanisms are in place to review the performance and support the development of Executive and Non Executive members of the Board of Directors.
- Makes recommendations to the Board of Directors regarding the membership of its committees.

The Nominations Committee met three times in 2009/10.

Members' attendance at Nominations Committee meetings was as follows:

Member	**11/08/09**	**10/11/09**	**14/01/10**
Tracy Doucét	Y	Y	Y
David Heathcote	Y	Y	Y
Bonnie Jones	Y	Y	Y
Carolyn White	N/A	N/A	N/A

Investments Committee Membership

Tracy Doucét - Chairman
David Heathcote - Non Executive Director
Bonnie Jones - Non Executive Director
Iain Younger - Non Executive Director
Carolyn White – Chief Executive
Lee Bond – Executive Director of Finance
Jane Warder – Executive Director of Strategy & Improvement

Code of Governance

The Foundation Trust Code of Governance (the Code) was published by Monitor in October 2006, with the intention of assisting Boards of NHS Foundation Trusts to improve their governance arrangements.

The Code also includes a number of ***Main & Supporting Principles*** and ***Provisions*** and we are required to publish a two-part statement in the Annual Report. The first part confirms how we have applied the main and supporting principles of the Code. The second part confirms if we comply with the provisions of the Code. If we do not comply, we must provide an explanation.

Part 1 – Main and supporting principles of the Code of Governance (the Code)

A. Directors

The Trust accepts the principles described within the Code in relation to its Directors. It is confident that the Trust is led by an effective Board of Directors, and that there is a clear division of responsibilities between the Chairman and the Chief Executive. The respective roles of the Boards of Directors and Governors are detailed in the Trust's Constitution, Standing Orders and in the Scheme of Delegation.

The Trust's Standing Orders, Standing Financial Instructions and, in particular, the Scheme of Delegation, detail the types of decisions that have been delegated to the Chief Executive and other staff by the Board of Directors, as well as those powers that have been reserved. The Scheme of Delegation was reviewed and amended during 2009/10. The Chief Executive is the Accounting Officer for the Foundation Trust.

The composition of the Board was reviewed prior to the appointment of Iain Younger on 1st December 2009, who provides additional commercial skills and FTSE Board experience identified in that review.

The Board of Directors is confident that its composition was appropriate to face the challenges of healthcare locally and during 2009/10 and the Nominations Committee reviewed the composition of the Board of Directors, its collective skills and expertise. This work will continue during 2010/11 to ensure that the Board of Director's governance arrangements continue to support the Trust meet its statutory obligations.

All of our Non-Executive Directors were determined as being independent. All Non-Executive Directors are appointed for terms of 3 years and their conditions of appointment including termination provisions are agreed by the Board of Governors and contained in a letter of appointment. The removal of a Non-Executive Director requires the approval of three-quarters of the members of the Board of Governors.

A register of Directors' interests is maintained by Mike Tasker, Company Secretary, at the Trust's headquarters.

Currently all directors can exercise one full vote, with the Chairman having a casting vote – the only circumstances when this would not be achieved would be if a director post was filled through job-sharing arrangements when in accordance with the constitution, the parties to the job share would exercise one 'collective' vote.

B. Governors

The Trust has accepted the principles described within the Code in relation to its Governors and has established a Board of Governors in accordance with the 2006 Act.

The Board of Governors has met on 5 occasions during 2009/10 and has adopted the Trust's key governance documents. A Code of Conduct for Governors has been issued to all Governors. The

Board of Governors has established a number of committees in order to meet its responsibilities and ensure that it focuses on issues of importance to members of the Trust.

During the year, the Chairman and Company Secretary led a review of governor's performance in light of updated guidance published by Monitor – 'Guide for Governor's - Your statutory Duties'. This review highlighted a small number of further improvements which were implemented during 2009/10. The Board of Governors also appointed a lead Governor in October 2009.

C. Appointments and Terms of Office

The Trust has applied the principles of the Code relating to appointment of Directors and their terms of office, and accepts that there should be a formal, rigorous and transparent procedure for the appointment or election of new Directors.

A Nominations Committee, chaired by the Chairman, has been established and has reviewed the structure, size and composition of the Board of Directors. The nominations committee is involved in reviewing the job specifications for all Executive and Non-Executive Director vacancies on the Board of Directors.

The Trust has established a separate Board of Governors nominations committee for the appointment of Non-Executive Directors chaired by the Trust Chairman or by the Trust's Lead Governor for the appointment of the Chairman or when conflicts of interest arise.

D. Information Development and Evaluation

During 2009/10, both the Board of Directors and the Board of Governors received information in a timely manner to enable them to discharge their respective duties.

During the year, performance evaluation and appraisals were undertaken for each member of the Board of Directors. The Chairman's performance was assessed through 360^0 appraisal led by the Senior Independent Director and Lead Governor and was reported to the Board of Governors. The Chairman subsequently conducted individual appraisals of the Chief Executive and Non-Executive Directors. The Chief Executive conducted appraisals for Executive Directors with input and discussion with the Chairman.

In addition to individual performance reviews, in December 2009, the Board of Directors used a Board diagnostic assessment to further review their collective performance and effectiveness with the support of the NHS Institute.

Assessment of the effectiveness of the Board of Directors committees, including Audit Committee was undertaken during 2009/10. The assessment process will be used again in 2010/11 and consideration will be given to further developing self assessment and external assessment mechanisms.

Directors and Governors joining the two Boards received induction and ongoing training.

Developmental sessions for directors and Governors and a joint session for Governors and directors have been held during the year. Action plans to address further developmental needs identified from these sessions have been agreed and implemented.

E. Director Remuneration

The Board of Directors and the Board of Governors accept that levels of remuneration for Directors should be sufficient to attract, retain and motivate people of a high calibre, without paying more than is necessary.

The Remuneration Committee reviewed levels of Executive Directors' pay in 2009/10 and the Board of Governors considered the remuneration of the Chair and Non-Executive Directors in April 2009.

F. Accountability and Audit

The Board of Directors accepts its responsibility to present a balanced and understandable assessment of its performance and endeavours to do this in all of its public statements and reports to regulators and inspectors.

With regard to internal control, the Board of Directors is assured through the Audit Committee that the Trust's systems are sound and that these safeguard public and private investment.

The Trust's external auditors KPMG, were appointed in November 2007, and an assessment of their work was considered by the Board of Governors in July 2009.

G. Dialogue with Stakeholders

The Board of Directors recognises the need to consult with, and involve members, patients, clients and the local community, regarding its plans and acknowledges the complementary role played by Governors in this responsibility.

A number of formal and informal opportunities for interaction between the two Boards have been created, including a joint developmental session in January 2010, specifically designed to consider the Trust's Annual Plan for 2010/11. In addition, Directors regularly attend Board of Governor meetings and meetings of its committees, and the Lead Governor and a Public Governor routinely attend public and confidential meetings of the Board of Directors.

Part 2 – Compliance with the Provisions of the Code of Governance (the Code)

The following section highlights those areas where the Board of Directors feels that compliance had not been fully achieved, together with an explanation for this assessment.

Principle A3 - Following Stephen Pearson's resignation at the end of his term of office on 31st December 2009, the Board have not yet successfully filled the vacancy for an additional non-executive director. We did not therefore have the majority of independent Non-Executive Directors required under our constitution during the period 1st January – 31st March 2010.

Section B.1.7 – The Constitution and Standing Orders for the Board of Directors provide mechanisms for the Board of Governors to raise concerns as described within the Code through the Senior Independent Director, however, a formal policy for raising concerns has not been established over and above these agreed mechanisms.

Section C.2.1 – The Remuneration Committee on behalf of the Board of Directors has previously considered the principle of the re-appointment of the Chief Executive and Executive Directors on a 5 yearly basis, but has considered that the contracts offered to the Chief Executive and Executive Directors included sufficient powers to address any areas of concern regarding performance without the time limit suggested.

Section G 2.1 – A schedule of specific third party bodies has not been developed over and above those detailed in Appendix E to the Compliance Framework.

Board of Governors

The Trust's first Board of Governors was formally established in February 2007 following our authorisation as an NHS Foundation Trust. We held our second round of elections during October/November/December 2009/10.

The composition of the Board of Governor's includes:
Public Governors (20) - representing the constituencies of Ashfield, Mansfield, Derbyshire and Newark & Sherwood all of whom are publicly elected by our members, in accordance with the Trust's election rules.

Staff Governors (9) - representing King's Mill Hospital and Newark Hospital staff and volunteers, all of whom are elected by our staff and volunteers constituencies.

Appointed Governors (7) – appointed by our stakeholders and representing Ashfield, Mansfield and Newark & Sherwood District Councils, Nottinghamshire County Council, NHS Nottinghamshire PCT, West Nottinghamshire College and the University of Nottingham.

The role and responsibilities of Governors include:

- The appointment of the Chairman and Non-Executive Directors (with the Chairman) and the setting of their terms and conditions of service;
- The appointment of the Trust's auditor;
- To comment on the Trust's forward plans;
- To consider and to provide comments on the Annual Plan;
- To receive the Annual Report and Accounts;
- To provide views on the Trust's strategic direction;
- The development of membership;
- To represent the interests of members;
- Holding the Board of Directors to account in relation to the authorisation.

All meetings of the Board of Governors are public meetings and in 2009/10, 5 meetings were held, including three meetings held in the Mansfield constituency, one in the Newark and Sherwood constituency and one in the Derbyshire constituency.

The Governors continued to represent the interests of their members in the development of the Foundation Trust and the local health community. During 2009/10 Governors were closely involved in proposals to establish a radiotherapy service for people from North Nottinghamshire and contributed to the Newark Strategy consultation process that was launched by NHS Nottinghamshire County in late 2009.

The Board of Directors ensured that Governors were able to become involved in our annual planning process and a joint development session for Governors and Directors was held in January 2010 when Governors had the opportunity to comment on proposed developments for the coming year.

The Board of Governors was also involved in the process for assessing evidence for the Trust's compliance with the Healthcare Commission's Standards for Better Health.

We have provided many opportunities during 2009/10 for members to meet their Governors first hand.

A number of member events were held focusing on issues that our members had indicated were their priority areas of interest. We have arranged events on diabetes, prostate cancer, infection prevention and control, incontinence, bowel cancer and the new hospital build. Members attending these events have been encouraged to meet their Governors and to share views on the services we provide.

We also held constituency meetings in the year and will be using the experiences of these to fashion our governor/member engagement activities for 2010/11.

The Board of Governor's appointments Committee which oversees the appointment, remuneration and appraisal of Non-Executive Director's also reviewed the expenses policy during 2009/10, and concluded that Non-Executive Director's should continue to receive expenses and allowances in accordance with the rates agreed by the NHS Appointments Commission. During the year, the chairman voluntarily published her expenses to ensure transparency.

During the previous year, the Chairman led the Board of Governors in reviewing its committee structure resulting in a number of changes and the establishment of the following committees:

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

The role of a governor is unpaid, although Governors can claim expenses for their work. The rates paid to Governors in 2009/10 were in line with those paid to other service user representatives at the Trust and across the county. A register of Governors' interests is maintained by the Trust and information regarding this can be obtained by contacting Mike Tasker, Company Secretary, at the Trust's headquarters.

Composition & Attendance of Governor's at 31st March 2010

Governor	Constituency	Elected or Appointed	Attendance of 5
Eve Booker	Ashfield	E	5
Mary Wilde	Ashfield	E	4
Beryl Perrin	Ashfield	E	5
Jennifer Doohan (to 1.9.09)	Ashfield	E	2
Richard Webster	Ashfield	E	3
Patricia Lee	Ashfield	E	5
Yvette Price-Mear	Mansfield	E	5
Christine Bacon (to 31.1.10)	Mansfield	E	4
Davina Fordom	Mansfield	E	3
Geoff Stafford	Mansfield	E	5
John Marsh	Mansfield	E	4
Hilda Tagg	Newark & Sherwood	E	3
Margaret Ralls	Newark & Sherwood	E	4
Geoff Seymour (to 31.1.10)	Newark & Sherwood	E	3
Enid Clarke (to 31.1.10)	Newark & Sherwood	E	5
Adrian Hartley (to 11.5.9)	Newark & Sherwood	E	1
Graham Tomlinson (to 31.110)	Newark & Sherwood	E	1
Dorothy Platts	Derbyshire	E	5
Walter Satterthwaite	Derbyshire	E	5
Nigel Mellors	Staff – King's Mill Hospital	E	5
Janice Matthews (to 31.1.10)	Staff – King's Mill Hospital	E	4
Kay Orgill (to 31.1.10)	Staff – King's Mill Hospital	E	5
Clive Gie (to 31.1.10)	Staff – King's Mill Hospital	E	3
John Wood (to 31.1.10)	Staff - King's Mill Hospital	E	5
Bucky Oladeinde (to 31.1.10)	Staff – Newark Hospital	E	4
Larry Khongwir (to 31.1.10)	Staff – Newark Hospital	E	2
Peter Gradwell (to 31 1.10)	Staff – Volunteers	E	4
Elaine Wilson (to 31 .1.10)	Staff – Volunteers	E	3
Barry Answer	Mansfield District Council	A	3
Mark Avis	Nottingham University	A	3
Mick Parker	Ashfield District Council	A	4
David Payne	Newark Sherwood District Council	A	4
Amanda Sullivan	NHS Nottinghamshire County	A	5
Patricia Harman	West Notts. College	A	4
Vickie Minion	Nottinghamshire County Council	A	2

A number of new Governors were elected to the Board of Governors following elections in 2009/10. These Governors joined the Board of Governors on the 1 February 2010. There were no formal meetings of the Board of Governors between the 1 February 2010 and the 31 March 2010.

Governor	Constituency	Elected or Appointed
Craig Gunton-Day	Ashfield	E
Christine Smith	Mansfield	E
Jim Barrie	Newark & Sherwood	E
Elaine Ellison	Newark & Sherwood	E
Patricia Richards	Newark & Sherwood	E
Frank Shields	Newark & Sherwood	E
Alison Beal	Staff – King's Mill Hospital	E
Alison Whitham	Staff – King's Mill Hospital	E
Simon Beshir	Staff – King's Mill Hospital	E
Sharon McAllister	Staff - King's Mill Hospital	E
Ron Tansley	Staff – Volunteers King's Mill Hospital	E
Nicola Juden	Staff – Volunteers Newark Hospital	E
Alison Luke	Staff – Newark Hospital	E
Angie Emmott	Staff – Newark Hospital	E

The Board of Directors recognises the need to seek Governors' views on developments at the Trust and to gain an understanding of members' aspirations and concerns. As a result, the Board of Directors has taken the following steps to engage with Governors:

- Directors, including Non-Executive Directors, have been invited to all Board of Governor meetings and have attended these regularly;
- Directors, including Non-Executive Directors, have attended Governors' induction meetings and developmental sessions;
- A joint event to discuss the Annual Plan was held in January 2010. This enabled all directors and Governors to meet and exchange views;
- Governors have been invited to and have attended Board of Directors meetings;
- Designated Non-Executive Directors attend Board of Governor committee meetings in order to assist with the committees' work.

Directors are encouraged to attend Board of Governor meetings and during 2009/10 the following attendance was recorded

Director	Position	Attendance out of 5
Tracy Doucét	Chairman	5
Bonnie Jones	Vice-chairman	3
Stuart Grasar	Non-executive director	5
David Heathcote	Non-executive director & SID	5
David Leah	Non-executive director	5
Iain Younger (from 1/12/09)	Non-executive director	1
Jeffrey Worrall	Chief Executive (to 30/11/09)	2
Jane Warder	Executive director, Strategy and improvement	5
Karen Fisher	Executive director, human resources	4
Lee Bond	Executive director, finance	3
Carolyn White	Executive nurse director (to 30/11/09) Chief Executive (from 1/12/09)	3
Mike Mowbray	Executive Medical Director	0

As an NHS Foundation Trust, the Board of Governors is responsible for the appointment of the Trust's external auditor, and a competitive procurement process was undertaken during 2007/08, following authorisation. This process resulted in the appointment of KPMG as the Trust's external auditors in November 2007 for an initial period of 3 years subject to annual evaluation. The contract can be extended by the Trust for a further 2 years.

Our Foundation Trust Membership

The Trust has four public constituencies and a staff constituency, consisting of four classes.

Public constituencies

Ashfield Constituency – including the geographic boundaries of Ashfield District Council and the Wards of Ravenshead and Newstead, from Gedling District Council.

Derbyshire Constituency – including Wards from Bolsover District Council and North East Derbyshire District Council.

Mansfield Constituency - including the geographic boundaries of Mansfield District Council and the Ward of Welbeck from Bassetlaw District Council.

Newark & Sherwood Constituency – including the geographic boundaries of Newark & Sherwood District Council plus Wards from Bassetlaw District Council, South Kesteven District Council and Rushcliffe District Council.

As well as residing within the geographic boundaries described above, members must be aged 16 years of age and over and meet other eligibility criteria as described in the Trust's Constitution.

At the 31 March 2010, the Trust had 19,016 public members and 911 affiliate members.

In order to ensure that our public membership is representative of those eligible to become members, we analysed the membership and compared it to the make-up of our catchment population.

The percentages of people living in the catchment areas of our four public constituencies are approximately as follows:

Ashfield - 28.5%
Derbyshire - 15.5%
Mansfield - 24.0%
Newark & Sherwood - 32.0%

As at the 31 March 2010 the percentages of members living in our four constituencies was approximately:

Ashfield – 28.7%
Derbyshire – 11.6%
Mansfield – 32.8%
Newark & Sherwood – 26.9%

We have also analysed other aspects of our public membership, against our catchment population.

- 6.3% of our catchment population is aged 16-21, and 74% is aged 22 years plus. In our public membership, 4.19% are aged 16-21, and 88.3% are aged over 22.

- 49.1% of our catchment population are males and 50.9% females. In our membership, 39.1% are males and 60.2% are females. 0.7% of our members have not confirmed their gender.

The Trust's Membership and Engagement Manager has played a significant part in driving forward membership by recruiting more members and enhancing our engagement programme. The profile of the membership has increased across the Trust and the community with the Board of Governors being heavily involved in the recruitment and engagement of the members in 2009/10.

During the year, the principal means of membership recruitment was through face to face contact at local events, community and voluntary groups and within the Trust. We have targeted all areas in our catchment area with a particular focus on those groups who are under-represented.

We will continue to use targeted recruitment methods to ensure that our public membership is representative of those eligible to join.

Staff constituency

The staff constituency is divided into 4 Classes – King's Mill Hospital, Newark Hospital, and Volunteers at King's Mill Hospital and at Newark Hospital. The Board of Governors recommended that the volunteer class of the staff constituency be separated into 2 separate classes during 2009/10, ahead of the elections for the new Board of Governors from February 2010.

During the year the Mansfield Community Hospital class of the staff constituency was abolished following the transfer of services to King's Mill Hospital. The Board of Governors recommended that the King's Mill Hospital class should not be increased as a result of this action.

We also encourage membership from organisations that work with or on behalf of the Trust, including our PFI partners.

Engagement with members

Engagement with our members is extremely important and we are constantly improving and increasing its level. There is evidence of an increase in the number of members responding to surveys and in attending member events and engagement is monitored regularly by the Membership and Engagement Committee of the Board of Governors, where innovative methods of engagement are discussed.

During 2009/10 representatives from the Trust, including Governors, attended a number of meetings of local community groups to highlight the work of Governors, and we held further staff and public constituency meetings.

Our member magazine 'Acorns' is published quarterly and has continued to receive excellent feedback from our members. Its size and content has increased significantly due to its popularity, and contains more information from Governors for members.

We also arranged further events during the year to include subjects that are of interest to members and to give members the opportunity to pass on their views to Governors. Events during 2009/10 included Diabetes, Prostate Cancer, Incontinence, Infection Prevention and Control, Bowel Cancer and the new hospital build. The member events have been very successful and well attended. These will continue in 2010/11.

Our public membership continued to grow during 2009/10 and increased by 14% from 16,713 at the end of March 2009 to 19,016 at the end of March 2010.

The Membership and Engagement Manager and the Membership and Engagement Sub-Committee of the Board of Governors analyses the membership on a monthly basis to ensure that it is representative of the local community and that the recruiting activities are targeting those groups who are under-represented.

There are a number of ways in which members can contact their Governors or Directors, in addition to the members meetings, or constituency meetings already described. For example, the Trust has set up an E-mail address and a direct telephone number for members. In addition, all Governors and Directors can be contacted through Mike Tasker, Company Secretary, at King's Mill Hospital.

Membership	Public Members at 31/03/10	2009/10 %	Public Members at 31/03/09	2008/09 %
Age				
0-16 years	112	0.59%	44	0.26%
17-22 years	680	3.6%	406	2.43%
22+	16,792	88.3%	15,025	89.9%
Unknown	1,432	7.51%	1,238	7.4%
Ethnicity				
White	17,584	92.5%	15,505	92.7%
Mixed	28	0.15%	23	0.14%
Asian or Asian British	98	0.52%	81	0.48%
Black or Black British	47	0.25%	40	0.24%
Other	12	0.06%	11	0.07%
Unknown	1,247	6.52%	1,053	6.3%
Gender				
Male	7,440	39.1%	6,710	40.15%
Female	11,441	60.2%	9,990	59.77%
Trans-gender	0	0%	0	0%
Unknown	135	0.7%	13	0.08%
Recorded Disability	2,460	12.9%	2,440	14.6%

A summary of the membership size in 2009/10 in comparison to 2008/09 is illustrated in the table above.

It was evident from the membership analysis at the end of 2009/10 that there were groups of the local population that were either under or over represented within the membership body:-

Age

The 0-16 year old age group is under-represented by 0.71% and the 17-21 year old age group is under-represented by 1.4%. This is an improvement from last year's analysis of both age groups due to the effort that has been made to recruit young members.

The 22+year old age group is over-represented by 14.3%. There were also 1,432 members (7.51%) who did not state their age on the membership form. The Trust has worked hard during 2009/10 to ensure that age was captured on the registration forms, particularly when recruiting face to face.

Ethnicity

The vast majority of the Trust's catchment area is comprised of a local population that fall into the white ethnic category (98.7%). However, analysis shows that the largest area of under-representation is in the white ethnic category (-6.2%). This is partly due to the 1,247 members on the register that have not stated their ethnicity.

As with age, the Trust has encouraged new members to provide this information. Within our membership we also have 2,460 public members that have expressed that they consider themselves to have a disability.

Gender

There was a slight imbalance within our membership relating to gender and the population profile at the end of 2009/10. As stated previously, a large amount of effort had been made to recruit males including targeting patients in clinics specifically for men. Work will continue in 2010/11 and the Trust will look at other ways of recruiting men.

Future membership recruitment and engagement

While the Trust was satisfied that its membership was broadly representative of its local population at the end of 2009/10, actions will be taken during 2010/11 to increase membership numbers and ensure that it is representative of the local population.

In 2010/11 there will be focus on the recruitment of:

- Young people
- Males
- Derbyshire and Newark and Sherwood constituencies
- Socio-economic group D

We will also improve and increase the level of engagement with our members – both public and staff. There are an encouraging and growing number of members attending member events and it is hoped that there will be a further increase in the number of members attending this year's Annual Members' Meeting.

ANNUAL ACCOUNTS & FINANCIAL STATEMENTS FOR THE PERIOD ENDING 31ST MARCH 2010

Independent Auditors Report

Auditors' Report to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006. These comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash flow Statement, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust("the Trust"), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to it 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 Trust and the Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

The Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor. Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year ended 31 March 2010

We review whether the statement on internal control on pages reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Annual Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read the information contained in the Annual Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Basis of audit opinion

We conducted our audit in accordance with the National Health Service Act 2006 and the Code of Audit Practice issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion the financial statements give a true and fair view of the state of affairs of Sherwood Forest Hospitals NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

Trevor Rees

Partner

KPMG LLP

St James' Square

Manchester

M2 6DS

3 June 2010

KPMG

Independent Auditor's Report to the Board of Directors of Sherwood Forest Hospitals NHS Foundation Trust on the NHS Foundation Trust Summarisation Schedules

We have examined the NHS Foundation Trust Consolidation Schedules (iFTCS) numbered iFTC 1 to iFTC 38 of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2010, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 to the National Health Service Act 2006 and for no other purpose.

In our opinion these summarisation schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion.

Trevor Rees
Partner
St James' Square
Manchester
M2 6DS

3 June 2010

Statement of the Chief Executives Responsibilities as the Accounting Officer

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of 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 Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the 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 Financial 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

• prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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 Accounting Officer Memorandum*.

Signed _____ **Date: 3 June 2010**
Carolyn White
Chief Executive

FTC SUMMARISATION SCHEDULES FOR THE SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Executive Director of Finance Certificate

1. I certify that the attached FTC schedules have been compiled and are in accordance with:

   - The financial records maintained by the NHS Foundation Trust; and
   - Accounting standards and policies which comply with the *NHS Foundation Trust Annual Reporting Manual* 2009/10 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

2. I certify that the FTC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the FTC schedules is consistent with the financial statements of the NHS Foundation Trust.

Lee Bond
Executive Director of Finance
3rd June 2010

Chief Executive Certificate

1. I acknowledge the attached FTC schedules, which have been prepared and certified by the Executive Director of Finance, as the FTC schedules which the NHS Foundation Trust is required to submit to Monitor, the Independent Regulator of NHS Foundation Trusts.

2. I have reviewed the schedules and agree the statements made by the Executive Director of Finance above.

Carolyn White
Chief Executive
3rd June 2010

Executive Director of Finance Report

Overview

Against a backdrop of improving patient services, notably through the provision of new facilities and increased access to services, it is very pleasing to report that the Trust has met its financial targets in year delivering a surplus of £4.183m, before a technical adjustment for impairment of fixed assets totalling £48.185m, which gave an overall loss of £44.02m.

Monitors' key financial performance indicators for the full year show achievement of an overall rating of 3.8 (4) as detailed below:

Key Performance Indicators

		Annual Plan		Outturn	
Financial Metrics	**Weight**	**Value**	**Rating**	**Value**	**Rating**
EBITDA Margin %	25.0%	10.0%	4	9.9%	4
EBITDA % Plan Achieved	10.0%	100.0%	5	98.0%	4
Return on Assets %	20.0%	7.6%	5	11.4%	5
Income and Expenditure Surplus Margin %	20.0%	1.5%	3	1.8%	3
Liquid Ratio –Days	25.0%	21.4	3	16.9	3
Weighted Average			3.9		3.8

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 information available about the future prospects of the Trust and also covers Financial, Governance and Mandatory Service risks.

A detailed paper covering all these risks and the opinion drawn thereon was approved by the Audit Committee on the 20th April 2010, and is available separately on request. The review concluded that the Foundation Trust is a Going Concern, and has taken steps to ensure this remains the case for at least the next 12 months.

The Trust has adopted International Financial Reporting Standards, and 2009/10 will be the first year the accounts are presented in this format.

Statement of Comprehensive Income (Income and Expenditure)

Total income for the year was £235.9m (£218.9m in 2008/9) representing a growth of 7.8%. This growth included additional funding for inflationary pressures, growth in the unitary charge payable as part of the PFI contract as new buildings are brought on stream, an increase in emergency activities, and continued delivery of the 18 week referral to treatment targets.

Overall 2009/10 was a difficult year financially with marked fluctuations in income and expenditure throughout the year. The Trust was only partially successful in year in its effort to reduce costs and improve productivity. Cost control was particularly difficult in clinical areas with significant numbers of vacancies leading to increased costs. Achievement of the overall financial plan was therefore reliant on unplanned overtrading, particularly in out-patients and emergency activity, and through the receipt of non recurrent income.

As a result of this, the productivity and efficiency challenge for 2010/11 is increased yet further as the organisation looks to ensure that its underlying financial strength is maintained. Delivery of this agenda is critical within the 2010/11 financial plan.

Statement of Financial Position (Balance Sheet)

During 2009/10 the Foundation Trust invested significantly in its fixed asset infrastructure £11.6m (£11.8m in 2008/9). This includes £3.8m on upgrading or acquiring new equipment essential for the day-to-day operation of the Trust, £0.8m on improvements in information systems and technology in conjunction with the North Nottinghamshire Health Community, £7m on building works, and additions of £84.2m were recognised within the balance sheet to account for the new hospital funded via a Private Finance Initiative (PFI).

Due to the adoption of IFRS, the PFI scheme has been brought on balance sheet. This has had a significant adverse impact on the balance sheet and net assets due to the associated financing arrangements and losses recognised within the accounts on valuation of the assets as they have been brought into use.

As a Foundation Trust we benefit from increased flexibility and the ability to carry larger cash balances forward into future years. The closing cash balance at 31 March 2010 was £33.3m. This has reduced slightly from £36.6m at 31 March 2009 due to continuing capital commitments, repayment of PFI financing and movements on working capital.

Charitable Funds

During the financial year we received donations and legacies to our charitable funds of £724k (£357k in 2008/9), which included legacies of £8k (£105k in 2008/9) and a donation for £500k relating to Endoscopy redevelopment at Newark Hospital. (a further £500k is expected in 2010/11 for this same purpose).

The generosity of all those who made a donation or raised funds on behalf of our charitable funds is very much appreciated.

The Trustees were able to make grants totalling £458k (£344k in 2008/9) to support the activities of the Trust and for the welfare of patients and staff.

Outlook

As we move into 2010/11 we move ever nearer to the completion of the £393m redevelopment of Kings Mill Hospital and Mansfield Hospitals, together with significant refurbishment and upgrade works at Newark Hospital. (£367m relating to Kings Mill and Newark Hospitals).

The redevelopment is phased and the Trust has already benefited from the refurbishment of the Newark site, opening of the King's Treatment Centre and two of the three inpatient towers. The remainder of the scheme is scheduled for completion in 2011.

As reported in 2008/9, the redevelopment will enable the Trust to operate more efficiently and will bring many benefits to our patients. In particular:

- Ward accommodation will be in line with the latest standards with increased bed spaces comprising 50% single rooms and 50% in 4 bed bays.
- Rationalisation of service locations will bring to an end inefficiencies caused by services being scattered across sites.
- Dedicated Kings Treatment Centre, bringing together outpatient, diagnostic and day case facilities together in an efficient patient focussed manner.
- State of the art pathology laboratory, obtaining the efficiency benefits of technology.

The service and financial plans we have developed to improve our productivity mirror closely the development of the new facilities. These plans continue to be refined such that we are able to benefit fully from the new hospital developments outlined above.

The global economic outlook presents a period of significant challenge for the Trust in terms of the facilities we have available to provide patient care and the regulatory regime under which we operate. the Trusts future financial plans take account of known risk factors including forecast activity and demand management changes. They also take account of the wider economic downturn when considering cost and the likelihood of zero income inflation. The plans also identify the productivity and efficiency challenge faced by the Trust throughout the period. This detailed planning work has enabled the Trust to construct plans which mitigate against known risks as far as possible over the next 3 year period.

Significant risks to the Trust include:

- A significant cost reduction strategy recognising that the period of unprecedented growth in income enjoyed over recent years is unlikely to continue and pressures on the cost base, notably arising from the new hospital development, will require careful management. This remains a key risk within the future financial plans in ensuring the delivery of the productivity/efficiency agenda whilst simultaneously meeting statutory targets and maintaining strenuous quality standards. The financial plan has been constructed to reflect these parameters as far as possible, the remaining work being the finalisation of robust programmes to deliver the required productivity and efficiency gains.

- Income adjustments have been made taking account of projected demographic changes, practice based commissioner intentions and a number of demand management schemes which are being introduced in-year in primary care which are designed to limit demand for secondary care services. The risk to the Trust here lies in our ability to reduce costs in line with any income reductions that these development in primary care may bring.

- Adverse operating risks, particularly in the form of service migration to primary care under the supervision of the local practice based commissioning clusters do exist. The Trust is in continual dialogue with the PCT and with the clusters over this risk and the 2010/11 financial plan makes allowance for service changes led by the clusters in chronic obstructive pulmonary disease (COPD), rheumatology, diabetes, and dermatology.

- A more diverse market for healthcare, with independent sector providers, practice based commissioning and potential competition from neighbouring Foundation Trusts all competing for market share.

- The Trust will continue to work hard in securing positive working relationships within the local health economy, in order to ensure seamless healthcare delivery for the local population.

- Detailed activity volumes have been agreed and contracted for in 2010/11.

The Trust faces this period of significant change with a positive attitude and looks forward to being able to further improve the services we provide to patients.

A full set of audited accounts is attached at Appendix 1.

Lee Bond

Executive Director of Finance

3 June 2010

FOREWORD TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2010

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Sherwood Forest Hospital NHS Foundation Trust is required to "keep accounts in such form as Monitor (The Independent Regulator for NHS Foundation Trusts) may with the approval of Treasury direct" (paragraph 25(1), Schedule 7 to the National Health Service Act 2006 ('the 2006 Act'). The Trust is required to "prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Treasury direct" (paragraphs 24 and 25, Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by Monitor, with the approval of the Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts.

The previous accounts were for year ended 31 March 2009

Signed: 

Chief Executive

Name: Carolyn White

Date: 3 June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Note	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Operating income	*B1*	235,876	218,908
Operating expenses	*B5*	(269,930)	(246,031)
Operating surplus (deficit)		**(34,054)**	**(27,123)**
Finance Costs			
Finance income	*B12*	303	1,329
Finance expense – financial liabilities	*B12*	(10,204)	(6,091)
Finance expense – unwinding of discount on provisions		0	0
Dividends payable on public dividend capital		(48)	(3,790)
Net Finance Cost		**(9,949)**	**(8,552)**
Retained (deficit) for the year		**(44,003)**	**(35,675)**
Other Comprehensive Income			
Receipt of donated asset	*SOCIE*	245	103
Revaluation gains on property	*SOCIE*	8,065	0
Transfer from donated asset reserve in respect of depreciation	*SOCIE*	(387)	(360)
Total comprehensive (expense) for the year		**(36,080)**	**(35,932)**

The notes on pages 119 to 157 form part of these accounts.

All revenue and expenditure is derived from continuing operations.

Excluding the impairment charged to the 'Statement of Comprehensive Income' relating to the Private Finance Initiative scheme (PFI), (Note B.5) of £48.185m the underlying retained surplus for the year was £4.182m.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Note	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Non-current assets				
Intangible assets	*B14*	2,674	3,375	3,626
Property, plant and equipment	*B13*	262,534	224,045	118,911
Trade and other receivables	*B18*	1,070	1,147	885
Total non-current assets		**266,278**	**228,567**	**123,422**
Current assets				
Inventories	*B17*	2,844	2,318	2,341
Trade and other receivables	*B18*	10,826	9,156	7,339
Cash and cash equivalents	*B21*	33,253	36,580	39,898
Total current assets		**46,923**	**48,054**	**49,578**
Current liabilities				
Trade and other payables	*B19*	(20,456)	(20,796)	(25,766)
Borrowings	*B20*	(3,658)	(2,677)	(1,639)
Provisions	*B23*	(938)	(3,259)	(3,574)
Tax payable	*B19*	(2,968)	(2,685)	(2,594)
Other liabilities		(6,114)	(3,698)	(4,722)
Total current liabilities		**(34,134)**	**(33,115)**	**(38,295)**
Non-current liabilities				
Borrowings	*B20*	(258,229)	(186,577)	(41,505)
Provisions	*B23*	(595)	(587)	(640)
Other liabilities		(0)	(0)	(0)
Total non-current liabilities		**(258,824)**	**(187,164)**	**(42,145)**
Total assets employed		**20,243**	**56,342**	**92,560**
Financed by Taxpayers' equity				
Public dividend capital		84,303	84,303	84,303
Revaluation reserve		27,963	20,969	31,234
Donated asset reserve		1,965	2,109	3,420
Income and expenditure reserve		(93,988)	(51,039)	(26,397)
Total taxpayers' equity		**20,243**	**56,342**	**92,560**

The financial statements on pages 114 to 157 were approved by the Board and signed on its behalf by :

Chief Executive
Carolyn White
Date: 3 June 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC) £000	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 31 March 2009					
As previously stated	84,303	20,969	2,109	(51,039)	56,342
Retained (deficit) for the year				(44,003)	(44,003)
Net gain/(loss) on revaluation of intangible assets					
Net gain/(loss) on revaluation of property, plant and equipment		8,048	17		8,065
Net gain/(loss) on revaluation of available for sale financial assets					
Receipt of donated assets			245		245
Reduction in donated asset reserve in respect of depreciation, impairment and/or disposal of assets			(387)		(387)
Transfer to income and expenditure in respect of assets disposed of		(9)	(19)	9	(19)
Transfer of excess current cost depreciation over historical cost depreciation		(1,045)		1,045	0
New PDC received					
PDC repaid in year					
PDC written off					
Other transfers between reserves					
Taxpayers' equity at 31 March 2010	**84,303**	**27,963**	**1,965**	**(93,988)**	**20,243**

	Public dividend capital (PDC) £000	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 31 March 2008					
As previously stated	84,303	26,252	2,395	12,373	125,323
IFRS adjustments		4,982	1,025	(38,770)	32,763
Restated Taxpayers' equity at 31 March 2008	84,303	31,234	3,420	(26,397)	92,560
Retained surplus/(deficit) for the year				(35,675)	(35,675)
Net gain/(loss) on revaluation of intangible assets					
Net gain/(loss) on revaluation of property, plant and equipment					
Net gain/(loss) on revaluation of available for sale financial assets					
Receipt of donated assets			103		103
Reduction in donated asset reserve in respect of depreciation, impairment and/or disposal of assets			(360)		(360)
Transfer to income and expenditure in respect of assets disposed of		(8,805)	(29)		(8,834)
Transfer of excess current cost depreciation over historical cost depreciation		(1,460)		10,265	8,805
New PDC received					
PDC repaid in year					
PDC written off					
Other transfers between reserves			(1,025)	1,025	0
Other transfers between reserves				(257)	(257)
Taxpayers' equity at 31 March 2009	**84,303**	**20,969**	**2,109**	**(51,039)**	**56,342**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	Note	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Net cash generated from operating activities			
Operating (deficit) from operations		(34,054)	(27,123)
Depreciation and amortisation		9,023	13,354
Impairments and reversals		48,185	40,925
Net foreign exchange (gain)/loss		0	0
Transfer from donated asset reserve		(400)	(360)
(Increase) in trade and other receivables		(1,593)	(2,079)
(Increase)/decrease in inventories		(526)	23
(Decrease) in trade and other payables		(975)	(4,970)
(Decrease) in provisions		(2,313)	(368)
Other movements in operating cash flows		2,817	(3,046)
Net cash inflow from operating activities		**20,164**	**16,356**
Cash flows from investing activities			
Interest received		303	1,329
Payments to acquire intangible assets		(484)	(681)
Receipt from disposal of intangible assets			
Purchase of property, plant and equipment		(10,525)	(8,835)
Proceeds from disposal of property, plant and equipment			
Net cash (outflow) from investing activities		**(10,706)**	**(8,187)**
Cash flows from financing activities			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Loans received		0	0
Loans repaid		0	0
Dividend paid		0	0
Capital element of finance lease rental payments		(32)	(89)
Capital element of private finance initiatives		(2,549)	(1,517)
Cash transferred (to)/from other NHS bodies		0	0
Interest paid		0	0
Interest element of finance lease		(2)	(21)
Interest element of private finance initiative		(10,202)	(6,070)
Public dividend capital paid		0	(3,790)
Net cash used in financing activities		**(12,785)**	**(11,487)**
(Decrease) in cash and cash equivalents		**(3,327)**	**(3,318)**
Cash and cash equivalents at 1 April		**36,580**	**39,898**
Cash and cash equivalents at 31 March		**33,253**	**36,580**

NOTES TO THE ACCOUNTS

A. Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Reporting Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Reporting Manual issued by Monitor. From the current year, the accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to NHS Foundation Trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1. Consolidation

1.1 Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year [except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.2 Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses It is also reduced when any distribution e.g. share dividends are received by the Trust from the associate. Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.3 Joint ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries. Joint ventures are accounted for by consolidating the Trust's share of the transactions, asset, liabilities, equity and reserves of the entity. Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.4 Joint operations

Joint operations are activities which are carried on with one or more other parties but which are not performed through a separate entity. The Trust includes within its financial statements its share of the activities, assets and liabilities.

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 healthcare services. Where income is received for a specific activity which is to be delivered in the following 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.

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.

3. Expenditure on employee benefits

3.1 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.

3.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers 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 operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

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.

5. Property, plant and equipment

5.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and the cost of the item can be measured reliably.

5.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. 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.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

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. Currently assets are depreciated at the following rates.

- Plant and machinery 5-15 years
- Transport 7 years
- I.T. 5 years
- Furniture and furnishings 7-10 years
- Artwork 0 years

Freehold land and artwork are considered to have an infinite life and are 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 and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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'.

5.3 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

5.4 Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

5.5 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. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

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.

The service charge is recognised in operating expenses and the finance cost is charged to "finance costs" in the 'Statement of Comprehensive Income'.

6. Intangible assets

6.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately 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 and expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery;
- benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

6.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

6.3 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

7. Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used 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.

8. Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

9. Financial instruments and financial liabilities

9.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

9.2 De-recognition

All financial assets are de-recognised when the rights to receive cashflows 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.

9.3 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'.

9.4 Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category.

Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

9.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current asset investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest rate 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 rate method and credited to the Statement of Comprehensive Income.

9.6 Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'finance costs' in the Statement of Comprehensive Income.

9.7 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 rate 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 rate 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.

9.8 Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices / independent appraisals.

9.9 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 cashflows 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.

10. Leases

10.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to 'finance costs' in the Statement of Comprehensive Income.

10.2 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.

10.3 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. Leased land is treated as an operating lease.

11. Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms.

11.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is £17.676m.

11.2 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to 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.

12. 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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

13. 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 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 Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are

calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held within the 'Government Banking Services' accounts.

14. Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

15. Corporation Tax

No liability for corporation tax has been recognised or incurred applying current legislation.

16. 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.

17. Third party assets

Assets belonging to third parties such as money held on behalf of patients are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the Foundation Trust Annual Accounting Manual.

18. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

19. 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 each individual case is handled.
Losses and special payments are charged to the relevant functional headings in the statement of comprehensive income statement on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks.

B. Notes to the accounts

1. Operating Income

1.1 Income from activities	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
NHS Trusts	1,230	1,402
Primary Care Trusts	183,972	160,102
Department of Health	75	5,183
NHS other	46	34
Non NHS:		
- Private patients	183	161
- NHS injury scheme *	977	1,084
	186,483	167,966

* NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

1.2 Analysis of income from activities

	£000	£000
Inpatient – elective income	41,700	39,028
Inpatient - non elective income	67,206	61,119
Outpatient income	41,036	33,825
A & E income	8,615	8,452
Other NHS clinical income	25,461	22,895
Private patient income	183	161
Other non protected clinical income	2,207	2,486
Total income	**186,408**	167,966
Market Forces Factor	**75**	0
Income from activities	**186,483**	167,966

1.3 Other operating income

	£000	£000
Research and development	333	152
Education and training	11,394	10,170
Charitable and other contributions to expenditure	458	344
Transfer from donated asset reserve in respect of depreciation	400	360
Non patient care services to other bodies	16,939	15,111
Other income	19,869	24,805
Total other operating income	**49,393**	50,942
Income from continuing operations	**235,876**	218,908

1.4 Income from Mandatory Services

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Income from activities	**186,483**	167,966
Less: NHS Injury cost recovery scheme	(977)	(1084)
Private Patient Income	(183)	(161)
	185,323	166,721

2. Private patient income

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	**Base Period** £000
Private patient income	**183**	161	198
Total patient related income	**184,482**	167,966	101,221
Proportion (as a percentage) *	**0.10%**	0.10%	0.20%

* Under its terms of authorisation the Trust must ensure that the proportion of patient related income derived from private patients does not exceed the proportion received as an NHS Trust in 2002/3 (the base year). The Trust received 0.10% of its patient related income from private patients during the year ended 31 March 2010, which is within the limit which Monitor has set at 0.20%.

3. Segmental analysis

Sherwood Forest Hospitals NHS Foundation Trust acts as a lead body for East Midlands Procurement Hub and the Nottinghamshire Health Informatics Service. Income and expenditure for these functions is not material to the overall accounts and has not therefore been separately disclosed. Expenditure is broadly in line with income for both of these bodies. In line with the Monitor NHS Foundation Trust Annual Reporting Manual all income and assets are reported as healthcare and can therefore be reviewed in the statement of financial position and statement of comprehensive income.

4. Income generation activities

The trust undertakes some minor income generation activities with an aim of achieving profit, which is then used in patient care. £34k has been recognised in respect of these activities in 2009/10.

5. Operating expenses

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Services from Foundation Trusts	184	0
Services from other NHS Trusts	1,042	927
Services from PCTs	0	0
Services from other NHS bodies	964	919
Purchase of healthcare from non NHS bodies	712	810
Employee expenses – Executive directors	651	654
Employee expenses – non executive directors	122	122
Employee expenses – staff	144,922	130,679
Drugs	10,684	8,846
Supplies and services – clinical	16,597	16,474
Supplies and services – general	811	1,315
Establishment	2,953	2,676
Transport	199	145
Premises	11,166	10,067
Provision for impairments of receivables	(35)	106
Depreciation of property, plant and equipment	8,143	12,488
Amortisation of intangible assets	878	866
Impairments of property, plant and equipment	48,185	40,925
Auditor's services – statutory audit	49	48
Other auditors' remuneration	23	9
Clinical negligence	3,112	2,371
Loss on disposal of intangible fixed assets	0	49
Loss on disposal of property, plant and equipment *	119	374
Legal fees	125	103
Consultancy services	2,530	1,796
Training, courses and conferences	858	830
Redundancy	0	70
Early retirements	56	55
Hospitality	246	270
Losses, ex gratia and special payments	220	315
Other	14,414	11,722
Operating expenses of continuing operations	269,930	246,031

* The losses noted above all relate to plant property and I.T equipment which are all non protected assets.

6. Operating leases (excluding off balance sheet PFI)	**Year ended 31 March 2010**	Year ended 31 March 2009
***6.1* As Lessee**	**£000**	£000
Minimum lease payments plant and machinery	491	493
Total	**491**	**493**
***6.2* Future minimum lease payments due**	**£000**	£000
Payable		
Not later than one year	300	416
Between one and not later than five years	575	645
Later than five years	246	335
Total	**1,121**	**1,396**
***6.3* As Lessor**	**£000**	£000
Rents recognised in period	500	486
Total	**500**	**486**
***6.4* Total Future minimum lease payments**	**£000**	£000
Receivable		
Not later than one year	269	486
Between one and not later than five years	265	466
Later than five years	686	821
Total	**1,220**	**1,773**

***7.* Limitation on auditors' liability**	**Year ended 31 March 2010**	Year ended 31 March 2009
	£000	£000
Limitations on auditors' liability	1,000	1,000

This limit is subject to our Auditors' general terms and conditions of engagement and covers loss or damage suffered arising out of or in connection with the services provided.

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2010 £000	Permanently Employed £000	Other £000	Year ended 31 March 2009 £000
Salaries and wages	115,847	115,763		106,642
Social security costs	8,600	8,600		7,748
Employer contributions to NHS Pension scheme	13,541	13,541		12,522
Other pension costs	56	56		52
Termination benefits	605	605		
Agency costs	6,924		6,924	4,369
	145,573	**138,565**	**6,924**	**131,333**

8.2 Average number of persons employed

	Year ended 31 March 2010 Number	Permanently Employed Number	Other Number	Year ended 31 March 2009 Number
Medical and dental	443	385	58	406
Administration and estates	903	897	6	845
Healthcare assistants and other support staff	570	570		528
Nursing, midwifery and health visiting staff	1,042	997	45	1,004
Nursing, midwifery and health visiting learners	0			0
Scientific, therapeutic and technical staff	444	437	7	401
	3,402	**3,286**	**116**	**3,184**

9. Retirements due to ill-health

During 2009/10 there were 4 (2008/09 4) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £259k (2008/09 £274k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

10. Better Payment Practice Code

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2010		Year ended 31 March 2009	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	53,962	93,081	47,630	85,585
Total non-NHS trade invoices paid within target	50,673	89,413	43,994	79,801
Percentage of non-NHS trade invoices paid within target	94%	96%	92%	93%
Total NHS trade invoices paid in the year	1,679	17,904	1,562	13,820
Total NHS trade invoices paid within target	1,584	17,604	1,387	12,354
Percentage of NHS trade invoices paid within target	94%	98%	89%	90%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11. The Late Payment of Commercial Debts (Interest) Act 1998

	Year ended 31 March 2010	Year ended 31 March 2009
	£000	£000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

12. Finance income

12.1 Interest receivable

	Year ended 31 March 2010	Year ended 31 March 2009
	£000	£000
Bank accounts	303	1,329
Total	**303**	**1,329**

12.2 Finance costs

	£000	**£000**
Interest on loans	2	21
Interest on obligations under finance leases	10,202	6,070
Total	**10,204**	**6,091**

13. Property, Plant and Equipment

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: At 1 April 2009	18,584	291,077	0	4,406	25,122	0	4,286	197	343,672
Additions purchased		5,675	152	76,354	3,754		411	44	86,390
Additions donated					240		5		245
Impairments									0
Reclassifications		770	732	(1,503)	30		620	(1)	648
Revaluation surpluses	(2,574)	(37,297)	(249)						(40,120)
Other in year revaluation									
Reclassified as held for sale									
Disposals					(1,992)		(783)		(2,775)
At 31 March 2010	**16,010**	**260,225**	**635**	**79,257**	**27,154**		**4,539**	**240**	**388,060**
Depreciation at 1 April 2009		104,936			12,089		2,525	77	119,627
Provided during the year		4,690			2,778		645	30	8,143
Impairments									
Reversal of impairments									
Reclassifications		(2)			17		410	(1)	424
Revaluation surpluses									
Other in year revaluation									
Reclassified as held for sale									
Disposals					(1,896)		(772)		(2,668)
Depreciation at 31 March 2010		**109,624**			**12,988**		**2,808**	**106**	**125,526**
Net book value at 31 March 2010									
Purchased	16,010	150,534	635	79,257	12,296		1,711	134	260,577
Donated		0			5				5
Finance lease		67			1,865		20		1,952
Total at 31 March 2010	**16,010**	**150,601**	**635**	**79,257**	**14,166**		**1,731**	**134**	**262,534**
Protected	**14,370**	**150,001**	**0**	**0**	**0**		**0**	**0**	**164,371**
Non Protected Assets	**1,640**	**600**	**635**	**79,257**	**14,166**		**1,731**	**134**	**98,163**

Prior year:

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: At 1 April 2008	18,584	96,952	0	6,005	23,775		6,404	682	152,402
Additions purchased		167,438		4,984	4,161		664	61	177,308
Additions donated					79		7		86
Impairments									
Reclassifications		85,157		(6,583)	13		13	8	78,608
Revaluation surpluses									
Other in year revaluation									
Reclassified as held for sale									
Disposals		(58,470)			(2,906)		(2,802)	(554)	(64,732)
At 31 March 2009	**18,584**	**291,077**	**0**	**4,406**	**25,122**		**4,286**	**197**	**343,672**
Depreciation at 1 April 2008		16,459			12,010		4,481	541	33,491
Provided during the year		8,987			2,677		793	31	12,488
Impairments		40,925							40,925
Reversal of impairments									
Reclassifications		78,577			11		2	5	78,595
Revaluation surpluses									
Other in year revaluation									
Reclassified as held for sale									
Disposals		(40,012)			(2,609)		(2,751)	(500)	(45,872)
Depreciation at 31 March 2009		**104,936**			**12,089**		**2,525**	**77**	**119,627**
Net book value: At 31 March 2009									
Purchased	18,584	13,399	0	4,406	10,957		1,739	120	49,205
Donated	0	51	0	0	2,012		22	0	2,085
Finance lease	0	172,691	0	0	64		0	0	172,755
Total at 31 March 2009	**18,584**	**186,141**	**0**	**4,406**	**13,033**		**1,761**	**120**	**224,045**
Protected	**18,584**	**196,141**	**0**	**0**	**0**		**0**	**0**	**204,725**
Non Protected Assets	**0**	**0**		**4406**	**13,033**		**1,761**	**120**	**19,320**

14. Intangible Assets

	Computer software (purchased) £000	Computer software (internally generated) £'000	Software licenses and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2009			5,681			**5,681**
Revaluation						
Impairments						
Reclassifications			(648)			**(648)**
Revaluation surpluses						
Additions purchased			415			**415**
Additions internally generated						
Additions donated						
Reclassified as held for sale						
Disposals			(310)			**(310)**
Gross cost at 31 March 2010			**5,138**			**5,138**
Amortisation at 1 April 2009			2,306			**2,306**
Provided during the year			878			**878**
Indexation						
Impairments						
Reversal of impairments						
Reclassifications			(424)			**(424)**
Other revaluation						
Reclassified as held for sale						
Disposals			(296)			**(296)**
Amortisation at 31 March 2010			**2,464**			**2,464**
Net book value: At 31 March 2010						
Purchased			2,661			**2,661**
Donated			13			**13**
Total at 31 March 2010			**2,674**			**2,674**

Prior year:

	Computer software (purchased) £000	Computer software (internally generated) £000	Software licenses and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2008			5,175			**5,175**
Revaluation						
Impairments						
Reclassifications			5			**5**
Revaluation surpluses						
Additions purchased			661			**661**
Additions internally generated						
Additions donated			17			**17**
Reclassified as held for sale						
Disposals			(177)			**(177)**
Gross cost at 31 March 2009			**5,681**			**5,681**
Amortisation at 1 April 2008			1,549			**1,549**
Indexation						
Provided during the year			866			**866**
Impairments						
Reversal of impairments						
Reclassifications			18			**18**
Other revaluation						
Reclassified as held for sale						
Disposals			(127)			**(127)**
Amortisation at 31 March 2009			**2,306**			**2,306**
Net book value: At 31 March 2009						
Purchased			3,351			**3,351**
Donated			24			**24**
Total at 31 March 2009			**3,375**			**3,375**

15. Impairments

Impairments in the period arose from:	**Intangible**		**Tangible**	
	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000
Changes in market price	0	0	48,185	40,925
Total	**0**	**0**	**48,185**	**40,925**

All impairments in year reflect the general economic conditions relating to the fall in property prices.

16. Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were:

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Property, plant and equipment	561	694	2,033
Intangible assets	33	306	
Total	**594**	**1,000**	**2,033**

17. Inventories

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Drugs	849	750	823
Materials	1,982	1,550	1,505
Energy	13	18	13
Total	**2,844**	**2,318**	**2,341**

17.1 Inventories recognised in expenses

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Inventories recognised as an expense in the period	20,446	16,308
Total	**20,446**	**16,308**

18. **Trade and other receivables**	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Current (falling due within one year)			
NHS receivables	8,100	6,682	3,976
Other trade receivables			
Provision for the impairment of receivables	(235)	(272)	(177)
Prepayments	372	940	84
Accrued income	49	318	359
Other receivables	2,540	1,488	3,097
Total current trade and other receivables	**10,826**	**9,156**	**7,339**
Non-current (falling due after more than one year)			
NHS receivables	984	1,058	794
Other trade receivables			
Provision for the impairment of receivables			
Prepayments	86	89	91
Accrued income			
Other receivables			
Total non-current trade and other receivables	**1,070**	**1,147**	**885**
Total trade and other receivables	**11,896**	**10,303**	**8,224**

The great majority of income and therefore creditors relate to Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

No interest is charged on trade receivables.

The value of trade receivables that are past their due payment date but not impaired is £849k, however, the Trust is aware of no reason why these are not recoverable. The Trust does not hold any collateral over the balances.

***18.1* Movement in the provision for the impairment of receivables**	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000
Balance at 1 April	272	177
Increase in provision	5	112
Amounts utilised / reversed	(42)	(17)
Balance at 31 March	**235**	**272**

All debts are reviewed and provisions made based on national guidance for the compensation recovery unit (7.8%), and the probability of payment for non NHS debtors following referral to external debt recovery agencies. No provisions are made for NHS debtors.

19. Trade and other payables

Current (falling due within one year)	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Receipts in advance	387	992	12,333
NHS payables	1,852	1,576	1,889
Non-NHS trade payables – capital	3,362	2,777	517
Non-NHS trade payables – revenue			
Tax and social security costs	2,968	2,685	2,594
Accruals	10,677	11,025	7,033
Other payables	4,178	4,426	3,994
Total trade and other payables	**23,424**	**23,481**	**28,360**

20. Borrowings

Current	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	Year ended 31 March 2008 £000
Finance lease liabilities	2	32	121
Private finance initiative contract (PFI)	3,656	2,645	1,518
Total current	**3,658**	**2,677**	**1,639**
Non-current			
Finance lease liabilities	0	2	34
Private finance initiative contract	258,229	186,575	41,471
Total non-current	**258,229**	**186,577**	**41,505**
Total borrowings	**261,887**	**189,254**	**43,144**

***20.1* Amounts payable under finance leases:**

PFI obligations	**Minimum lease payments**	
	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Gross PFI liability	261,885	189,220
Of which liability is due:		
Within one year	3,656	2,645
Between one and five years	20,052	18,391
After five years	238,177	168,184
Net PFI liability	**261,885**	**189,220**

Equipment finance lease obligations	**Minimum lease payments**	
	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Gross liability	2	34
Of which liability is due:		
Within one year	2	32
Between one and five years		2
Finance lease liability	**2**	**34**

The Trust does not consider there to be any difference in the present value of minimum lease payments to the value of the minimum lease payments.

***20.2* Finance lease receivables**

The Trust has no finance leases where it is the lessor in operation.

20.3 PFI schemes deemed to be off-balance sheet

The Trust is currently committed to one off-balance sheet PFI scheme.

Expenditure recognised within the operating expenses of the Trust for the year ended 31 March 2010 is as follows:

	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet – gross	247
Amortisation of PFI deferred asset	(152)
Net charge to operating expenses	**95**

A credit was also recognised within operating expenses relating to the unitary charge offset to recreate the fixed assets of the Trust over the life of the PFI contract. However, in line with the DOH guidance this has been excluded in the above net charge calculation.

Leicester Housing Association

The Trust is committed to make the following payments during the next year with regard to Leicester Housing Association.

	£000
PFI scheme which expires; 26 to 30 years (inclusive)	**243**

	£000
Estimated capital value of the PFI scheme	5,700
Contract Start date:	September 2000
Contract End date:	September 2035

The Trust entered into a Private Finance Initiative contract with Leicester Housing Association, which included 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 the Leicester Housing Association. The value shown above relates solely to the Trust's committed element of the contract and not the full income received by Leicester Housing Association.

21. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Balance at 1 April	36,580	39,898	17,339
Net change in year	(3,327)	(3,318)	22,559
Balance at 31 March	**33,253**	**36,580**	**39,898**
Made up of			
Cash with the Government banking service (RBSG / Citibank) / Office of Paymaster General	33,248	36,575	39,893
Cash in hand	5	5	5
Cash and cash equivalents	**33,253**	**36,580**	**39,898**

22. Key judgements and estimation uncertainty

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.

23. Provisions for liability and charges

	Pensions relating to other staff £000	Legal claims £000	Other £000	31 March 2010 Total £000
At 1 April 2009	516	153	3,177	3,846
Arising during the period	67	120	31	218
Utilised during the period	(56)	(83)	(831)	(970)
Reversed during the period		(44)	(1,517)	(1,561)
Unwinding of discount				
At 31 March 2010	**527**	**146**	**860**	**1,533**
Expected timing of cashflows:				
Within one year	51	146	741	938
Between one and five years	203	0	30	233
After five years	273	0	89	362
	527	**146**	**860**	**1,533**

	Current			Non-current		
	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000	31 March 2010 £000	31 March 2009 £000	31 March 2008 £000
Pensions relating to former staff (excluding directors)	51	48	51	476	468	523
Other legal claims	146	153	183	0	0	0
Other	741	3,058	3,340	119	119	117
Total	**938**	**3,259**	**3,574**	**595**	**587**	**640**

£17,676m is included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the Trust (31/03/09 £16,990m).

24. Contingent Liabilities

	31 March 2010 £000	31 March 2009 £000
Gross value	143	105
Amounts recoverable	0	0
Net contingent liability	**143**	**105**

This relates to clinical negligence un-provided liabilities.

Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The directors consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

25. Prudential Borrowing Limit

The Trust has a maximum cumulative long term borrowing limit of £377.9 million.
Monitor has also authorised the Trust to have a £15m working capital facility in place. The Trust did not exercise this option in year.

	Year ended 31 March 2010 Actual	Approved	Year ended 31 March 2009 Actual	Approved
Minimum dividend cover – times	278.5	>1.0 Times	1.0	>1.0 Times
Minimum interest cover – times	2.3	>2.0 Times	3.0	>2.0 Times
Minimum debt service cover - times	1.8	>1.5 Times	2.0	>1.5 Times
Maximum debt service to revenue %	5.4	<10.0%	3%	<10.0%

26. Management Costs

Management costs	7,014	6,817
Income (net of NMET income)	224,654	208,780
Percentage	3.12%	3.60%

27. Financial instruments and related disclosures

	Carrying Value 31 March 2010 £000	Carrying Value 31 March 2009 £000	Carrying Value 1 April 2008 £000
Current financial assets			
Cash and cash equivalents	33,253	36,580	39,898
Loans and receivables:			
Trade and receivables	10,405	7,898	7,255
Non-current financial assets			
Loans and receivables:	0	0	0
Trade and receivables	984	1,058	794
Total financial assets	**44,642**	45,536	47,947
Current financial liabilities			
Financial liabilities measured at amortised cost:			
Finance leases	3,658	2,677	1,639
Trade and other payables	29,538	27,179	33,082
Provisions under contract	1,533	3,846	4,214
Non-current financial liabilities			
Financial liabilities measured at amortised cost:			
Finance leases	258,229	186,577	41,505
Provisions under contract	0	0	0
Total financial liabilities	**292,958**	220,279	80,440

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

28. Changes to Accounting Standards

The Trust is aware of proposed changes to accounting standards which are relevant to this Trust such as IAS 27, consolidation of financial statements, IFRS 3 business combinations, IAS 39 financial instruments: recognition and measurement and IFRS 5 assets for disposal. Based on the current proposals any changes implemented would have no impact on the financial statements as presented.

29. Post year end 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 on its going concern basis.

*30.*Third Party Assets

The Trust held £580.00 (£1,824.33 2008/9) as cash in hand or at bank at 31 March 2010 on behalf of patients.

31. Sickness Absences

Sum of WTE days sick in period	Sum of WTE days available	Total number of WTE - days lost to sickness absence	Total number of WTE - years available	Average number of days' sickness absence per WTE
63,485	1,265,970	39,135	3,468	11.3

The above figures are based on the period 1st January to 31December 2009 and have been provided by the Department of Health.

31. Related party transactions

Sherwood Forest Hospitals NHS Foundation Trust is a body corporate 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.

The Trust has also received revenue and capital payments from Sherwood Forest Hospitals Charitable Funds for which a number of Trustees are also members of the NHS Trust Board of Directors. The Sherwood Forest Hospitals Charitable Fund purchased goods and services for the Trust during the financial year, and also provided purchases for patients and staff at the 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.

Details of the significant entities with NHS organisations are listed below:

	Income £000	Expenditure £000	Income £000	Expenditure £000
Bassetlaw Primary Care Trust	1,129		833	0
Department of Health	977		5,192	0
Derby City PCT	334	2	180	3
Derby County PCT	19,870	6	17,091	10
Derby Hospitals NHS Foundation Trust	308	44	307	45
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	12	173	0	72
East Midlands Ambulance Services NHS Trust	4	1,024	0	897
East Midlands Strategic Health Authority	11,365		10,324	2
Imperial College Trust			0	17
Kettering Foundation Trust	60		67	0
Leicester County and Rutland PCT	8,474	33	2,429	33
Leicester City PCT	72		167	0
Leicester Partnership Trust	64	126	65	141
University Hospitals Leicester Trust	168	59	683	52
Lincolnshire Primary Care Trust	4,126		2,968	0
Moorfield's Eye Hospital NHS Foundation Trust (FT)		35	0	25
NHS Blood and Transplant	1	1,052	0	1,006
NHS Business Services Authority		679	0	264
NHS Litigation Authority		3,112	0	2,371
Northampton Teaching PCT	271		194	0
Northampton Trust	103		160	0
Nottingham University Hospitals NHS Trust	3,466	1,411	2,819	1,399
Nottingham City PCT	4,170	43	3,605	137
Nottinghamshire County Primary Care Trust	168,496	1,305	156,252	2,442
Nottinghamshire Healthcare NHS Trust	1,584	303	1,209	266
NHS Purchasing and Supply Agency	3	5,423	3	4,088
Oxfordshire and Buckinghamshire Mental Health NHS FT			0	154
Sheffield Children's NHS FT	35	51	0	51
Sheffield Teaching Hospitals NHS FT		36	0	25
United Lincolnshire Hospitals NHS Trust	190	2	187	1

32. Senior Managers Disclosure

32.1	2009/10				2008/09			
Name and Title	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £000)**	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £000)**
	£000	**£000**	**£**	**£000**	**£000**	**£000**	**£**	**£000**
Executive Directors								
Mrs C. White [1] (Chief Executive)	**45-50**	**0**	**2,100**	**7**	*N/A*	*N/A*	*N/A*	*N/A*
Mr J. Worrall [2] (Chief Executive)	**95-100**	**0**	**4,400**	**11**	*135-140*	*0*	*6,700*	*19*
Dr M. Mowbray (Executive Medical Director)	**25-30**	**175-180**	**7,500**	**0**	*25-30*	*155-160*	*7,400*	*0*
Mrs C. White [1] (Executive Nursing Director)	**55-60**	**0**	**3,000**	**9**	*85-90*	*0*	*5,200*	*12*
Ms J. Warder (Executive Director of Strategy and Improvement)	**90-95**	**0**	**4,100**	**13**	*85-90*	*0*	*3,000*	*12*
Mr L. Bond (Executive Director of Finance)	**110-115**	**0**	**3,800**	**16**	*100-105*	*0*	*3,800*	*15*
Ms K. Fisher (Executive Director of Human Resources)	**90-95**	**0**	**0**	**13**	*75-80*	*0*	*0*	*11*

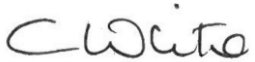
32.1	2009/10				2008/09			
Name and Title	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £000)**	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £000)**
	£000	**£000**	**£**	**£000**	**£000**	**£000**	**£**	**£000**
Ms T. Doucet	**40-45**	**N/A**	**N/A**	**N/A**	*40-45*	N/A	N/A	N/A
Mr P. Harris [3]	**N/A**	**N/A**	**N/A**	**N/A**	*10-15*	N/A	N/A	N/A
Mr S. Pearson [4]	**05-10**	**N/A**	**N/A**	**N/A**	*10-15*	N/A	N/A	N/A
Mr D. J. Leah	**10-15**	**N/A**	**N/A**	**N/A**	*10-15*	N/A	N/A	N/A
Mrs B. Y. Jones	**10-15**	**N/A**	**N/A**	**N/A**	*10-15*	N/A	N/A	N/A
Mr D. B. Heathcote	**10-15**	**N/A**	**N/A**	**N/A**	*10-15*	N/A	N/A	N/A
Mr S. Grasar	**10-15**	**N/A**	**N/A**	**N/A**	*0-5*	N/A	N/A	N/A
Mr I. M. Younger [5]	**0-5**	**N/A**	**N/A**	**N/A**	*0*	N/A	N/A	N/A

1 Appointed Chief Executive 1 February 2010 for a 12 month period.
2 Chief Executive to 30 November 2009.
3 To January 2009 included for comparative purposes.
4 To 31 December 2009.
5 From 1 December 2009.

32.2	2009/10					2008/09				
Name and Title	**Real increase during the year in pension and lump sum at age 60 (bands of £2,500)**	**Total accrued pension (incl. lump sum) at age 60 at 31 March 2010 (bands of £5,000)**	**Value of Cash Equivalent Transfer Value as at 1 April 2009 (nearest £1,000)**	**Real increase in Cash Equivalent Transfer Value during the year ended 31 March 2010 (bands of £1,000)**	**Value of Cash Equivalent Transfer Value at the end of the reporting period - 31 March 2010 (bands of £1,000)**	**Real increase during the year in pension and lump sum at age 60 (bands of £2,500)**	**Total accrued pension (incl. lump sum) at age 60 at 31 March 2009 (bands of £5,000)**	**Value of Cash Equivalent Transfer Value as at 1 April 2008 (nearest £1,000)**	**Real increase in Cash Equivalent Transfer Value during the year ended 31 March 2009((bands of £1,000)**	**Value of Cash Equivalent Transfer Value at the end of the reporting period - 31 March 2009(bands of £1,000)**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Executive Directors										
Mr J. Worrall [1] (Chief Executive)	**10-12.5**	**235-237.5**	**1,103**	**100**	**1,281**	*30-32.5*	*215-217.5*	*719*	*367*	*1,103*
Dr M. Mowbray (Executive Medical Director)	**32.5-35**	**230-232.5**	**951**	**216**	**1,192**	*22.5-25*	*190-192.5*	*589*	*347*	*951*
Mrs C. White [2] (Chief Executive)	**15-17.5**	**130-132.5**	**492**	**103**	**608**	*0-2.5*	*110-112.5*	*376*	*107*	*492*
Ms J. Warder (Executive Director of Strategy and Improvement)	**5-7.5**	**110-112.5**	**375**	**44**	**428**	*20-22.5*	*100-102.5*	*238*	*131*	*375*
Mr L. Bond (Executive Director of Finance)	**12.5-15**	**92.5-95**	**258**	**57**	**321**	*2.5-5*	*77.5-80*	*194*	*60*	*258*
Ms K. Fisher (Executive Director Human Resources)	**12.5-15**	**127.5-130**	**450**	**77**	**539**	*5-7.5*	*110-112.5*	*328*	*114*	*450*

The Trust has made no payments and the Directors are not entitled to receive any benefit under share options or money and assets under long term incentive schemes. In addition no advances, credits or guarantees have been made on behalf of any of the Directors.
The Trust has made no payments to related parties in the year ended 31 March 2010.

1. Figures are to the 30 November 2009.
2. Figures reflect both the role of Executive Director of Nursing (April to November 2009) and Chief Executive (December 2009 to March 2010).

Signed:  Chief Executive 3 June 2010
Carolyn White

33. Transition to IFRS

Reconciliation of UK GAAP Cash Flow Statement to IFRS Statement of Cash Flows

GROUP CASH FLOW STATEMENT	UK GAAP	IFRS adjustments: IAS 1	IAS 17 IFRIC 4 SIC 15 SIC 27	IAS 18	IAS 19	IFRIC 12	Other	Total	IFRS Restated	GROUP CASH FLOW STATEMENT
	2008/09								2008/09	
	£000								£000	
OPERATING ACTIVITIES - Note 19.1										
		10,909	(12)		473	(38,493)	0	(27,123)	(27,123)	Surplus/(Deficit) from continuing operations
		0	0	0	0	0	0	0	0	Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations
OPERATING SURPLUS/(DEFICIT)	11,323								(27,123)	**Operating surplus/(deficit)**
										Non-cash income and expense:
Depreciation and amortisation	6,942					6,412		6,412	13,354	Depreciation and amortisation
Fixed asset impairments	0					40,925		40,925	40,925	Impairments
Fixed asset reversal of impairments	0	0	0	0	0	0	0	0	0	Reversals of impairments
Transfer from the donated asset reserve	(360)	0	0	0	0	0	0	0	(360)	Transfer from the donated asset reserve
(Increase)/decrease in debtors	(2,015)	0	0	0	0	(64)	0	(64)	(2,079)	(Increase)/Decrease in Trade and Other Receivables
		0	0	0	0	0	0	0	0	(Increase)/Decrease in Other Assets
(Increase)/decrease in stocks	23	0	0	0	0	0	0	0	23	(Increase)/Decrease in Inventories
Increase/(decrease) in creditors	(8,194)	0	0	0	0		3,224	3,224	(4,970)	Increase/(Decrease) in Trade and other Payables
		0	0	0	0	0	(933)	(933)	(933)	Increase/(Decrease) in Other Liabilities
Increase/(decrease) in provisions	105	0	0	0	0	0	(473)	(473)	(368)	Increase/(Decrease) in Provisions
	0	0	0	0	0	0	0	0	0	Tax (paid) / received
Other movements *	842	0	0	0	0	(482)	(2,473)	(2,955)	(2,113)	Other movements in operating cashflows
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**8,666**	**0**	**0**	**0**	**0**	**46,791**	**(655)**	**46,136**	**16,356**	**NET CASH GENERATED FROM/(USED IN) OPERATIONS**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:										**Cash flows from investing activities**
Interest received	1,329							0	1,329	Interest received
		0	0	0	0	0	0	0	0	Purchase of financial assets
		0	0	0	0	0	0	0	0	Sales of financial assets
							(681)	(681)	(681)	Puchase of intangible assets
		0	0	0	0	0	0	0	0	Sales of intangible assets
						0	(8,835)	(8,835)	(8,835)	Purchase of Property, Plant and Equipment
		0	0	0	0	0	0	0	0	Sales of Property, Plant and Equipment
Interest paid	0									
Interest element of finance lease rental payments	(7)									
		0	0	0	0	0	0	0	0	Cash flows attributable to investing activities of discontinued operations
								0	0	cash from aquistions of business units and subsidiaries
								0	0	cash from (disposals) of business units and subsidiaries
NET CASH INFLOW/(OUTFLOW) FROM RETURNS ON INVESTMENTS AND SERVICING OF FINANCE	**1,322**	**0**	**0**	**0**	**0**	**0**	**(9,516)**	**(9,516)**	**(8,187)**	**Net cash generated from/(used in) investing activities**
TAXATION PAID / RECEIVED										
CAPITAL EXPENDITURE:										
(Payments) to acquire tangible fixed assets	(8,835)									
Receipts from sale of tangible fixed assets										
(Payments) to acquire intangible fixed assets	(681)									
Receipts from sale of intangible fixed assets										
(Payments)/receipts for fixed asset investments										
NET CASH INFLOW/(OUTFLOW) FROM CAPITAL EXPENDITURE	(9,516)									
DIVIDENDS PAID										
NET CASH INFLOW/(OUTFLOW) BEFORE MANAGEMENT OF LIQUID RESOURCES AND FINANCING	472									
MANAGEMENT OF LIQUID RESOURCES:										
(Purchase) of current asset investments										
Sale of current asset investments										
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID RESOURCES	0									
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	472									
FINANCING:										**Cash flows from financing activities**
New public dividend capital received		0	0	0	0	0	0	0	0	Public dividend capital received
Public dividend capital repaid	(3,790)	0	0	0	0	0	0	0	0	Public dividend capital repaid
Loans received from Foundation Trust Financing Facility		0	0	0	0	0	0	0	0	Loans received
Other loans received		0	0	0	0	0	0	0		
Loans repaid to Foundation Trust Financing Facility		0	0	0	0	0	0	0	0	Loans repaid
Other loans repaid		0	0	0	0	0	0	0		
Other capital receipts		0	0	0	0	0	0	0	0	Cash flows from (used in) other financing activities
Capital element of finance lease rental payments			0	0	(89)	0	0	(89)	(89)	Capital element of finance lease rental payments
			0	0	0	(1,517)	0	(1,517)	(1,517)	Capital element of Private Finance Obligations
		(7)	0	0	(14)	0	0	(21)	(21)	Interest element of finance lease rental payments
			0	0	0	(6,070)	0	(6,070)	(6,070)	Interest element of Private Finance Initiative obligations
		0	0	0	0	0	(3,790)	(3,790)	(3,790)	PDC Dividend paid
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(3,790)**	**(7)**	**0**	**0**	**(103)**	**(7,587)**	**(3,790)**	**(11,487)**	**(11,487)**	**Net cash generated from/(used in) financing activities**
INCREASE/(DECREASE) IN CASH	(3,318)	(7)	0	0	(103)	(7,587)	(3,790)	(11,487)	(3,318)	**Increase/(decrease) in cash and cash equivalents**
									39,898	**Cash and Cash equivalents at 1 April 2008**
									36,580	**Cash and Cash equivalents at 31 March 2009**

Reconciliation of UK GAAP Income and Expenditure to IFRS Statement of Compehensive Contract

GROUP INCOME AND EXPENDITURE ACCOUNT	UK GAAP	IAS 1	IAS 17 IFRIC 4 SIC 15 SIC 27	IAS 19	IFRIC 12	Other	Total	IFRS Restated	GROUP INCOME AND EXPENDITURE ACCOUNT
	31/03/2009 £000							31/03/2009 £000	
INCOME AND EXPENDITURE ACCOUNT									**STATEMENT OF COMPREHENSIVE INCOME**
Income from Activites	167,966	50,942	0	0	0	0	50,942	218,908	Operating Income
Other Operating Income	50,933	0	0	0	0	0	0		
Operating Expenses	(207,576)	(423)	(12)	473	(38,493)	0	(38,455)	(246,031)	Operating Expenses
OPERATING SURPLUS / (DEFICIT)	**11,323**							(27,123)	**OPERATING SURPLUS / (DEFICIT)**
									FINANCE COSTS
		1,329	0	0	0	0	1,329	1,329	Finance income
		0	(21)	0	(6,070)	0	(6,091)	(6,091)	Finance expense - financial liabilities
		0	0	0	0	0	0	0	Finance expense - unwinding of discount on provisions
		(3,790)	0	0	0		(3,790)	(3,790)	PDC Dividends payable
Profit / (loss) on disposal of fixed asssets	(414)	414	0	0	0	0	414		
SURPLUS / (DEFICIT) BEFORE INTEREST	**10,909**							(8,552)	**NET FINANCE COSTS**
Finance Income	1,329	(1,329)				0	(1,329)	0	
Finance costs - interest expense	(7)		7				7	0	
SURPLUS / (DEFICIT) BEFORE TAXATION & MI	**12,231**								
SURPLUS / (DEFICIT) AFTER TAXATION & MI	**12,231**								
PDC dividends payable	(3,790)	3,790				0	3,790	0	
RETAINED SURPLUS FOR THE YEAR	**8,441**							(35,675)	**Surplus/(Deficit) from continuing operations**
								(35,675)	**SURPLUS/(DEFICIT) FOR THE YEAR**
STATEMENT OF RECOGNISED GAINS AND LOSSES									**OTHER COMPREHENSIVE INCOME**
Surplus/(deficit) for the financial year before dividend payments	12,231								
Increase in the donated asset reserve due to receipt of donated assets	103						0	103	Increase in the donated asset reserve due to receipt of donated assets
Reduction in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	(360)						0	(360)	Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets
TOTAL RECOGNISED GAINS AND LOSSES FOR THE FINANCIAL YEAR	**11,974**							(35,932)	**TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR**
Prior period adjustments **	0						0	0	Prior period adjustments **
TOTAL RECOGNISED GAINS AND LOSSES IN THE FINANCIAL YEAR	**11,974**							(35,932)	**TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR**
(a) profit/(loss) for the period attributable to:									**(a) profit/(loss) for the period attributable to:**
(i) minority interest, and							0	0	(i) minority interest, and
(ii) owners of the parent.						(35,675)	(35,675)	(35,675)	(ii) owners of the parent.
(b) total comprehensive income for the period attributable to:									**(b) total comprehensive income for the period attributable to:**
(i) minority interest, and							0	0	(i) minority interest, and
(ii) owners of the parent.						(35,932)	(35,932)	(35,932)	(ii) owners of the parent.

Reconciliation of UK GAAP Balance Sheet to IFRS Statement of Financial Position

GROUP BALANCE SHEET	UK GAAP 31 Mar 2008 £000	IAS 1	IAS 2	IAS 12	IAS 17 IFRIC 4 SIC 15 SIC 27	IAS 19	IAS 37	IAS 38	IFRIC 12	Other	Total	IFRS Restated 01/04/2008	Statement of Financial Position
FIXED ASSETS:													**NON-CURRENT ASSETS**
Intangible assets	3,453	0	0	0	0	0	0	173	0	0	173	3,626	Intangible assets
Tangible assets	71,880	0	0	0	179	0	0	(181)	47,033	0	47,031	118,911	Property, Plant and Equipment
		0	0	0	0	0	0	0	0	0	0	0	Investment property
		0	0	0	0	0	0	0	0	0	0	0	Investments in Associates
		0	0	0	0	0	0	0	0	0	0	0	Other Investments
		36,557	0	0	0	0	0	0	(35,672)	0	885	885	Trade and Other Receivables
Investments	0	0	0	0	0	0	0	0	0	0	0	0	Other Financial Assets
		0	0	0	0	0	0	0	0	0	0	0	Tax receivable
		0	0	0	0	0	0	0	0	0	0	0	Other Assets
TOTAL FIXED ASSETS	**75,333**											123,422	**TOTAL NON-CURRENT ASSETS**
CURRENT ASSETS:													**CURRENT ASSETS**
Stocks and work in progress	2,341	0	0	0	0	0	0	0	0	0	0	2,341	Inventories
Debtors	43,896	(36,557)	0	0	0	0	0	0	0	0	(36,557)	7,339	Trade and Other receivables
Investments	0	0	0	0	0	0	0	0	0	0	0	0	Other Financial Assets
		0	0	0	0	0	0	0	0	0	0	0	Tax Receivable
		0	0	0	0	0	0	0	0	0	0	0	Non-current assets held for sale, and assets in disposal groups
Cash at bank and in hand	39,898	0	0	0	0	0	0	0	0	0	0	39,898	Cash and Cash Equivalents
TOTAL CURRENT ASSETS	**86,135**											49,578	**TOTAL CURRENT ASSETS**
CREDITORS:													**CURRENT LIABILITIES**
Creditors falling due within one year	(33,114)	4,723	0	2,594	32	0	0	0	0	(1)	7,348	(25,766)	Trade and Other Payables
		0	0	0	(121)	0	0	0	(1,518)	0	(1,639)	(1,639)	Borrowings
		0	0	0	0	0	0	0	0	0	0	0	Other Financial Liabilities
		0	0	0	0	(1,183)	(2,391)	0	0	0	(3,574)	(3,574)	Provisions
		0	0	(2,594)	0	0	0	0	0	0	(2,594)	(2,594)	Tax Payable
		(4,723)	0	0	0	0	0	0	0	1	(4,722)	(4,722)	Other Liabilities
		0		0	0	0	0	0	0	0	0	0	Liabilities in disposal groups
NET CURRENT ASSETS/(LIABILITIES)	**53,021**											(38,295)	**TOTAL CURRENT LIABILITIES**
TOTAL ASSETS LESS CURRENT LIABILITIES	**128,354**												
CREDITORS:													**NON-CURRENT LIABILITIES**
Creditors falling due after more than one year	0	0	0	0	0	0	0	0	0	0	0	0	Trade and Other Payables
		0	0	0	(34)	0	0	0	(41,471)	0	(41,505)	(41,505)	Borrowings
		0	0	0		0	0	0	0	0	0	0	Other Financial Liabilities
PROVISIONS FOR LIABILITIES AND CHARGES	(3,031)	0	0	0	0	0	2,391	0	0	0	2,391	(640)	Provisions
		0	0	0	0	0	0	0	0	0	0	0	Tax payable
		0	0	0	0	0	0	0	0	0	0	0	Other Liabilities
												(42,145)	**TOTAL NON-CURRENT LIABILITIES**
TOTAL ASSETS EMPLOYED	**125,323**											92,560	**NET ASSETS**
FINANCED BY TAXPAYER'S EQUITY													**TAXPAYERS' EQUITY:**
		0	0	0	0	0	0	0	0	0	0	0	Minority Interest
Public dividend capital	84,303	0	0	0	0	0	0	0	0	0	0	84,303	Public Dividend Capital
Revaluation reserve	26,252	0	0	0	18	0	0	0	4,964	0	4,982	31,234	Revaluation reserve
Donated asset reserve	2,395	0	0	0	0	0	0	0	1,025	0	1,025	3,420	Donated asset reserve
Available for sale investments reserve	0	0	0	0	0	0	0	0	0	0	0	0	Available for sale investments reserve
Other reserves	0	0	0	0	0	0	0	0	0	0	0	0	Other reserves
		0	0	0	0	0	0	0	0	0	0	0	Merger reserve
		0	0	0	0	0	0	0	0	0	0	0	Pension reserve
Income and expenditure reserve	12,373	0	0	0	38	(1,183)	0	(8)	(37,617)	0	(38,770)	(26,397)	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	**125,323**											92,560	**TOTAL TAXPAYERS' EQUITY**

Reconciliation of UK GAAP Balance Sheet to IFRS Statement of Financial Position

GROUP BALANCE SHEET	UK GAAP	UK GAAP Adjustment for Errors	IAS 1	IAS 12	IAS 17 IFRIC 4 SIC 15 SIC 27	IAS 19	IAS 37	IAS 38	IFRIC 12	Other	Total	IFRS Restated 31/03/2009	STATEMENT OF FINANCIAL POSITION
	31/03/2009 £000												
FIXED ASSETS:													**NON-CURRENT ASSETS**
Intangible assets	3,203	0	0	0	0	0	0	172	0	0	172	3,375	Intangible assets
Tangible assets	58,153	0	0	0	64	0	0	(177)	166,005	0	165,892	224,045	Property, Plant and Equipment
			0	0	0	0	0	0	0	0	0	0	Investment property
			0	0	0	0	0	0	0	0	0	0	Investments in Associates
			0	0	0	0	0	0	0	0	0	0	Other Investments
			54,383	0	0	0	0	0	(53,236)	0	1,147	1,147	Trade and Other Receivables
Investments	0	0	0	0	0	0	0	0	0	0	0	0	Other Financial Assets
			0	0	0	0	0	0	0	0	0	0	Tax receivable
			0	0	0	0	0	0	0	0	0	0	Other Assets
TOTAL FIXED ASSETS	**61,356**											228,567	**TOTAL NON-CURRENT ASSETS**
CURRENT ASSETS:													**CURRENT ASSETS**
Stocks and work in progress	2,318	0	0	0	0	0	0	0	0	0	0	2,318	Inventories
Debtors	63,539	0	(54,383)	0	0	0	0	0	0	0	(54,383)	9,156	Trade and Other receivables
Investments	0	0	0	0	0	0	0	0	0	0	0	0	Other Financial Assets
			0	0	0	0	0	0	0	0	0	0	Tax Receivable
			0	0	0	0	0	0	0	0	0	0	Non-current assets held for sale, and assets in disposal groups
Cash at bank and in hand	36,580	0	0	0	0	0	0	0	0	0	0	36,580	Cash and Cash Equivalents
TOTAL CURRENT ASSETS	**102,437**											48,054	**TOTAL CURRENT ASSETS**
CREDITORS:													**CURRENT LIABILITIES**
Creditors falling due within one year	(27,179)	0	3,698	2,685	0		0	0	0	0	6,383	(20,796)	Trade and Other Payables
			0	0	(32)		0	0	(2,645)	0	(2,677)	(2,677)	Borrowings
			0	0	0		0	0	0	0	0	0	Other Financial Liabilities
			0	0	0	(710)	(2,549)	0	0	0	(3,259)	(3,259)	Provisions
			0	(2,685)	0		0	0	0	0	(2,685)	(2,685)	Tax Payable
			(3,698)	0	0		0	0	0	0	(3,698)	(3,698)	Other Liabilities
			0	0	0		0	0	0	0	0	0	Liabilities in disposal groups
NET CURRENT ASSETS/(LIABILITIES)	**75,258**											(33,115)	**TOTAL CURRENT LIABILITIES**
TOTAL ASSETS LESS CURRENT LIABILITIES	**136,614**												
CREDITORS:													**NON-CURRENT LIABILITIES**
Creditors falling due after more than one year	0	0	0	0	0	0	0	0	0	0	0	0	Trade and Other Payables
			0	0	(2)	0	0	0	(186,575)	0	(186,577)	(186,577)	Borrowings
			0	0	0	0	0	0	0	0	0	0	Other Financial Liabilities
PROVISIONS FOR LIABILITIES AND CHARGES	(3,136)	0	0	0	0	0	2,549	0	0	0	2,549	(587)	Provisions
			0	0	0	0	0	0	0	0	0	0	Tax payable
			0	0	0	0	0	0	0	0	0	0	Other Liabilities
												(187,164)	**TOTAL NON-CURRENT LIABILITIES**
TOTAL ASSETS EMPLOYED	**133,478**											56,342	**NET ASSETS**
FINANCED BY TAXPAYER'S EQUITY													**TAXPAYERS' EQUITY:**
		0	0	0	0	0	0	0	0	0	0	0	Minority Interest
Public dividend capital	84,303	0	0	0	0	0	0	0	0	0	0	84,303	Public Dividend Capital
Revaluation reserve	16,110	0	0	0	5	0	0	0	4,854	0	4,859	20,969	Revaluation reserve
Donated asset reserve	2,109	0	0	0	0	0	0	0	0	0	0	2,109	Donated asset reserve
Available for sale investments reserve	0	0	0	0	0	0	0	0	0	0	0	0	Available for sale investments reserve
Other reserves	0	0	0	0	0	0	0	0	0	0	0	0	Other reserves
		0	0	0	0	0	0	0	0	0	0	0	Merger reserve
		0	0	0	0	0	0	0	0	0	0	0	Pension reserve
Income and expenditure reserve	30,956	0	0	0	25	(710)	0	(5)	(81,305)	0	(81,995)	(51,039)	Income and expenditure reserve
TOTAL TAXPAYERS' EQUITY	**133,478**											56,342	**TOTAL TAXPAYERS' EQUITY**

Statement on Internal Control 2009/10

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Responsibility for the effectiveness of organisational systems of control and risk management rests with the board of directors and the chief executive as accounting officer. However, specific responsibilities are delegated to other directors, and senior managers through the trust's risk management policy. This policy is reviewed annually and was approved by the board of directors in January 2010.

Management structures are in place within the organisation headed by myself as accounting officer. Operating within that structure and with the specific remit to manage risk are the risk management committee (non-clinical), which is chaired by the executive director of finance, and the clinical governance committee, chaired by the medical director. These are the principal committees charged with managing risk and clinical governance across the Trust.

These committees have dual reporting responsibility as they report routinely to the audit committee in order to provide assurance over the effectiveness of their systems but also to the executive management board. The executive management board is the most senior operational group within the organisation and is chaired by myself.

The audit committee is a non executive sub committee of the board which meets at least quarterly and is responsible for ensuring that systems and processes are in place for managing all aspects of governance across the organisation. This extends beyond finance and corporate governance to include information and clinical governance. Its remit covers the setting and monitoring of the internal audit plan, external audit plan and also the annual counter fraud plan together with ongoing review of all associated action plans. The audit committee reports after every meeting to the board of directors.
The board of directors receive further assurance on financial issues from the investments committee. The investments committee deals specifically with investment decisions and associated risks faced by the trust. It receives reports covering areas ranging from the trusts charitable fund operations to the progress of the new hospital development. This committee assists the board of directors in forming plans to action or mitigate against identified risks in these areas. The investments committee also reports after every meeting to the board of directors;

Staff are trained and equipped to manage risk in a number of ways:

- The management and divisional structures are well established and identify clear responsibilities for governance and risk management at board, corporate and divisional level.

- Awareness training on risk management, risk assessment, incident reporting and awareness of counter fraud are included in the trust's core induction programme which must be attended by all staff on their first day of work.

- Compliance with the risk management policy supports the assessment and management of risk at all levels in the organisation. This is supplemented by a number of other policies and procedures which are in place within the organisation. Examples include:
    - accident and incident reporting
    - handling complaints and claims
    - managing health and safety
    - dealing with fraud and corruption

Clearly all trust employees have a part to play in managing risk including reporting incidents, accidents and near misses; complying with all trust policies and procedures; attending training, including new joiner induction sessions as stated in the trust's mandatory training plans and being familiar with emergency procedures.

The Trust aims to ensure that it learns from good practice through:

- The trust employs a system of root cause analysis (RCA) to review processes and significant incidents in order to identify ways of reducing risks and learning from experiences. RCA has been used extensively during 2009/10 with health care acquired infections such as MRSA bacteraemia and C-difficile. This practice has also been extended to include breaches of the thrombolysis target and same sex accommodation breaches. The trust also links with partner organisations to provide appropriate education and training in this area.

- Action plans arising from external reviews such as the NHS litigation authority assessment standards, MHRA, peer review and PEAT. The board also formally reviews Care Quality Commission reports (CQC) for example, it recently considered the recent inquiry into the Mid-Staffordshire Hospitals NHS foundation trust and will consider the associated reports and regulatory guidance in detail.

- Implementation of good practice guidance such as that contained within the NPSA patient safety alerts.

- The trust has an emergency planning group which continually review the trust's ability to respond to a major incident and specifically this year has developed and exercised an influenza pandemic plan.

Risk and Control framework

Risk management is a core discipline within the organisation's activities with risks routinely being reported, using a standard reporting tool, throughout the different levels of the organisation. This "bottom up" approach to risk management is complimented by the "top down" board assurance framework The board assurance framework lists the principal risks to the achievement of corporate objectives as identified in the trust's annual plan and identifies and evaluates the systems of control in place to manage these risks and the assurance that these risks are being managed effectively.

The board of directors recognises the importance of involving public stakeholders in the management of risks that may impact on them and has established mechanisms to enable this involvement:

- The clinical governance committee includes 2 public governors;
- summaries of monthly performance are provided through team briefing and governors are provided with updates on performance issues at their meetings;
- the board of governors has established a number of committees that receive assurance in relation to the management of the risks associated with key aspects of the trust's work. For example, the performance and strategy committee of the governors reviews all of the trusts performance issues.
- the board of governors works with the non-executive directors in assessing the evidence used by the executive directors to support the annual Standards for Better Health declaration.

During 2009/10 the board assurance framework was considered regularly by the board of directors. Gaps identified related to a wide range of risks, including financial risks (for example the performance of the trust's productivity improvement programmes; and clinical risks (for example, achievement of the health care acquired infection (HCAI) reduction target).

In January 2010 the Trust recognised a risk to its authorisation as a foundation trust as a result of forecast failure to meet performance targets relating to thrombolysis and cancer waiting time targets. At the year end, the Trust was in breach of its authorisation in terms of performance failure in these specific areas.

Looking forward, the Trust is working hard to ensure that it recovers this position in terms of its authorisation as a foundation trust and has put plans in place to ensure that this happens.

The most significant risk facing the trust as we move into 2010/11 concerns the financial position of the organisation. The Trust is forecasting a balanced financial plan over the coming three year period. The financial forecasts require significant gains to be made by the Trust in terms of its productivity and efficiency over the period and plans are now being drawn up to deliver these whilst maintaining the quality of clinical services provided.

The single largest threat to the achievement of our plans over the longer term is the extremely challenging financial environment which exists both nationally and locally across the Nottinghamshire health community. It is inevitable that actions to reduce the financial pressure in commissioning plans will impact upon the Trust. The trusts financial plans take these risks into consideration and the trust is working closely with all health partners in order to ensure that this risk is mitigated as far as possible.

Information Governance

The executive director of finance has board level responsibility for governance and risk management systems and processes including those associated with information. He acts as the senior information risk owner and can confirm that the organisation is compliant with the information governance toolkit at level 2. This was confirmed by internal audit.

During 2009/10, the trust reported one serious untoward incident relating to a breach of confidentiality. In January 2010, an employee's car was stolen from outside the employee's home. The car contained patient identifiable information (a list of patients and a set of case notes for one patient). The information was retrieved intact later the same day. The patient was informed and an investigation was conducted. Adherence to the trust's policy regarding the use and security of patient identifiable information was reinforced to staff.

Standards for Better Health

During the year, the trust conducted an annual self-assessment against the Standards for Better Health. An interim declaration of full compliance was made in October 2009. No significant lapses were identified in the remaining six months of the year to the 31 March 2010.

The Foundation Trust is fully compliant with the core Standards for Better Health.

Registration with the Care Quality Commission (CQC)

The trust applied for registration with the CQC in January 2010, and registration with conditions was granted from the 1 April 2010:

Condition 1 – related to concerns that the trust had inadequate systems to assess and monitor the quality and safety of service provision and the trust was required to implement an action plan and provide evidence of improvement by the 31 July 2010;

Condition 2 – related to clinical governance arrangements within the integrated critical care unit (ICCU) and the trust was required to provide an action plan and evidence of improvement by the 31 May 2010.

The trust will demonstrate evidence within agreed timescales, to enable the restrictions to be removed.

Equality and Diversity

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

The trust has introduced a process for conducting equality impact assessments (EqIAs) and a diversity and inclusivity committee regularly monitors progress with these assessments. Initially, EqIAs have been conducted on key policies within the trust and a programme to extend these further is being implemented.

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

Carbon Reduction and Sustainability

The Foundation Trust has undertaken risk assessments and has put in place Carbon Reduction Delivery Plans 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.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, 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 incorporates the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The board has put in the following steps to assure itself that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

The steps cover areas such as:

- Governance and leadership – The board identified Executive Director sponsors in 2009/10 who were charged with overseeing the specific priorities identified for the year. This included monitoring against key performance indicators. In addition, part of the audit committees remit is to ensure that the quality report is produced in line with regulatory guidance.

- A quarterly quality report is presented to the board of directors that provides an update on performance. Specific aspects of the Quality Report have been provided through the clinical governance committee, EMB, and a small number of data quality issues have been subject to internal audit, including thrombolysis and A&E 4 hour wait targets. An internal review of 18 weeks data was also conducted at the beginning of 2010/11.

- Policies – a number of Policies have been put in place to provide controls for the use, recording and publication of data;

- Systems and processes – the trust has a number of systems and processes in place to provide controls for the use, recording and publication of data;

- People and Skills – The board has identified a number of specialist staff to manage the functions described within the Quality Report. For example the trust has a well developed infection control team that oversees the trust's arrangements and provides data on performance against hospital acquired infections. Equally we have groups in place who are responsible for cancer and 18 week waits;

- Data use and reporting – The board has developed quality key performance indicators (KPIs) and receives regular updates on performance against these through quarterly quality reports.

For data relating to patient experience, the board is confident that the right processes are in place to ensure accurate data is collected and that what is reported reflects the current vision of patient experience. The questions chosen to ask patients are from key areas in the Health Care Commission patient survey results and the Commissioning for Quality and Innovation (CQUIN) requirements.

The directors have applied the following process to maintain and review the effectiveness of the systems of internal control in relation to the Quality Report.

- Consideration and approval by the audit committee

- Consideration of quarterly quality reports from the lead executive directors responsible for the agreed priorities;

- regular reports to the clinical governance committee in relation to aspects of the quality KPIs that include updates against key performance indicators;

- the quality report to the board of directors has been reviewed and will be developed further during 2010/11 to provide regular assurance on a range of key clinical performance indicators to include;

    - Clinical incident reporting.
    - Tissue viability and specifically pressure ulcers.
    - Hospital acquired infections.
    - Slips, trips and falls.
    - Hospital standardised mortality rates.

This will provide a wider range of assurance for the Board of Directors and will address concerns identified within the CQC's quality risk profile.

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

The board of directors reviews the economy, efficiency and the effectiveness of the use of resources through monitoring processes. On a monthly basis the executive team reviews the performance of operational management through regular performance management meetings and regular reports are provided to the board of directors on progress against the trust's overall financial performance

Internal audit reports, reports from external audit, (principally the audit of the annual accounts and the production of the annual management letter), and regular reports from the Local Counter Fraud Specialist to the audit committee have also provided the board of directors with assurance that the trust's assurance mechanisms are sound and effective.

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, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, and the Executive Management Board and plans to address weaknesses and ensure continuous improvement of the system are in place.

I have also been advised by the following processes:

- Regular review by the board of directors of the board assurance framework and of the risk register;
- regular reports from the audit committee to the board of directors on issues of internal control and regular review of the minutes of audit committee meetings;
- regular reports from internal audit, to the audit committee on matters of internal control as described in the internal audit plan;
- the head of internal audit opinion which provides significant assurance over the system of internal control;
- consideration of board of directors' meeting agendas, papers and the quarterly board assurance framework updates that provide me with evidence of the effectiveness of controls;
- the outcome of visits, reports and assessments of external independent agencies including:
    - Our achievement of a financial risk rating of 4 from Monitor
    - Retention of NHSLA standard 1 for acute services in February 2010 and for Maternity Services in October 2009;
    - compliance with the Standards for Better Health in October 2009, with no significant lapses identified at 31 March 2010;
    - maintenance of Improving Working Lives Practice + status;

- PEAT inspections
- Clinical Pathology accreditation

- maintenance of Investors In People status;

- positive Postgraduate Dean report on training activities;

- positive report from the Healthcare Commission's ratings of trusts, confirming ratings of 'good' for our services and 'excellent' for our use of resources;

- gap analysis of the trust's position compared with key findings from the Mid Staffordshire NHS foundation trust hospital inquiry.

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by receiving the minutes and action plans of the key groups for promoting risk management as identified above. In addition I am aware of the importance of the following:

- The board of directors' role to provide active leadership of the trust within a framework of prudent and effective controls that enable risk to be assessed and managed;
- the role of the audit committee, as part of an integrated committee structure, which is pivotal in advising the board of directors on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the board of directors via the audit committee;
- the role of the executive management board in assisting me in ensuring a comprehensive and coherent framework of risk management that integrates clinical, non-clinical and corporate governance;
- directors' and managers' roles and responsibilities;
- the trust's internal auditors, who provide regular reports to the audit committee and full reports to the executive director of finance and line managers within the trust. The audit committee also receives details of any actions that remain outstanding following the follow up of previous audit work. The executive director of finance also meets regularly with the internal audit manager;
- the trust's external auditors, who provide an annual management letter and regular progress reports to the audit committee.

Conclusion

As accounting officer and based on the information provided above I am assured that the only significant control issues currently faced concerns compliance with our terms of authorisation which arose in quarter four as a result of our failure to meet performance targets concerning governance, and with the Care Quality Commissions registration conditions. I am satisfied that the actions being put in place will be sufficient to rectify both these issues early in 2010/11.

Finally, whilst we recognise that we have an extremely challenging financial plan to deliver going forward there is an unknown level of financial risk posed by the external financial climate. The Trust continues to work with its local partners to ensure that this risk is managed appropriately and that the quality of services provided is considered paramount at all times.

Signed…….. Date: 3 June 2010

Chief Executive