Sherwood Forest Hospitals NHS

NHS Foundation Trust

Annual Report & Accounts

2011/12

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

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FOREWORD

Chairman and Chief Executive's Foreword

Sherwood Forest Hospitals NHS Foundation Trust remains committed to providing the best care, with the best people and in the best place for our patients, ensuring the quality of care and our hospitals are a source of pride for our community, and for our staff.

As one of the largest employers locally, we are also committed to continuing to play an important role in contributing to the wider economic and social regeneration of our community and we are proud of our role in helping to build a healthier future for the people of Mansfield, Ashfield, Newark and Sherwood, Derbyshire and further afield.

We continue to exist with the primary mission to deliver high quality, effective and affordable healthcare for our local population and other stakeholders, by ensuring that we provide the best care; that taxpayers receive value for money; and that we continue to be a well led NHS Foundation Trust.

The last year has been one of the most challenging in our five year history as a Foundation Trust. It has seen us making difficult choices in order to deliver increased cost reductions and productivity as a result of an increasingly difficult financial and operating environment. Additionally, as a consequence of those increased pressures, we have experienced greater regulatory scrutiny as further external assurance is required in relation to the effectiveness of our response. We are exceptionally proud of the efforts of our staff in supporting us to continue to deliver higher quality and excellent clinical care throughout this period. This really is testament to the commitment and strength of every single member of our team – and is proof, if it is needed, that we really do believe that healthcare is all about teamwork, professionalism, compassion and service. It is like no other organisation or job - it is a passion.

Our Annual Report for the year ending 31 March 2012 takes us on a journey through the many achievements and highlights of the last 12 months and it summarises our operating, clinical and financial performance for stakeholders. We hope that it will also reinforce our passion and commitment to you, our friends and partners. Above all, we hope it demonstrates that delivering the best quality care has remained, and always will be, our highest and most important priority.

Looking ahead, we will be operating in a radically transformed environment and in a marketplace which is becoming increasingly competitive, financially challenging and complex. The Health and Social Care Bill, which gained Royal Assent in March 2012 will drive the largest change in healthcare delivery that we have seen for a generation. This increasingly market led approach will result in increased competition and increased choice for patients. It will re-define 'where', 'how' and 'by whom' healthcare is delivered in the future. Together with unprecedented financial challenges and significant national and local efficiency requirements, the result will be pivotal in driving and radically re-shaping the NHS and wider healthcare landscape for many years to come.

Sherwood Forest Hospitals NHS Foundation Trust is an ambitious Trust. We are well placed to adapt to and meet the challenges posed by these changes and we will do so by retaining and winning the essential and valuable support of our community.

Our willingness to embrace the challenges ahead, whilst truly delivering the best care and becoming the hospital of choice for our local population, will set us apart, ensuring that we continue to be a successful organisation in the future.

The motivation behind these ambitions is simple - our commitment to the people we serve, our commitment to our community and our desire to build a healthier future for all.

Our successes over the last year would not have been possible without the support of our governors, members, volunteers and donors. Your tireless support is very much appreciated. You are what makes us 'the best', and you are crucial in keeping us close to the patients and communities we serve.

Finally, and most importantly, we would like to take this opportunity to thank all our staff for their hard work, for their commitment and for their teamwork despite these challenging times. Your achievements are a source of huge pride and it is an immense privilege to work as a part of your team.

Tracy Doucét
Chairman

Martin Wakeley
Chief Executive

1. ANNUAL REPORT

1.1 DIRECTORS' REPORT

1.1.1 Our Vision and Values

Throughout 2011/12, we have worked in partnership with our staff, with our members and with our governors to continue to deliver our vision to ensure that our hospitals, and the quality of care we provide are a source of pride for our community.

Our vision is clear and it is simple, and it reflects what matters most to our patients.

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	Pledges to Staff
We will listen to you	**We will appreciate you**
We will work together as a team	**We will listen to you**
We will show kindness and compassion	**We will support you to do the best in your job**
We will communicate effectively	**We will provide a safe environment**
We will care for you in a safe and clean environment	

These pledges were developed with our patients and with staff during 2009/10. They remain as powerful today as when they were first conceived and they support us to work together with pride, energy and passion to deliver our best care vision.

Our progress in delivering our vision and performance against our quality, operational and financial objectives over the past year is presented through this, our 2011/12 Annual Report.

1.1.2 Highlights of the Year 2011/12

Providing the 'Best Care'

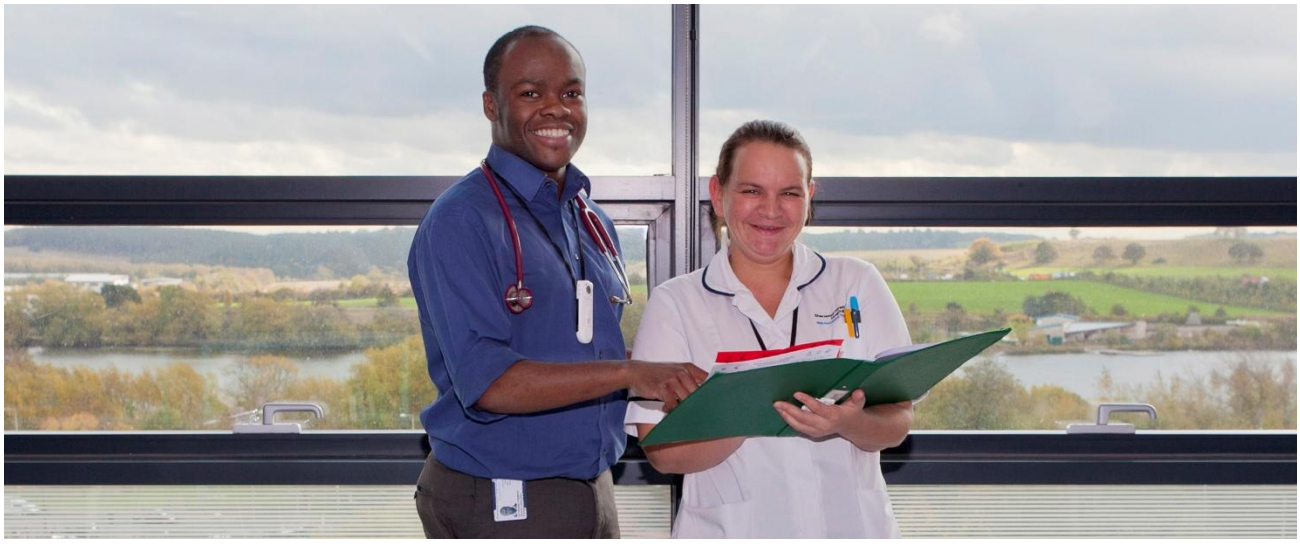
- We made the most of our fantastic new facilities at King's Mill Hospital and King's Treatment Centre supporting us to deliver the 'best care'.
- We were delighted to discover the care provided at Newark Hospital is consistently rated as 'excellent' or 'good' by more than 90% of our patients; and we introduced an additional 43 new clinics per month at Newark Hospital
- As a result of winning a competitive tender during 2010/11, we delivered a range of community based inpatient and outpatient services at both Ashfield and Mansfield community hospitals and across the community, placing us in a strong position to create a future vision based upon community care
- We treated over 46,500 people as inpatients in our hospital beds within spacious new wards, many of whom benefited from world class facilities and 50% en-suite single rooms at King's Mill
- We treated 29,300 day case patients preventing the need for an overnight stay, reflecting commissioner and our own ambitions to deliver more day case surgery
- We provided 392,000 outpatient appointments throughout the year across a broad range of specialist clinics, providing diagnoses, care and advice for more than 115,000 patients in the King's Treatment Centre
- We had the first full year in our new Emergency Care Centre (ECC) treating more than 111,500 people; a significant increase of over 10% on the previous year
- We delivered more than 3,500 babies in our specially designed maternity facilities and were able to facilitate 130 home births
- During the year we were unable to consistently deliver all national targets each quarter with respect to quarters 2, 3 and 4 for C. difficile. All other national targets were reported as compliant in our Quarterly returns. However, on a monthly basis we breached a number of internal targets due to unprecedented operational demand. These related to a number of cancer targets and A/E performance although end of year performance was met.
- Once again, we achieved zero cases of hospital acquired Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia across our hospitals, this means that we have performed amongst the best hospitals nationally for the last two years
- We achieved zero grade 4 pressure ulcers (grade 1 ulcers are reddening of the skin, grade 4 ulcers are open wounds exposing muscle or bone) for nearly 2 years, with a commitment to eliminating avoidable grade 3 ulcers during 2012/13
- We successfully achieved accreditation of new key national clinical pathway revisions including stroke, PCI (percutaneous coronary intervention), and trauma
- We were accredited as the first designated level 2 Trauma Unit in the East Midlands' Trauma Network, enabling us to receive and stabilise trauma patients prior to sending them to the designated Trauma Centre at NUH (Nottingham University Hospitals), Queen's Medical Centre.

- We developed new and innovative patient services including: a new treatment for retinal vein occlusion, enhanced recovery for surgical procedures, and additional services for children at Newark Hospital

- We successfully met the demands of new national screening programmes, including the extension of the age range for breast screening for women aged between 47 and 49 and between 71 and 73 (previously screening was between 50-70 years unless clinically indicated) and for the respiratory screening programme

- Our Board invited patients to share their experiences, both good and bad, at Board meetings to help us to drive improvements and to ensure that patient experience remains at the heart of everything we do

- We introduced telemedicine between our hospitals at Newark and King's Mill to reduce the need for patient travel, to strengthen the integration of patient services between our hospitals and to improve safety



With the 'Best People'

- We developed integrated performance dashboards to strengthen reporting, management and accountability from board-to-ward ensuring risks such as cancer waiting times and Care Quality Commission (CQC) compliance could be identified at service or ward level in order that focused actions could be undertaken to mitigate failure. An example of this was our ability to recognise the requirement to focus our Mental Capacity Assessment (MCA) action plan on the Emergency Admissions Unit (EAU)

- We implemented a major strategic workforce review, ensuring that we remain financially secure, improve productivity and retain a highly skilled, flexible and responsive workforce

- Out of the 10 Trusts who undertook the testing phase of the National HIS (Health Informatics Service) Accreditation Standard, led by the Health Informatics Benchmarking Club (HIBC), our Health Informatics Service was one of three nationally that passed the assessment, confirming that our IT service provider was compliant against national standards of quality and assurance. This is particularly important in safeguarding the security of our patient systems and patient information

- We implemented the changes consulted on as part of the 'Newark Healthcare Review', changing the way in which patients requiring emergency care were looked after (they now go to local A&E (Accident & Emergency) units which have greater resources available to them). This is in addition to creating specialist rehabilitation services in Newark for patients requiring longer term rehabilitation following specialist care in other hospitals

- The Newark Healthcare Review also provided some new opportunities such as the closer integration of services across primary and secondary care, including urgent assessment clinics for quick access to specialist opinion, preventing unnecessary admissions

- We worked more closely with our growing membership base of almost 21,000 Foundation Trust members through activities such as recruitment fairs, newsletters and engaging members and governors in consultative meetings around our clinical priorities

- We launched our Leadership & Management Development Programme, enhancing and building the skills of our future leaders

- We showcased our Achieving Best Care (ABC is our lean programme provided in conjunction with Unipart) work on national platforms to demonstrate best practice and in the year ahead we will work to share this best practice further for the benefit of organisations across the NHS as well as within our hospitals

- We enrolled in the national Leading Improvement in Patient Safety (LIPS) programme and we appointed a new deputy medical director for patient safety to provide greater internal capacity in order to deliver our new quality objectives such as the reduction in Summary Hospital-level Mortality Indicator (SHMI).

- We reduced our workforce by over 160 staff within the year in addition to changes in terms and conditions such as the removal of paid breaks

- We delivered on our strategic workforce review challenges in partnership with our trade union partners and our staff

- We created a mortality review group to support our ambitious plans to reduce our Summary Hospital-level Mortality Indicator rates (SHMI) to below 93 during 2013/14 (a reduction from 101 to 97 targeted during 2012/13). We introduced a revolutionary Acute Response Team (ART) as an additional support mechanism

- Reflecting our ambition to care for more patients closer to home we introduced a new and innovative Emergency Department Admission Avoidance Support Scheme (EDAASS) ensuring the safe discharge and care of patients from our emergency department. This has resulted in over £200,000 worth of savings to commissioners since the project commenced as a result of avoided admissions

1.1.3 Business Review 2011/12

The directors present their report, together with the audited financial statements and accounts for the year ended 31 March 2012, prepared under direction issued by Monitor, the Foundation Trust regulator.

About Us – An Introduction

Sherwood Forest Hospitals NHS Foundation Trust was established in February 2007. This year we celebrated our 5th anniversary as a Foundation Trust.

We have spent the last five years developing an ambitious 'best care' vision - a vision which we believe will, over time, radically transform the quality of care provided to our patients and for our community.

Over the last year, we have continued to build upon the strong foundations previously laid to support the delivery of our ambition. Our many successes have included the continued achievement of quality aspirations; improved clinical outcomes and safety standards; the achievement of many of our stretching financial and performance objectives.

Our vision, mission and supporting goals start to define a different focus for the Trust moving forward. For the mutual benefit of patients, commissioners and our partners, one of these focused on creating improved integrated care models that seek to break down organisational barriers which sometimes exist between health and social care organisations.

Quality remains our number one priority. It is at the heart of everything we do.

Many of our achievements and investments throughout the year have made a major contribution towards further improving the quality, safety and effectiveness of our care.

During the past 12 months we began work to create truly transformational change, building on our innovative Achieving Best Care work, developed in partnership with Unipart, and which sought to apply 'lean' techniques to redesigning some of our patient care pathways.

We have focused our energies and aligned our resources to continue to ensure that we provide the absolute best care for our patients, and we have adopted 'zero tolerance' as a driving principle of service improvement. An example of this was the adoption of seeking zero tolerance of MRSA and whilst over 2 years ago no one would have thought it possible to go for over 2 years without an MRSA blood borne infection, our commitment to 'zero tolerance' has made this possible.

We continue to be proud to be the only NHS Hospitals Foundation Trust serving the communities of Nottinghamshire and we commend to you our 2011/12 Annual Report.

Our Principal Activities

Sherwood Forest Hospitals NHS Foundation Trust is responsible for the main acute hospitals (King's Mill and Newark) providing high quality healthcare services for a local population of around 418,000 people across Mansfield, Ashfield, Newark, Sherwood (in central Nottinghamshire) and increasingly from further afield, particularly east Derbyshire and west Lincolnshire, and wider Nottinghamshire.

The principal activity of the Trust is the provision of acute healthcare services and during the past 12 months we have successfully expanded our activities and services to provide a number of community services enabling us to provide seamless integrated care for our patients.

We provide a wide range of diagnostic services, treatment and care from our two main hospitals - Newark Hospital and King's Mill Hospital in Sutton in Ashfield. In addition, from April 2011, we have also provided inpatient, outpatient and community based services from both Mansfield and Ashfield community hospitals.

This increased provision of services provides an ideal opportunity for us to redesign and integrate care pathways to better meet the needs of our communities, continuing to provide the very best care for our patients and to deliver value for money for taxpayers and for our commissioners.

We serve a diverse population including densely populated urban areas across both Sutton in Ashfield and Mansfield stretching to more rural communities across Newark, Lincolnshire and east Derbyshire. Much of our area is characterised by comparatively lower economic prosperity and a proud industrial past, a strong heritage in coal mining and textiles, which in turn brings high levels of respiratory problems and higher rates of other chronic illness, long-term conditions and disabilities.

The impact of this is that our hospitals experience higher hospitalisation rates than the national average, with particularly high levels of emergency admissions.

This high level of health need, together with the increased numbers of patients using our hospitals, has been reflected in increased demand for our services and in higher than average growth in our income since becoming a Foundation Trust in 2007.

With an annual income of around £253 million, we continue to play a vital and successful role in supporting the social and economic regeneration of our local economy - creating much needed employment and training opportunities, as well as purchasing goods and services from local suppliers where possible.

Sherwood Forest Hospitals NHS Foundation Trust is immensely proud to be one of the 144 Foundation Trusts nationally, who collectively now provide more than half of all NHS services. As a Foundation Trust, we remain firmly within the NHS, yet we differ from NHS Trusts in that we are not directed by Government.

Having successfully gained our licence to operate as a Foundation Trust in February 2007, we have greater freedom to decide our own strategy; to manage our finances and to invest in service development to improve the way our services are run in response to the needs of our local communities.

Significantly, as a Foundation Trust, we are committed to the highest standards of transparency and we take seriously our responsibilities to our local community.

As a Foundation Trust, we differ from NHS Trusts in that we are accountable to:

- Our local community through our 20,818 public members, whose interests are represented by 20 democratically elected public governors

- Our 3,630 staff members and wider partners and stakeholders, whose interests are represented through the appointment and nomination of 16 governors (out of 36 in total)

- Our commissioners through our annual contract

- Monitor, the Foundation Trust regulator and to Parliament

We are not directed by Government, and are therefore able to use our freedoms to develop our strategy and services to meet the needs of our patients. We are also free to borrow and to retain any surpluses we generate to invest in improved facilities and services for the benefit of our community.

We are proud of our record and significant achievements in doing this successfully during 2011/12 to further improve the quality of care we provide. We remain committed to using our Foundation Trust freedoms in the future to continuously improve the excellence of the care we provide.

Our community, our people and our commitment to delivering ‘best care’ remain at the very heart of everything we do.

Operating Context and Summary Operational Performance

This Directors' report presents a summary analysis of our operational and financial performance, key trends and position of the Trust, through the eyes of the Board of Directors, and provides a balanced view of our performance over the last year.

Operating Context

The last 12 months have been the most challenging in our five year history as a Foundation Trust. The national context has resulted in a reversal of the trend of more recent years of NHS growth exceeding 5% per annum to an environment where the NHS nationally has had to generate efficiencies equivalent to £20 billion over a four year period. The impact of this is that the Trust has had to plan for declining income whilst at the same time its cost base has been increasing, with its PFI charge linked to Retail Price Index inflation uplift creating additional cost pressures.

An added complexity specific to PFI hospitals is that when seeking to reduce capacity in the face of reducing demand it is necessary to reduce both pay and fixed costs. Whilst the Trust has sought to reduce its pay bill it cannot reduce its fixed costs due to the nature of the PFI charge. Work is ongoing to ensure that the semi-fixed costs are being reduced by making volume adjustments where possible but as further reductions in demand are experienced then the impact of not being able to reduce fixed costs will need non-traditional solutions such as encouraging other healthcare providers to utilise the PFI assets.

Despite this challenging environment, the Trust met the majority of its key financial targets in the 12 month period, albeit contingencies were sought towards the end of the year as the failure of some Cost Improvement Programme (CIP) schemes became more obvious. At year end, our overall financial performance exceeded plan. This was as a result of marginally higher than expected income; lower than forecast operating expenditure, together with the successful delivery of the £15.6m in-year cost improvements (6.3%), and improved cash and liquidity at year end.

Overall, we ended the 2011/12 with a Financial Risk rating (FRR) of 3 against a plan of 2.
(Where 1 = High Risk, 5 = Low Risk).

Our good progress and better than planned financial performance will enable us to meet the challenges ahead with increased confidence. However, it has also required us to make difficult choices, with our main challenge getting the balance right between reducing our cost base quickly to ensure long term financial sustainability, whilst also ensuring that we continue to protect and improve the quality, safety and effectiveness of our services.

Investing in new services and infrastructure, such as a replacement patient administration computer system, whilst at the same time simultaneously managing our cash to ensure that we remain sustainable over the longer term, has also proved increasingly difficult as the external financial environment tightens further.

Throughout the year, however, Sherwood Forest Hospitals NHS Foundation Trust has continued to deliver a high standard of patient care and we have invested further in continually improving the quality, safety and effectiveness of the services we provide.

During the year we have also continued to invest to improve the facilities at our principal sites, King's

Mill and Newark hospitals, and invested in improving services at both Mansfield and Ashfield community hospitals.

Most notably, we completed the final stages of the redevelopment of King's Mill Hospital, creating a truly world class hospital. We have designed and opened a new renal dialysis unit and in partnership with the University of Nottingham we completed the new King's Mill Conference Centre, integrating undergraduate medical and nurse training facilities with our own internal staff training and development provision, reinforcing our commitment to ensuring we have the very best people now and in the future.

In addition to investing in our infrastructure, during the year we have introduced a number of new clinical services to meet the needs of our community and to improve quality.

Most notably, over the last twelve months we have achieved the following:

- Colorectal cancer patients now benefit from a new way of care before, during and after surgery in King's Mill Hospital thanks to the introduction of an enhanced recovery programme. This improves outcomes for patients and speeds up recovery following surgery, allowing patients to safely leave hospital earlier and get back to their normal activities sooner

- Investment in a new role of children's complex needs and palliative care nurse specialists has made a huge difference to many young lives. The specialist nurse role ensures that children with complex needs receive their treatment at home wherever possible, thus helping to avoid an unnecessary hospital stay or reducing the number of days in hospital by more than half

- Investment in a new renal dialysis unit at King's Mill Hospital means that local kidney patients are now receiving their treatment in modern, state-of-the-art facilities. The unit houses an extra four renal stations, complete with the latest dialysis equipment, bringing the total number of stations to 20. This provides extra flexibility for patients to access treatment at the time of day that suits them and offers them much improved surroundings for their care

- The launch of a new clot busting treatment at King's Mill Hospital means that more north Nottinghamshire patients now receive gold standard stroke treatment closer to home

- Two leading edge techniques for the treatment of kidney stones and conditions were introduced at King's Mill Hospital. Shock wave lithotripsy and percutaneous nephrolithotomy (keyhole surgery using ultrasound) reduce patients' pain and discomfort and speed up recovery

- A new support service for junior doctors and nursing staff at King's Mill Hospital ensures that acutely ill patients whose condition worsens receive the fastest possible treatment by medical specialists. A memorable bleep number enables ward staff to summon the acute response team 24/7, which offers a new middle level of support in between calling the cardiac arrest team and the critical care outreach service. This ensures senior medical help to the sickest patients faster

- The East Midlands Cancer Network 23 hour Ambulatory Breast Care Project mastectomy pathway was introduced. This enables women undergoing surgery to be treated and

discharged within 23 hours, reducing their length of stay in hospital and improving their overall patient experience. Patients are able to recover in their own home with regular contact and support from the Trust's specialist breast care nursing team

- A new daily consultant led children's service has been introduced at Newark Hospital. These daily clinics include asthma, allergy and epilepsy and ensure children requiring an urgent assessment by a specialist, but not necessarily a hospital admission, can be seen and cared for locally at the earliest possible opportunity

- King's Mill Hospital became one of the only hospitals nationwide to offer on the NHS a revolutionary eye treatment which prevents blindness. The new treatment helps to restore the sight of patients who develop macular oedema when one of the major veins of the retina becomes blocked, known as retinal vein occlusion

Further detailed information on our commitment to and performance in improving the clinical quality, safety and effectiveness of our services can be found in our Quality Report in section 2.

Activity and Demand for Our Service

Sherwood Forest Hospitals provides elective services in a market of geographically close competitor providers, including Nottingham University Hospitals NHS Trust, Derby Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and Chesterfield Royal Hospital NHS Foundation Trust, as well as the two independent treatment centres located in Nottingham and Barlborough.

During the year, the Trust delivered record levels of emergency and unplanned activity; together these exceeded the forecasts of our commissioners and added to the challenges of planning our capacity and reducing our staff and variable pay costs.

Details of our actual activity against our planned contracted activity are provided in the table below:

Clinical Activity	***2010/11 Actual***	***2011/12 Plan***	***2011/12 Actual***	***Variance Plan v Actual***
Elective inpatients and day cases	40,620	36,750	36,580	-0.46%
Non-elective inpatients	39,279	35,030	39,137	+11.7%
New outpatients	88,809	82,511	85,213	+3.3%
Accident and emergency	106,788	101,400	111,940	+10.4%

During the year, we generated 88% of our contract income from our two main Clinical Commissioning Groups: Mansfield & Ashfield which surrounds King's Mill Hospital, and Newark & Sherwood which surrounds Newark Hospital. Of the remaining 12%, 10% comes from east Derbyshire with smaller volumes from west Lincolnshire, Bassetlaw and the southern areas of Nottinghamshire.

For both Clinical Commissioning Groups (CCGs), we are the largest provider of secondary care services. In Mansfield and Ashfield, our overall market share for both admitted patients and outpatients is 80%. In Newark & Sherwood our market share for admitted patients is 58%, and for outpatients 63.1%.

Our largest competitor in both CCGs is Nottingham University Hospitals NHS Trust (NUH) – together we successfully serve more than 87% of the total market in the two CCG areas.

In recent years, we have seen both admitted and outpatient activity decrease as GPs provide services in the community and as our commissioners implement clinical assessment services (CAS) and other methods to reduce the demand for secondary care.

In the last year, our share of the admitted market has fallen more sharply (2.6% decrease) than the overall fall in market volumes (2%). This has largely been due to changes in the way emergency admissions are handled in Newark & Sherwood which has seen care shift to Nottingham University Hospitals and Lincoln Hospitals.

For outpatients, our share of the market has increased and we have seen a smaller decrease in activity (-3.9%) compared to the overall decrease in market size (a 7.7% reduction in the Nottinghamshire outpatient market as reported by commissioners). This has largely been due to the Trust's strategy to shift more work from admitted to ambulatory care and to an increase in market share in the Newark & Sherwood localities due to more focussed marketing of the hospital.

Whilst we have been successful in significantly increasing our revenue and our share of the market over the last few years, we anticipate that competitive pressures will increase as commissioners seek to reduce overall costs. This requires that we constantly review our service offering, that we engage with our local GPs in order to ensure that we are delivering the quality of service that they require for their patients, and that we improve our administration to ensure that the patient journey is as simple as possible.

Whilst there remain further opportunities to strengthen our market share for elective activity, in future, continuing to grow revenue and margin will be extremely challenging, particularly where it is dependent upon taking market share from competitors who have identical ambitions.

Conversely, the market for community/home based delivery of health care services, vertically integrated with acute and primary care providers as well as horizontally linked with social care providers, is strong and provides a significant 'joined-up' opportunity.

Meeting National Service Performance Targets

Our performance in meeting national service targets has been excellent evidencing high levels of operational performance and critically, ensuring the timely care and treatment of patients throughout the year.

With the exception of C. difficile, the Trust met all service performance targets in each quarter throughout the year. For C. difficile, we narrowly failed to meet our annual reduction target of 20% with 45 cases against a target of 43 (a reduction of 17% year on year). Since March 2012, our C. difficile numbers stand at 2 cases per month. This will enable us to start the new year target of 36 with some confidence that we do have systems that enable us to deliver low levels; although

sustaining them throughout the year is recognised as difficult and has been identified by the Board as a risk for 2012/13.

An overview of our performance against all of the mandatory national targets during 2011/12 is provided as follows.

Target	Standard	Q1	Q2	Q3	Q4
Referral to treatment – admitted patient care, treated within 23 weeks	23	18.00	18.00	18.14	19.86
Referral to treatment – non-admitted patient care, treated within 18.3 weeks	18.3	15.29	16.00	16.43	16.86
A&E Clinical Quality – total time in A&E less than 4 hours	95%	96.70%	97.22%	95.70%	95.21%
Cancer 31 days for second or subsequent treatment	98% Drugs	98.36%	100%	98.91%	99.12%
Cancer 31 days for second or subsequent treatment	94% surgery	97.96%	98.11%	100.00%	100.00%
Cancer 62 days for all referrals to treatment	85% GP	88.53%	88.53%	89.41%	91.80%
Cancer 62 days for all referrals to treatment	90% Screening	100.0%	93.75%	96.23%	97.70%
Cancer 2 week wait – all cancers	93%	95.02%	93.06%	96.99%	96.30%
Cancer 2 week wait – breast symptomatic	93%	93.15%	95.39%	97.90%	97.86%
Cancer 31 days from diagnosis to treatment	96%	99.27%	100%	99.41%	99.70%
Infection Prevention Control: MRSA Bacteraemia (No. of cases attributed to Trust)	3	0	0	0	0
Infection Prevention Control: Clostridium Difficile Infections (No. of cases attributed to Trust)	43 cases	6	15	16	8
Access to Healthcare for people with learning disabilities	6 Standards	Compliant	Compliant	Compliant	Compliant

A particularly notable performance on A&E was achieved despite 10.3% increase in activity year on year, and a 17.7% increase in complex activity over the same period. This growth is almost double the national average and our performance places us in the top two Trusts in the East Midlands.

The Trust has also achieved all the cancer waiting times standards throughout 2011/12, ensuring the timely care and treatment of patients. Whilst this has been fantastic, we can do more. Patients choosing to delay their appointments, diagnostic tests and treatments continues to be one of the biggest challenges to our ongoing achievement of performance against mandatory national targets and during the year ahead we will work together with GPs and patients to increase attendance at urgent appointments.

Reducing hospital acquired infection rates will always be a priority for us and we are really proud of our record on infection prevention and control and on the cleanliness of our facilities. This year, in addition to continuing to reduce C. difficile infections, we recorded zero hospital acquired MRSA blood borne infections.

We have now celebrated more than two years without a hospital acquired MRSA blood borne infection – making us one of the best performing hospitals in the UK, a record that we are justifiably extremely proud of. We also know that this continues to be one of the things that matters most to our patients.

In addition to performing well against mandatory access targets, the Trust is also committed to ensuring ongoing compliance with the terms of our registration with the Care Quality Commission. The Trust was assessed by the CQC against the 16 essential standards of quality and safety throughout the year with an initial assessment being undertaken in May 2011 at which the Trust was found to be non-compliant against seven of the standards and again in October where the Trust was considered to be non-compliant against two. On both occasions the Trust Board commissioned action plans to respond to the non-compliance observations provided by the CQC.

Following internal and external assessment of the Trust's compliance against outcomes 2 and 21, the Trust considered itself fully compliant with the CQC in March and notified the CQC of its assertion on 15 March 2012.

The CQC inspected the Trust on 27 April 2012. They provided verbal confirmation of full compliance at the end of their visit and we received formal confirmation on 9 May of full compliance.

More detailed and comprehensive information on our performance in improving national service performance targets can, again, be found in our Quality Report (see section 2).

The Views of Our Patients

Whilst our good performance against national targets is something to be proud of, nothing matters to us more than the views of our patients.

The results from the independently undertaken National Adult Inpatient Survey during 2011/12 highlights the increasing number of areas in which we performed in the top 20% of hospitals across the country.

Based on the views of 415 patients who received care in our hospitals during July 2011, we scored better than other Trusts nationally in seven main areas for patients:

- Noticing that nurses washed or cleaned their hands between touching patients
- Describing toilets and bathrooms as clean
- Being given enough privacy when being examined or treated
- Being given enough privacy when discussing their condition or treatment
- Having a choice of food
- Not ever being bothered by noise at night from other patients
- Letters between the hospital doctors and family GP being written in a way they could understand

This was supported by patient comments such as:

"The hospital was very clean. The staff were excellent and so was the food."

"Newark Hospital was a lovely caring place. I received excellent care."

None of our scores were amongst the bottom 20% of Trusts.

In addition to the national survey, we also continued to use independent volunteers throughout the year to gain real-time feedback from patients on the quality of care. Critically, during the year we asked more than 2,100 patients attending our hospitals whether they would recommend us?

More than 90% of those we spoke to would recommend us to a friend or a member of their family. This is huge testament to the progress we are making to provide the best care for our patients and community. That said, we are not satisfied. During the year ahead we will continue our zero tolerance approach to failure and we will work harder, once again, to ensure that we deliver the best care, at the right time and in the best way for each and every one of our patients.

Regulatory Performance - Compliance with our Terms of Authorisation

Each year Monitor, the independent Regulator of Foundation Trusts, publishes an Annual Compliance Framework. The Framework sets out a series of mandatory service performance targets and financial performance measures. The Trust's performance throughout the year is assessed, scored and risk rated depending on achievement of, and compliance with, these measures and performance criteria throughout the year.

Each year, the Board of Directors develops and submits its Annual Plan. This plan covers the Trust's vision, strategy, high level aims, milestones and its three year financial plan.

Prior to submission, based on its assessment of historic trends and assessment of risks, the Board of Directors formally reports risks to ongoing compliance.

Based on this and on the information submitted in the Trust's Annual Plan and in-year submissions, a planned risk rating for three areas is assigned – finance, governance and mandatory services.

- The *'financial risk rating'* (FRR) is derived from a number of indicators and is described as a numeric rating from 1 to 5, with 5 being the lowest risk possible
- The *'governance risk rating'* (GRR) is a derived from performance against a number of service performance indicators, and includes third party reports and is described in a 'traffic light' rating of green, amber/green, amber/red, red
- The *'mandatory service rating'* is derived from a number of indicators relating to the risk of ongoing provision by the Trust of its mandatory services in line with our terms of authorisation

At 31 May 2011, the Trust declared a number of potential forward risks:

Service Performance (Governance Risk Rating)
The Trust declared risk to both the achievement of the mandatory national targets for C. difficile reduction and Cancer 62 day waiting times, resulting in an overall governance risk rating of amber-red.

Both risks were declared on the basis of the Board's robust assessment of historic performance and trends:

- Specifically in relation to the Trust's 2011/12 C. difficile reduction targets, the Board remained concerned that the reduction in comparison with its 2010/11 target which reduced by 20% was a risk, given the Trust's top quartile performance nationally. During the year, the Trust narrowly missed its target achieving a 17% reduction in year, but registering 45 cases against a target ceiling of 43
- In relation to the achievement of Cancer 62-day waiting time targets, in addition to historic trends, the Board remained concerned that the number of patients changing, cancelling or not attending urgent appointments remained a key risk to achievement. This was particularly material given the small numbers of patients treated in certain pathways. During the year the Trust achieved its targets in each quarter as the result of robust performance management, control of risks and mitigating actions

Financial Performance (Financial Risk Rating)
At the time the Trust submitted its plans, the Board declared a risk to its ability to continue to maintain a financial risk rating of 3 during the final quarter of the year (January 2012 – March 2012). This was declared on the basis of the Board's assessment of the forecast outcome of commercial negotiations in year combined with forecast deteriorating cash balances through the year. Throughout the year, the Board and management team worked to mitigate the risks. The Trust ended the year with a financial risk rating of 3, better than plan.

A summary of our regulatory performance comparing both our planned and actual performance during 2010/11 and 2011/12 is provided below:

2010/11	Annual Plan 2010/11		Q1 2010/11		Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	3		4		4	3	3
Governance risk rating	Amber	Green	Amber	Green	Green	Green	Green
Mandatory services	Green		Green		Green	Green	Green

2011/12	Annual Plan 2011/12		Q1 2011/12		Q2 2011/12		Q3 2011/12		Q4 2011/12	
Financial risk rating	3		3		3		3		3	
Governance risk rating	Amber	Red	Amber	Red	Amber	Red	Amber	Red	Amber	Red
Mandatory services	Green		Green		Green		Green		Green	

The Trust's failure to meet both its ongoing C. difficile trajectory and to be CQC compliant in all the essential standards of quality and safety, resulted in the red governance risk rating. However, as highlighted, and following a CQC inspection on 27 April 2012, we received formal confirmation on 9 May of full compliance.

Summary Financial Performance

This financial overview summarises our performance for the financial year which ended on 31 March 2012.

The Trust, against a backdrop of continuously improving the quality of patient service delivery has had to operate in a very challenging financial environment, one where the need to drive significant cost improvements has been essential. Despite this context the Trust met the majority of its financial targets in year and reported an overall surplus of £4.2m. This surplus however was the result of a technical adjustment of £10.4m for the effects of a revaluation of the Trust's land and buildings. The underlying position once we remove this accounting adjustment was a deficit of £6.2m. Whilst this deficit is significant it was actually an improvement on the original forecast outturn deficit of £9.4m, and the improvement reflects the intense focus on driving efficiencies across the organisation.

This improved position means the Trust reported an improved financial risk rating (FRR) at year end, achieving an FRR of 3 against an original forecast of 2 (where a score of 1 is 'high risk' and 5 'low' risk).

In preparing the Annual Accounts the Trust is also required to assess the basis of their preparation, specifically questioning the status of the Trust as a 'going concern'. This assessment takes into consideration all information available about the future prospects of the organisation and also covers financial, governance and mandatory service risks.

Statement of Comprehensive Income (Income and Expenditure)

Total income for the year was £266.1m (£258.5m in 2010/11) representing a growth of 2.9%, however this includes income for the additional services transferred to the Trust under Transforming Community Services (TCS) contract and the effect of a reversed impairment. Like for like, the underlying position was £238.5m, representing a £20.0m reduction. This is in large part due to the increased pressures on the need for QIPP (Quality, Innovation, Productivity & Prevention) efficiencies required from our main commissioner, NHS Nottinghamshire County PCT (Primary Care Trust).

The Trust was successful in meeting its cost improvement ambitions, successfully delivering in year savings of £15.6m against a plan of £15m. Achieving ongoing cost improvements will remain a key part of our strategy as the productivity and efficiency challenges remain into 2012/13 and beyond.

Included within the expenditure figures are voluntary and mandatory redundancy costs relating to 122 staff who left the Trust as part of service reconfigurations to meet our cost improvement programme.

Statement of Financial Position (Balance Sheet)

During 2011/12 the Trust invested £4.5m in its fixed asset infrastructure (£19.0m in 2010/11). This included completion of the new renal and training units, upgrading or acquiring new medical equipment essential for the day-to-day operation of the Trust and improvements in information systems and technology in conjunction with the Nottinghamshire health community for which the Trust provides IT (Information Technology) and information support services. The significant

reduction in capital expenditure is a reflection of completion of the Private Finance Initiative (PFI) hospital redevelopment in 2010/11 and the consequent need for less building and asset replacement in year.

Due to the adoption of IFRS (International Financial Reporting Standards) in 2009/10, the PFI (Private Finance Initiative) scheme is on the Trust's balance sheet. This capitalisation continues to have a significant adverse impact on the balance sheet as a result of the associated financing arrangements and the asset values being relatively low in comparison.

At the 2011/12 year end, our cash, cash equivalents and investments were £22.8m representing an improvement against plan of £11.2m, but a deterioration of £6.9m from the £29.7m held at 31 March 2011. Cash holding and cash management will remain a key focus for the Trust going forward.

General Financial Performance

Improved Efficiency and Value for Money

Our total operating expenses (excluding impairments and depreciation) rose during the year to £227.8m, £2.7m below plan. Of this £153.4m (67%) was spent on staffing including 446 medical and dental staff, 1,150 registered nurses and midwives, 462 scientific, technical and therapeutic staff and 1,488 other health professionals and clinical staff.

Over 16% of our total operating expenses (excluding depreciation) was spent on drugs and clinical supplies, both essential in ensuring our patients continue to access necessary treatments.

The Trust reported a loss before the reversal of impairments of £6.2m against a forecast deficit of £9.4m for 2011/112.

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 2011/12 with private patient income accounting for 0.08%.of our clinical revenue.

Charitable Funds

The Trust adopted a change in accounting standard in year which has resulted in the need to recognise £360k of charitable income in the income and expenditure statement to match the value of purchasing equivalent medical equipment from charitable funds. £176k of this funding was received from the Sherwood Forest Hospitals General Charitable Fund with the remainder sourced from other charitable donations received.

The Trustees were able to make further grants totalling £285k (£450k total in 2010/11) to support the activities of the Trust and for the welfare of patients and staff.

During the financial year we also received donations to our charitable funds of £270k (£959k in 2010/11), which included legacies of £67k (£270k in 2010/11). The generosity of all those who made a donation or raised monies on behalf of our charitable funds continues to be very much appreciated.

Our Key Partners

In delivering our key services we have a number of material contracts the majority of which are managed through NHS Nottinghamshire County, our local Primary Care Trust (PCT) and main commissioner on behalf of the Clinical Commissioning Groups (CCGs). Other key partner organisations include Nottinghamshire Healthcare NHS Trust, Central Nottinghamshire Clinical Services (the local out-of-hours service) and Nottingham University Hospitals NHS Trust, for which the Department of Health is the parent body. The Trust also provides considerable clinical training services from King's Mill Hospital working with our key partners at the University of Nottingham and the Deanery.

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 of Newark Hospital, the League of Friends (Mansfield and Sutton), hospital volunteers, Lions Clubs and the Doughty Family 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 2011/12, we remained within our £359.4m prudential borrowing limit. Monitor also authorised the Trust to have a £19.0m working capital facility in 2011/12, which was provided by Lloyds TSB Bank Plc. This has not been drawn upon in the year due to robust cash control measures put in place by the Trust.

Going Concern

The next two financial years represent a significant challenge with large cost improvement programmes and demand management initiatives needing to be delivered. Extensive financial modelling of the impact of these pressures has been undertaken in year, and the Board of Directors has a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operation for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the accounts for 2011/12.

External Audit Service

The Council of Governors approved the extension to the appointment of KPMG as the Trust's external auditors from 1 November 2010 for a period of two years. Since this is the last year of the contract this is subject to renewal in 2012/13. We incurred £78k in audit service fees in relation to the statutory audit of our accounts for the twelve month period to 31 March 2012 (£70.5k for period to 31 March 2011, and the Quality Account £13k). No other audit or non-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.

TCS (Transforming Community Services)

As part of the national TCS agenda for services to transfer from commissioners to providers the Trust entered into a three year contract with effect from 1 May 2011 to run inpatient and outpatient services at Mansfield and Ashfield community hospitals, sexual health and stroke early supported discharge services. These services had previously been delivered by NHS Nottinghamshire County PCT.

252 staff transferred to the Trust as part of this process and due diligence was undertaken prior to agreement to ensure that all risks were identified and mitigated. The income associated with this transfer is circa £14.3 million and throughout the year costs have been managed within the agreed plan. This service is now integrated into the Trust and is reported within the main financial statements.

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

Accounting Policies for Pensions and other Retirement Benefits

Our accounting policies for pensions and other retirement benefits are set out in note B.4 to the accounts, and details of senior employees' remuneration can be found in the annual accounts note C.29.

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 set of audited accounts is attached at the end of this report.

1.1.4 Remuneration Report

Role and Responsibilities of the Remuneration Committee

The primary role of the Remuneration Committee is to establish and maintain a formal and transparent procedure for developing policy on executive remuneration and for setting the pay and reward packages of individual directors. It determines the remuneration and terms and conditions of the Chief Executive, Executive Directors and their direct reports. The committee also approves severance payments and employer based clinical excellence awards.

Specifically, the Remuneration Committee:

- Has delegated authority for setting and approving the levels of pay (including basic and corporate and individual performance elements) and terms and conditions appropriate to attract and retain the Chief Executive, Executive Directors and their direct reports ensuring they are of the quality and with the skills and experience required to successfully lead the Trust

- Monitors the level and structure of remuneration for the Chief Executive, Executive Directors and their direct reports to Executive Directors, including regularly assessing the levels of remuneration in relation to other healthcare organisations, and where necessary the external marketplace

- Considers the consequences to the Trust of salary increases, pension and other changes in pensionable remuneration and associated employers in relation to the Chief Executive, Executive Directors and their direct reports

- Acts in accordance with the scheme of reservation and delegation and takes delegated responsibility for setting remuneration for all Executive Directors and direct reports, including pension rights, and compensation payments

- Oversees and approves all severance payments, including redundancy, across the Trust in accordance with delegated limits including those of the Mutually Agreed Resignation Scheme (MARS)

- Submits all non-contractual severance payment requests to Monitor for Treasury authorisation in line with government policy

The Composition of the Remuneration Committee

The Board of Directors appoints the Remuneration Committee and its membership is limited to Non-Executive Directors. The Committee, chaired by the Trust's Chairman, acts on behalf of the Board. It meets regularly to determine the remuneration strategy for the organisation, including the framework of executive and senior manager pay and remuneration.

During 2011/12 the Committee received reports from Ms Carolyn White (Interim Chief Executive), Mr Martin Wakeley (Chief Executive) and Ms Karen Fisher (Executive Director of Human Resources). No executive or senior manager participated in any decision relating to their own remuneration during the year.

The Remuneration Committee met 5 times during 2011/12. Attendance is detailed in the table below:

Tracy Doucét - Chairman	5 of 5
David Heathcote – Non-Executive Director	5 of 5
Bonnie Jones – Non-Executive Director	5 of 5
Stuart Grasar – Non-Executive Director	4 of 5

Setting Remuneration

The Remuneration Committee used national benchmarking information to consider and determine remuneration for Executive Directors. Specific benchmarking data was obtained from Capita and annual data collated by the Foundation Trust Network was also used to assess levels of remuneration. In addition, the committee considers annual pay awards granted to Agenda for Change staff, medical and dental staff and very senior manager staff in setting remuneration at appropriate levels.

The Remuneration Committee received assurance from the Nominations Committee, Chairman and Chief Executive, that Executive Directors had achieved the required levels of performance. The Chairman reported on the appraisal and performance of the Chief Executive. The Chief Executive provided reports on appraisal outcomes and performance of Executive Directors.

All Executive Directors' contracts are substantive and are contracted to work the hours necessary for the full performance of their duties, including such cover that may be necessary to sustain the management of the Trust in the absence of colleagues. Notice periods by either party are six months, except when related to qualification, conduct or capability.

Non-Executive Directors serve terms of three years and are able to serve two concurrent terms, dependant on formal assessment and confirmation of satisfactory ongoing performance. Non executives are able to apply (through competitive process) to serve a third term.

Current Non-Executive Directors Terms of Office and contract expiry dates are provided below:

Job Title	**Name**	**Contract for Service Commencement**	**Current Contract for Service Termination**
Chairman	Tracy Doucét	2 April 2008 2 April 2011	1 April 2014 (Second Term)
Non-Executive Director (Vice Chair)	Bonnie Jones	1 February 2008 1 February 2011	31 January 2014 (Second Term)
Non-Executive Chair (SID)	David Heathcote	1 February 2008 1 February 2011	31 January 2014 (Second Term)
Non-Executive Director	Stuart Grasar	10 November 2008	Temporary extensions (entered Second Term 11 November 2011)
Non-Executive Director	David Leah	1 November 2005 1 November 2009	31 October 2012 (Second Term)
Non-Executive Director	Iain Younger	1 December 2009	30 November 2012

During the year the Trust made a number of new Board level appointments. The posts of Chief Executive, Chief Financial Officer and Commercial Director, are eligible for performance related pay which is only payable on the achievement of pre-determined objectives and was approved as part of our review of our executive recruitment and retention strategies. The post of Chief Financial Officer also attracted a one-off payment on commencement in order to secure an early start date with the Trust which was necessary for ongoing Trust performance. The Committee considered benchmark data in determining the remuneration packages for all advertised posts.

The remuneration and expenses for the Chairman and Non-Executive Directors are determined by the Council of Governors Nominations Committee, taking account of the external benchmarking information, salary surveys conducted by independent management consultants and by the salary levels in the wider market place.

Termination Payments

During 2011/12 a restructuring of the executive team was completed resulting in the post of Chief Operating Officer being declared redundant. A contractual redundancy payment and notice period payment was made as specified on page 203 of the Annual Accounts.

Scope of the Report

The remuneration report summaries the Trust's remuneration policy, and particularly its application in connection with the Executive Directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS Foundation Trust Code of Governance. It is compliant with Sections 420 to 422 of the Companies Act (where relevant), and with Regulation 11 and Schedule 8 of the Large and Medium sized Companies and Groups Regulations 2008 (SI2008/410) as interpreted for the context of NHS Foundation Trusts.

The salary and pension entitlements for directors for the financial year, including remuneration and pension benefits, are shown in note C.29 on page 203 of the Annual Accounts. This information has been subject to audit.

1.1.5 An Ambitious Future

Looking Forward

Trading Environment and Forward Risks

The ongoing effects of the national austerity measures and global economic slowdown continue to have a detrimental and long term impact on the health of public finances. Given the scale of economic challenge, despite the commitment to fund real term increases in NHS spending by the government, the NHS continues to face the prospect of a significant and sustained reduction in overall funding for the next four years.

Increased demographic pressures also create challenges for our commissioners who are seeking to maximise the efficiency and reduce expenditure in secondary care. These challenges are translated through commissioning intentions which forecast reductions to our activity and associated income and onward through pricing and contracting structures that seek to drive system change in terms of demand management, quality and productivity improvements. All these factors have a direct impact on our patient treatment income and the contract requirements we have to satisfy in order to earn that income.

During 2011/12, we have sought to build upon the risk management processes initiated in 2010/11. This approach is focused on helping the Trust to mitigate these risks and enable us to manage the impact of reduced income on our services and long term viability.

During 2011 we commissioned external advisers to support us to assess our long term financial sustainability and to risk assess our three year financial plan and ambitious cost improvement programme from 2011/12 onwards. This long term financial plan has recently been refreshed and shows a likely deficit for 2012/13, with deteriorating cash balances by the end of March 2013. At no time over the next three years are cash balances forecast to be negative.

To address this, the Trust is refreshing its strategy whilst it continues to implement significant cost improvement programmes, with an ambition to return to financial breakeven over the life of the three year financial plan. These financial challenges place a significant pressure on our going concern assessment due to a significant deterioration in our liquidity position. At this stage, the Trust does not envisage needing to utilise its working capital facility in either 2012/13 or 2013/14.

The directors continue to work with our commissioners to identify further ways to mitigate the risks in our current assumptions.

Significant Additional Forward Risks to the Trust include

- As demand for our services falls, if we are unable to substitute other revenue generating services then, because of our inability to reduce the fixed cost element of our estate, our financial position will deteriorate further. To respond to this unique PFI challenge the Trust is in continual dialogue with NHS Nottinghamshire PCT over this risk and is shaping its strategy, recognising the need for more integrated care service

- 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 contract for 2012/13 includes financial penalties for failing to meet key targets relating to performance measures such as 'Choose and Book' and quality measures relating to areas such as pressure ulcers and infection control. The Trust is confident that these can be effectively managed and delivered in year and is developing an approach to strengthen the way it manages its clinical contract across all service areas

- Significant cost reduction pressures arising from PFI costs and a significant reduction in income due to commissioner demand management initiatives combined with rising PFI costs which are indexed throughout the remaining 30 year contract period

These remain key risks within our future financial plans as we must ensure delivery of the productivity/efficiency agenda whilst simultaneously meeting statutory targets and maintaining exemplary quality standards. The principal risk to the Trust lies in our ability to reduce costs in line with any income reductions that these developments bring and to seek new opportunities for utilising our resources where feasible.

Our forward strategy has been refined to ensure we mitigate these risks as far as possible. The Trust also continues to work hard in securing positive working relationships within the local health economy so as to ensure high quality and seamless healthcare delivery for the local population as we move forward with this challenging agenda.

An Ambitious Future

We begin with a 2020 vision which directs and facilitates the development of a truly transformational strategy based upon integration.

Our 2020 Vision

We will be **recognised across the region as the best provider of secondary care and as the co-creator and best provider of high quality, cost effective integrated health care**…

We will do so by delivering
the Best Care, with the Best People, in the Best Place for our local community

We will achieve this goal by 2020

Our 2020 vision will ensure that the achievement of high quality care, effectiveness, innovation and productivity are part of the same continuum rather than competing entities. We believe that reducing costs and providing increased tax payer value are legitimate quality objectives.

The journey towards the achievement of our ambitious vision and the delivery of our key objectives will differentiate us from our main competitors and enable us to meet the challenges ahead.

Key objectives

To Provide the Best Care: Quality. Excellence. Consistency. Delivery.

1. **Developing a clinical strategy which supports our sustainability and improves healthcare;**

2. **Gaining a reputation for quality excellence by ensuring that we deliver the right care, effectively, first time, every time . . . and in the right place for our patients and customers;**

With the Best People: Trust. Pride. Focus. Partnership.

3. **Ensuring the continued development of a well led NHS FT;**

4. **Working with our partners to co-lead the creation of a devolved, affordable and high quality local health care economy;**

5. **Continuing to improve as a high quality organisation which attracts; develops and retains quality people; operates efficiently; remains within the terms of our licence (authorisation) and meets high professional standards;**

6. **Working with our governors to ensure that we listen to the views of our community and equipping our governors to undertake their current and future roles;**

7. **Contributing effectively to the wider economic and social regeneration of our local Community;**

In the Best Place: Sustainable. Effective. Efficient. Value.

8. **Ensuring we become financially robust and sustainable;**

9. **Ensuring our assets are utilised effectively to support wider changes in future healthcare delivery;**

10. **Providing increased value for money whilst ensuring the provision of high quality care.**

During 2012/13 we will reduce our cost base by £14m (6.8% of our operating costs less PFI operating costs) with a full year effect of £22m.

Over the three years of our plan, we will deliver £45m cost improvements averaging 6.8% per annum in order to continue to protect our underlying liquidity and ensure we continue to stabilise our position and shape a financially sustainable future.

At the same time, we will connect our financial stabilisation and improvement to a compelling vision of the future. A future in which seizing opportunities to integrate, maximising service efficiencies and undertaking frequent strategic re-positioning . . . all become the norm.

Instead of retreating, we will continue to expand - but we will do so in areas where there is mutual benefit. In doing so, we will work in partnership with clinicians across primary and community care – '*delivering care in new settings and in new ways'*.

As leaders and clinicians, we will work as a single team to develop the relationships, to make sense of national strategy, to develop the skills and drive the focus and pace of change required.

We will ensure that we deliver services which are:

- Safe (for our patients and our staff)
- Effective (right care, right place, right time)
- Patient-centred (designed and delivered to meet the needs of patients and customers, not organisational boundaries)
- Timely (because accessing care quickly during the pathway improves outcomes)
- Efficient (high quality, timely and good value)
- Equitable (including fair to staff)
- Extraordinary (not only to our patients but to their physicians in both primary and secondary care)
- Exceptional quality of clinical care (clinically extraordinary)

In short, we will work together to deliver the best care for our patients.

1.1.6 Valuing Our Staff

Our staff are our greatest asset and they embody the ethos of the whole organisation.

The Board of Directors is committed to working with our staff and trade union partners to deliver continuous improvement to the standards and quality of care we provide to our community. During the past year, we worked together to improve levels of staff engagement, to promote health, safety and wellbeing, and to develop policies and best practice. In addition we have increased activities around training and management development.

The Trust has specified a handful of 'pledges' that set out the standards we work to and which crystallise what care and services our patients, carers and visitors can expect from us.

Staff Engagement

During the year ending March 2012 the Trust commenced a three-year transformation programme to reduce spending by £46m. As a significant proportion of the Trust's expenditure is attributable to pay, it was essential to focus on workforce transformation and associated cost reductions. This was divided into two areas: direct pay and non-direct pay, which resulted in an overall targeted reduction of £8.2m in terms of the Trust's pay expenditure by year end. The areas of focus were:

- Medical and dental – restructuring of the medical workforce to reflect service demand in addition to reducing variable pay and eliminating vacancies
- Nursing and midwifery – undertaking a full establishment and skills-mix review, including an assessment of non-ward based nurses and theatre vacancies
- Administrative and Clerical: clinical - ensuring administrative roles are more appropriately linked to the patient pathway, and providing efficient ward administration services to prevent mis-communication, duplication of effort, hand-offs and re-work
- Administrative and Clerical: corporate - streamlining corporate functions
- Non-direct pay efficiency savings - full implementation of schemes within the current pay framework which are able to be agreed locally. The schemes relate to the removal of paid breaks, revised on-call arrangements and improving expenses controls

The Trust committed to achieving these improvements by openly engaging staff and communicating the changes. Regular '*Meeting the Challenge'* workshops and events have been held to brief employees, encourage feedback of ideas and contribute to plans to meet the savings challenge. Over 1,800 staff have been engaged in this process. Careful consideration was given to improving workforce efficiency and ways of working, whilst minimising any negative impact on the delivery of patient care services. All activities were progressed in conjunction with Staff Side and Trade Union colleagues working together in partnership.

Staff Membership Information

Details about staff membership of the Foundation Trust can be found on page 69.

"We will listen to you"

The Trust is committed to fairness and transparency at work, and to improving the work environment.

The Chief Executive and Executive team hold monthly '*Team Brief*' sessions on the plans, priorities and objectives contained within the Annual Plan. These set out our vision and strategy for the coming year and clarify priority actions for each month in advance. The information is cascaded through the management and staff teams.

In addition, the Trust has a number of existing formal and informal mechanisms in place to support meaningful engagement. The Joint Staff Partnership Forum and Medical Local Negotiating Committee exist so that staff side representatives and managers can meet to discuss issues that matter to staff and these are the formal consultation forums and meet on a monthly basis.

The Workforce Committee is responsible to the Executive Management Committee for providing assurance around workforce matters. This Committee has representation from across the Trust; it drives the workforce strategy and agrees policy and processes.

The Workforce Change Group assesses proposals for workforce change and promotes a consistent approach to managing transformation. This group works in partnership with trade unions and has reviewed how it can successfully enable and support effective workforce transformation.

The Trust continues to encourage feedback and comments from staff by utilising the national NHS Staff Survey, in-year survey methods regarding specific topics, and engagement sessions with our staff and Governors. We aim to make good use of information technology and social media; the Chief Executive has a blog and we embrace the safe and appropriate use of Twitter and Facebook.

Staff are consistently made aware of Trust priorities and work with us to seek continued improvement in the way we deliver best care to our patients.

2011 National NHS Staff Survey

The Trust participates in the national NHS Staff Survey on an annual basis in which it surveys 850 randomly sampled staff.

There are two types of key findings – percentage scores and scale summary scores for which the minimum score is always 1 and the maximum score is 5. An analysis of the response rate and top and bottom four ranking scores from the 2010 and 2011 surveys is shown below:

Staff Survey Summary

	2010		**2011**		**Trust Improvement/Deterioration**
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	52%	52%	49%	52%	Decrease in % points 2011 Trust = Below Average

	2010		**2011**		**Trust Improvement/Deterioration**
Top 4 Ranking Scores 2011	Trust	National Average	Trust	National Average	
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.					
	75%	74%	83%	74%	Increase in % points (positive) 2011 Trust highest (best) 20%
Percentage of staff receiving job-relevant training, learning or development in last 12 months.					

	83%	78%	82%	78%	Not changed significantly. 2011 Trust highest (best) 20%
Percentage of staff working extra hours.					
	62%	66%	59%	65%	Not changed significantly. 2011 Trust lowest (best) 20%
Percentage of staff suffering work-related injury in last 12 months.					
	16%	16%	12%	16%	Not changed significantly. 2011 Trust lowest (best) 20%

	2010		**2011**		**Trust Improvement/Deterioration**
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months.					
	10%	8%	10%	8%	Not changed significantly. 2011 Trust lowest (worst) 20%
Percentage of staff appraised in last 12 months.					
	74%	78%	75%	81%	Not changed significantly. 2011 Trust below (worse than) average
Percentage of staff using flexible working options.					
	63%	63%	58%	61%	Not changed significantly. 2011 Trust below (worse than) average
Percentage of staff having equality and diversity training in last 12 months.					
	33%	41%	39%	48%	Not changed significantly. 2011 Trust below (worse than) average

Note: National Average figures given represent those for Acute Trusts in England.

The 2011 staff survey outcomes suggest the need to continue to improve our approach to staff appraisal, equality and diversity training, health and safety training and job related training. During the year significant work was completed to ensure as many staff as possible receive necessary training inputs and it was pleasing to note improvements in relation to job related and health and safety training. Whilst improvements were made in relation to equality and diversity training this remains an area of focus, together with ensuring all staff receive an appraisal annually.

The 2011 staff survey outcomes identify many positive responses, with the Trust performing average or above in 30 out of the 38 key finding areas – see below. The overall indicator of staff engagement for the Trust was 3.69 compared to the national average of 3.67, placing the Trust slightly above average. This is an important indicator which incorporates the key finding area relating to whether staff would recommend the Trust as a place to work or be treated.

The survey responses show an improvement in one key finding area, no change in 36 areas and one area which has worsened.

Staff Survey: 38 key findings

	2010	**2011**
Best 20%	9 Areas	5 Areas
Better than Average	9 Areas	18 Areas
Average	13 Areas	7 Areas
Worse than Average	6 Areas	7 Areas
Worse 20%	1 Area	1 Area

Whilst the Trust is pleased with the survey outcomes there remain a number of areas which require improvement. Consequently the Trust's action plan for 2012/13 will focus on:

- Ensuring that all staff have an annual appraisal
- Providing innovative ways of delivering equality and diversity training
- Improving the perceptions of staff regarding the actions taken regarding physical violence
- Maintaining engagement and valuing staff during a period of significant workforce transformation
- Supporting staff to contribute to improvements at work
- Developing a better understanding of specific issues amongst staff groups

Detailed action plans are being drawn-up to address these priority areas, each fronted by an identified project lead. Delivery of the action plans will be overseen by the Workforce Committee.

Health and Safety

The moral and legal case for effective occupational health, safety and wellbeing in NHS organisations has been well made over a number of years. This is recognised within the NHS Constitution, which states that staff have a right to work in a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff.

An appropriately qualified and experienced manager leads the health and safety function within the Trust. The Board of Directors receive a detailed annual Health & Safety Report, 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 2011/12

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2011/12 Totals
Abusive, violent, disruptive or self-harming behaviour	65	50	48	56	**219**
Accident caused by some other means	17	12	7	12	**48**
Confidentiality of information	0	1	2	0	**3**
Environmental matters	3	0	4	0	**7**
Exposure to electricity, hazardous substance, infection etc	6	11	5	10	**32**
Fires, fire alarms and fire risks	5	0	0	0	**5**
Infrastructure or resources - other	1	1	1	11	**14**
Injury caused by physical or mental strain	10	5	7	4	**26**
Lifting accidents	4	11	10	13	**38**
Medical device/equipment	1	0	0	2	**3**
Needle-stick injury or other incident connected with sharps	32	26	47	46	**151**
Security incident related to Personal property	1	7	7	4	**19**
Security incident related to Premises, Land or Real Estate	1	2	1	2	**6**
Slips, trips, falls and collisions	31	21	45	31	**128**
Other	5	8	7	3	**23**
Total	182	155	191	194	**722**

The most likely reason for submitting a staff health and safety related incident report is abusive, violent, disruptive or self-harming behaviour (30% of incidents), followed by needle-stick injury or other incident connected with sharps (21%), and slips, trips, falls and collisions (18%). Together these three areas of risk account for 69% of all health and safety staff incident reports submitted via Datix. These areas of risk remain unchanged from the previous year.

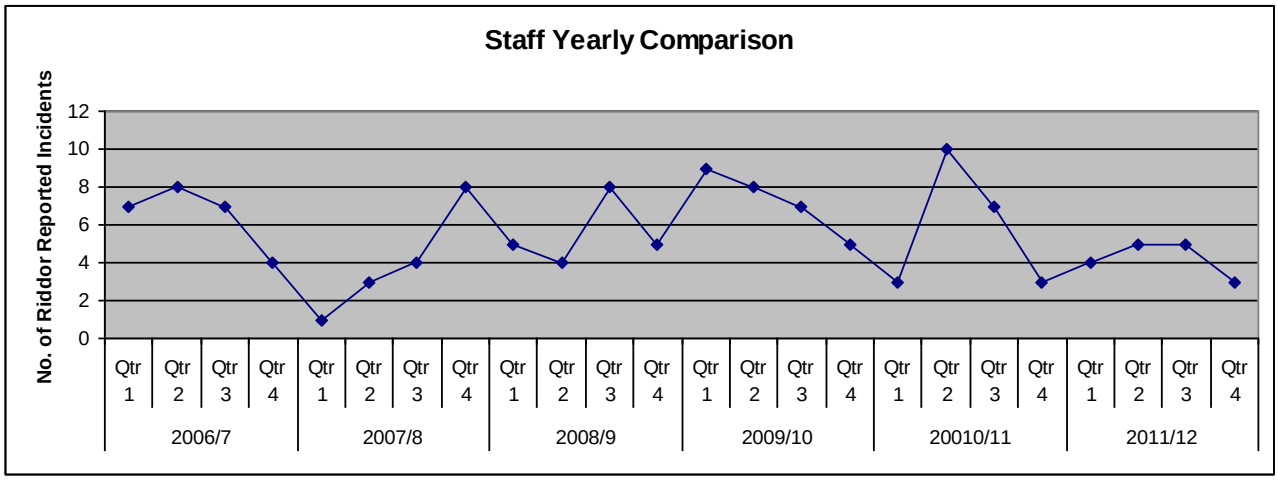
The number of staff accidents reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 decreased from 23 to 17. The decrease was due largely to fewer slip accidents arising as a consequence of the bad weather conditions in December and January (compared to the previous year). This resulted in zero RIDDOR reports being made compared with three reports of staff injuries due to slips in snow and ice the previous year.

RIDDOR Reports by Year

Year	Number of Employee RIDDOR Reports	Number of RIDDOR Reports re Members of the public	Total
2011/12	17	14	31
2010/11	23	8	31
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

Staff RIDDOR reports by Type and Year

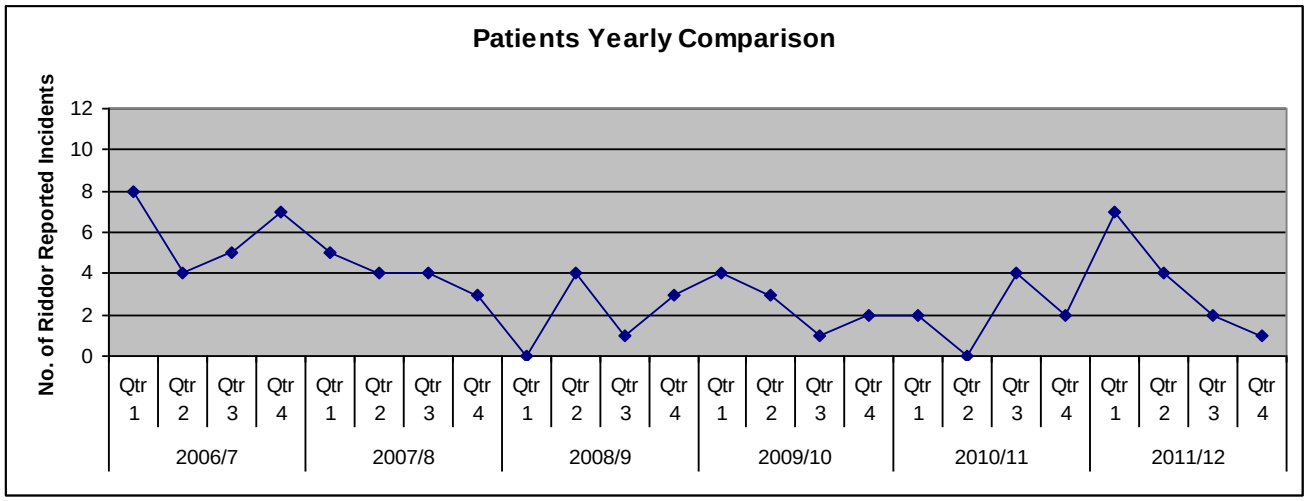
Type	2011/12	2010/11	2009/10
Moving and handling patient	7	7	11
Manual handling object	3	4	5
Violence and aggression from a patient	-	-	2
Burn from hot food or beverage	-	-	1
Slip	3	6	7
Trip	1	-	1
Hit by moving or falling object	1	2	0
Hit a stationary object	1	-	1
Contact with a hazardous substance	1	1	0
Other	-	3	1
TOTAL	**17**	**23**	**29**



The number of patient RIDDOR reports reported during 2011/12 increased from a low of 8 in 2010/11 to 14 in 2011/12. These additional reports were mainly linked to patient falls reported in the first quarter of the year. Since the first quarter the levels of reporting have fallen back to the low level usually seen. This may in part be due to the reissuing of advice on the criteria for reporting incidents under RIDDOR.

Patient RIDDOR reports by Type and Year

Type	2011/12	2010/11	2009/10
Unobserved fall	2	2	5
Fell from chair/toilet commode	4	1	0
Fell from bed/trolley	4	1	2
Walking to toilet unassisted	1	-	1
Mobilising without assistance	-	2	2
Slip	1	-	0
Trip	2	-	0
Patient transfer	-	2	0
Other			0
TOTAL	**14**	**8**	**10**



NHS Staff Survey

The annual NHS Staff Survey provides the Trust with valuable feedback on the perception of the Trust's performance by staff on a range of measures relating to health, wellbeing and safety. Of the 11 measures provided by the 2011 staff survey the Trust is in the best 20% in 2 areas, better than average in 3, average in 4, below average in 1 and in the worst 20% in 1 area. There were no statistically significant changes in the Trust's scores on these measures compared to the 2010 survey. The detailed key findings relating to health and safety from the 2011 survey over the past three years are documented below.

Annual Staff Survey – Key Findings	2011	2010	2009
Key Finding 16: Percentage of staff receiving health and safety training in last 12 months This is the percentage of staff who had received health and safety training paid for or provided by their Trust, in the last 12 months	86% (N. Av.81%) Above (better) than average	81% (N.Av.80%)	75% (N.Av.78%)

Annual Staff Survey – Key Findings	2011	2010	2009
Key Finding 17: Percentage of staff suffering work related injury in last 12 months This is the percentage of staff who, in the previous year, had been injured or felt unwell as a result of one of the following problems: moving and handling; needle-stick and sharps injuries; slips, trips or falls; or exposure to dangerous substances.	12% (N. Av.16%) Lowest (best) 20%	16% (N.Av.16%)	13% (N.Av.17%) Lowest (best) 20%
Key Finding 18: Percentage of staff suffering work related stress in last 12 months This is the percentage of staff who said that, in the last 12 months, they had been injured or felt unwell as a result of work related stress.	29% (N.Av.29%)	24% (N.Av.28%) Lowest (best) 20%	26% (N.Av. 28%)
Key Finding 20: Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month This is the percentage of staff who, in the previous month, had witnessed at least one error or near miss that could have potentially hurt patients or staff.	32% (N.Av.34%) Below (better than) average	33% (N.Av.37%) Lowest (best) 20%	33% (N.Av. 39%) Lowest (best) 20%
Key Finding 21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month This is the percentage of staff who had, in the last month, seen errors, near misses, or incidents that could have hurt staff or patients **and** said that they or a colleague had reported it. Respondents who had not seen any errors, near misses or incidents in the last month, or did not know whether such errors had been reported, were excluded from the calculation.	96% (N.Av.96%)	96% (N.Av.95%)	94% (N.Av. 95%)
Key Finding 22: Fairness and effectiveness of procedures for reporting errors, near misses and incidents Overall, this scale assesses the climate and culture of incident reporting in Trusts. The scale measures the extent to which staff are aware of the procedures for reporting errors, near misses and incidents; to what extent they feel that the Trust encourages such reports, and then treats the reports fairly and confidentially; and to what extent the Trust takes action to ensure that such incidents do not happen again. Possible scores range from 1 to 5, with 1 representing procedures that are perceived to be unfair and ineffective, and 5 representing procedures that are perceived to be highly fair and effective. (See section 2.2 above for information about how this type of score is calculated.) Positive climates of incident reporting enable learning and innovation in patient care. Negative climates tend to perpetuate errors, incidents and near misses.	3.46 (N.Av.3.46)	3.44 (N.Av. 3.45)	3.45 (N.Av 3.42) Statistically significant increase since 2008

Annual Staff Survey – Key Findings	2011	2010	2009
Key Finding 23: Percentage of staff experiencing physical violence from patients or relatives in last 12 months This is the percentage of staff who, in the previous 12 months, had experienced physical violence from patients / service users or the relatives of patients / service users. ***Because of changes to the format of the survey questions in 2010, comparisons between the 2010 score and the with the 2009 score are not possible.***	10% (N.Av.8%) Highest (worst) 20%	10% (N. Av. 8%) Highest (worst) 20%	11% (N.Av. 11%)
Key Finding 24: Percentage of staff experiencing physical violence from staff in last 12 months This is the percentage of staff who, in the previous 12 months, had experienced physical violence from colleagues or managers. ***Because of changes to the format of the survey questions in 2010, comparisons between the 2010 score and the with the 2009 score are not possible.***	1 (N.Av.1%) Below (better than) average	2% (N. Av. 1%) Above (worse than) average	1% (N.Av. 2%)
Key Finding 25: Percentage of staff experiencing harassment, bullying or abuse from patients or relatives in last 12 months This is the percentage of staff who, in the previous 12 months, had experienced harassment, bullying or abuse at work from patients / service users or the relatives of patients / service users. ***Because of changes to the format of the survey questions in 2010, comparisons between the 2010 score and the with the 2009 score are not possible.***	16% (N.Av.15%) Above (worse than) average	14% (N.Av.15%)	16% (N.Av. 21%) Lowest (best) 20%
Key Finding 26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months This is the percentage of staff who, in the previous 12 months, had experienced harassment, bullying or abuse from colleagues or managers.	12% (N.Av.16%) Lowest (best) 20%	13% (N. Av.15%)	14% (N.Av.18%) Lowest (best) 20%
Key Finding 27: Perceptions of effective action from employer towards violence and harassment Staff were asked questions about whether their employer takes effective action if staff are physically attacked, bullied, harassed or abused. Possible scores range from 1 to 5, with 1 representing the perception that the employer never takes any effective action, and 5 representing the perception that the employer takes highly effective action. (See section 2.2 above for information about how this type of score is calculated.)	3.58 (N.Av.3.58)	3.49 (N. Av.3.56) Lowest (worst) 20% Statistically significant fall since last survey	3.58 (N.Av. 3.55) Statistically significant increase since 2008

The Trust is again in the lowest (best) 20% of Trusts for staff suffering injury at work. This has been the case for 2 of the previous 3 years. It was also noted that the improvements made to ensuring staff receive health and safety related training is now above average. Perceptions of the effectiveness of Trust action taken against the perpetrators of violence has improved and is now in line with other Trusts.

The main areas of challenge for the Trust arising from the 2011 Staff Survey relate to staff experiencing physical violence and bullying, and abuse from patients and relatives.
Overall, Trust scores compared to last year on violence, bullying and harassment have remained about the same with some improvement of the effectiveness of Trust action against the perpetrators of violence score. The action plans developed for 2012/13 will focus on improving staff de-escalation and disengagement skills (for preventing physical assault from patients and relatives), and strengthening the ties the Trust has with the local police.

Areas for action on the Staff Survey results

- Improving awareness of the need to report violence experienced by staff
- Improving awareness of the need to report bullying/harassment in a confidential fashion
- Publicising (anonymously) the actions taken by the Trust against those perpetrating violence, bullying, harassment or abuse
- Implementing an action plan to improve staff de-escalation and disengagement skills for preventing physical assaults from patients and relatives

Attendance and Sickness Absence

The Trust is continuing with the ongoing development of effective wellbeing strategies that support staff to remain at work and maintain resilience during a time of intense change.

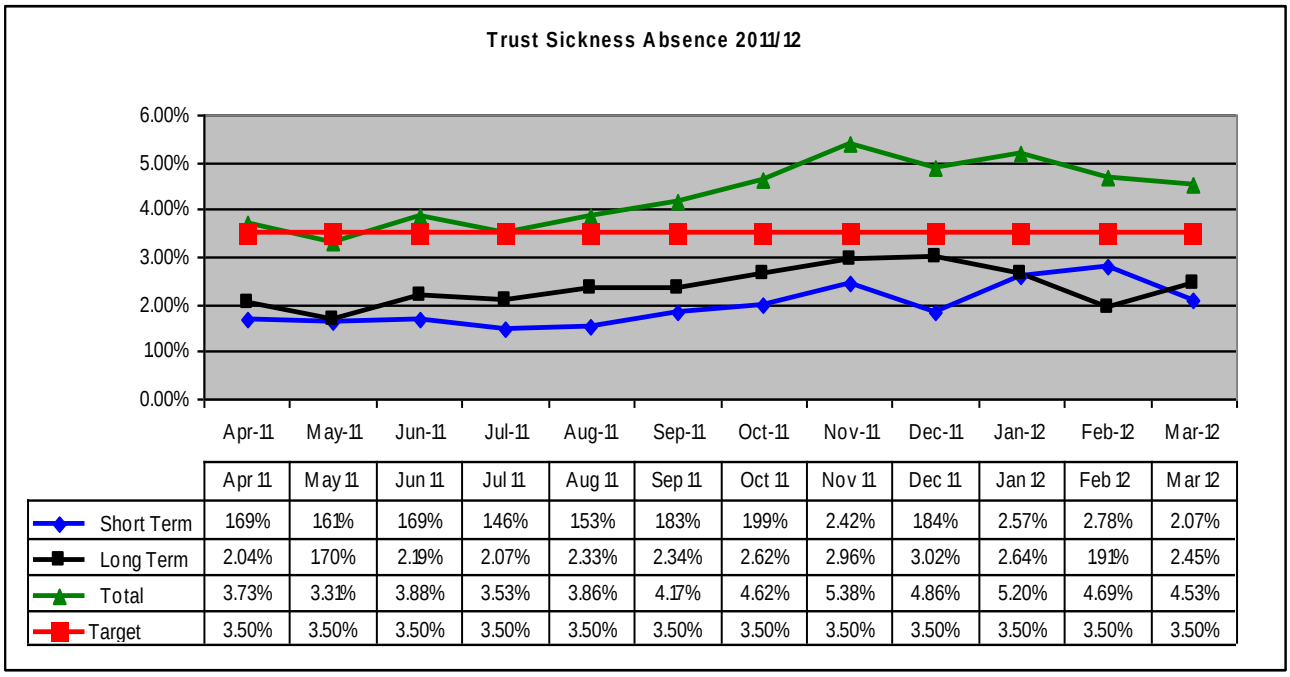
The Trust set a 3.5% target for sickness absence during 2011/12. The Trust took a number of positive steps during the year to drive down the incidence of sickness absence to this target level. Managers in the Trust closely monitor the levels of absence and aim to minimise the impact on patient care. Following the introduction of a revised sickness absence policy in 2010/11, the rate was reduced to 4.18%, a reduction of 0.59% from the previous year. Through 2011/12 the Trust has been able to stabilise the absence level in line with the previous year, resulting in levels remaining only slightly higher at 4.31% for the year.

The human resources team work closely with managers and occupational health to improve attendance, focusing on a comprehensive return to work interview and putting in place appropriate support mechanisms for staff returning to work after absence.

The Trust has been able to sustain a reduced level of short term absence and this has remained relatively unchanged since 2010/11, sitting at 1.96% in 2011/12 compared with 1.97% previously. This is positive action as short term absence tends to have the highest impact on the day-to-day operation of the Trust.

The level of long term absence for 2011/12 is 2.36%, an increase from 2.21% in 2010/11. Whilst not achieving delivery of the 3.5% overall target the Trust has made significant progress in stabilising sickness absence rates. A target of 3.5% continues to be the focus of our attention. The Board receive and review information on sickness absence trends on a monthly basis.

Sickness absence rates for 2011/12



	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Short Term	1.69%	1.61%	1.69%	1.46%	1.53%	1.83%	1.99%	2.42%	1.84%	2.57%	2.78%	2.07%
Long Term	2.04%	1.70%	2.19%	2.07%	2.33%	2.34%	2.62%	2.96%	3.02%	2.64%	1.91%	2.45%
Total	3.73%	3.31%	3.88%	3.53%	3.86%	4.17%	4.62%	5.38%	4.86%	5.20%	4.69%	4.53%
Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

Occupational Health Services

The Trust has an in-house occupational health service to provide for the needs of Trust staff as well as staff from other organisations, in total servicing over 11,000 people from both the NHS and private sector health community across the Mansfield, Ashfield and Newark areas.

The occupational health service currently operates from King's Mill Hospital, Mansfield Community Hospital and provides a weekly satellite clinic within the Eastwood Centre at Newark Hospital. The occupational health team is pivotal in supporting staff in return to work and also minimising the impact of sickness, and during the year was successful in leading a flu vaccination programme which resulted in 50.5% of staff who have patient contact receiving the vaccination.

The Trust is currently working towards national Safe Effective Quality Occupational Health Services (SEQOHS). It is expected that a full portfolio of evidence will be ready for submission to the SEQOHS in 2012/13. This is a national voluntary accreditation scheme which will provide occupational health services with a framework for quality assurance.

The Trust has a proactive stress awareness education programme for managers. Those areas with high stress levels have been prioritised, with a full roll-out anticipated in 2012/13. The Trust provides a specialist service for staff with muscular skeletal problems: 258 members of staff have been seen by the muscular-skeletal fast track service specialist physiotherapist, which is an increase of 48 referrals over the previous year. The majority of these staff are not currently off sick and the service aims to work more specifically on a preventative basis.

Equality, Diversity and Inclusivity

The Approach

The Executive Director of Human Resources is the Board lead and works with the diversity and inclusivity lead to support our partnership approach to employment matters. There is also a nominated staff side lead.

Diversity and inclusivity is fundamental to the way the Trust operates, both in the way we provide services to our community and the way in which we employ and manage our staff. The Trust is committed to treating all its service users with respect and dignity. We monitor compliments and complaints, and staff receive feedback so that they receive recognition and praise for improving patient experience.

How Success is Measured

The organisation regularly assesses the delivery of our diversity and inclusivity priorities through the Diversity and Inclusivity Committee. This Committee is led at executive level, meets bi-monthly and reports on plans and progress to the Workforce Committee. The Committee supports activities to ensure that the statutory responsibilities and obligations under the Equality Act are met.

The Committee held a workshop in January 2012 to engage with staff and develop the Trust Equality Objectives.

Publication Duties

The Equality Act 2010 sets out the Public Sector Duty which details specific equality duties relating to the publication of data to demonstrate an organisation has taken due regard to:

4 Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act

5 Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

6 Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

The Trust has developed and published its Equality Scheme 2011 - 2015 on its website to show how it intends to champion the diversity and inclusivity agenda and how this practice is implemented across the Trust. The Trust has published the following information to comply with the Equality Duty:

- Unity in Community Booklet
- Equality Scheme 2011/15
- Equality Impact Assessment Process
- Membership Data 2011
- Patient Experience Report July 2011
- Patient Survey Report 2010: Religion or Belief – A Practical guide for the NHS
- Sexual Orientation - A Practical guide for the NHS
- Staff Survey Summary 2010
- The gender and access to health services study
- The Secretary of State report on disability equality
- Trans – A practical guide for the NHS
- Transgender experiences – Information and Support
- Diversity and Inclusivity Working Group Annual Report 2010/11

- Diversity Workforce Information Jan 2011 – Dec 2011
- Employment Process Data from April 2009 – December 2011
- Equality Impact Assessment Report 26 January 2012
- Training and Development Inclusivity Diversity Report December 2011
- What our patients are telling us
- Annual complaints report 2010/11
- EDS Equality Objectives

Equality Delivery System

The Equality Delivery System (EDS) is a tool to help all staff and NHS organisations understand how equality can drive improvements and strengthen the accountability of services to patients and the public. It will help ensure that everyone – patients, public and staff have a voice in how organisations are performing and where they should improve.

The Trust has held a number of events to engage with staff and patients about the services the Trust delivers. The Trust will continue to hold such events to ensure the services we offer meet the needs of our local communities and put the patient at the heart of everything we do.

Equality Objectives

The Equality Duty required NHS organisations to publish Equality Objectives by 6 April 2012. The Trust has developed four key objectives to support the delivery of the general duty. The objectives were approved by the Trust Board of Directors in March 2012.

The objectives below have been agreed under these four Equality Delivery System (EDS) goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels

Objectives		**Narrative**	**Proposed actions requiring further work**	**EDS goal**	
1	As we engage with our many stakeholders during 2012/2013 we will ensure that we strive to ensure that all groups are appropriately represented, that we communicate with them in an effective fashion and that we are consistent in our approach.	The Trust held a workshop on the 12th January – 'Preparing to Launch the Equality Delivery System'. This workshop developed 4 objectives. Engagement is seen as key to influencing decisions and helping shape service developments. The aim is to ensure engagement activities are representative of the local population, patient groups and key stakeholders allowing services to be shaped in	Develop an engagement strategy and action plan. Develop systems and processes to capture actions and evidence of achievement.	**1**	**2**

		accordance with the needs of the local population.			
2	We will ensure that when we provide feedback to our stakeholders that they receive the outcomes and rationale of any decisions that we take/act upon.	The key to successful engagement is to ensure effective feedback is given to ensure outcomes, any changes in service and reasons for decision are communicated.	To be included in strategy and action plan as outlined above. Continue to work with and develop patient reference groups to allow effective communication and feedback of engagement with relevant groups.	**2**	
3	During 2012/13 we will further develop productive relationships with patient/service user groups and charities to build proactive working and explore the socio-economic aspects of care to encourage signposting to other agencies/charities etc.	As an NHS provider it is important to build relationships with support groups and patient reference groups not only to help shape services but to ensure additional support options are available to our patients. This ensures that the care patients receive and the support available is equally accessible by all.	Identify charities and agencies with which the Trust should have working relationships and engage with. Compile and develop relationships with outside agencies and charitable organisations to ensure patients in need of support are signposted.	**1**	**2**
4	We will Improve staff awareness and engagement on all sites enabling inclusive leadership at all levels.	It is essential that employees are aware of the work that is being conducted in line with the Equality and Diversity agenda. By raising greater staff understanding and wider engagement this will develop and improve the Trust workforce and patient experience.	Incorporate and develop an action plan linked to the staff survey outcomes into the wider staff engagement strategy. Explore the level of Equality and Diversity training to be included on the mandatory update and frequency. Test out the workforce understanding and measure understanding of the equality agenda and associated developments through staff surveys and wider engagement groups. Monitor the Staff Survey results and produce revised policies to support improved practice. Improve staff awareness and competence in equality and diversity	**3**	**4**

			matters so they understand and demonstrate individual and corporate responsibility. Ensure managers and leaders are appropriately trained around inclusion and diversity.		

Commitment to Developing our Staff

The Trust is committed to developing its staff in order to be equipped to provide the best quality care to patients. This commitment is demonstrated through reviewing a selection of achievements from 2011/12:

- Re-design of the mandatory update training programme to incorporate a blended learning approach which tests and re-enforces staffs underpinning knowledge
- Successful NMC inspection visit of the Trust's practice learning provision and positive feedback from nursing students working at the Trust
- Launch of the Trust's Leadership and Management Development training programme
- The human resources department has exceeded its dementia awareness training target
- Introduction of an online booking system designed to increase access to all staff wishing to book onto training courses
- Development and delivery of a bespoke masters level dementia training course in collaboration with the local health community
- Successful income generation of in excess of a quarter of a million pounds through the provision of external training courses, service level agreements and hiring of educational facilities
- First regional training events held in the new education centre, ‘Records on Trial’, delivered by the Coroner for Leicester and the East Midlands Rheumatology Meeting
- Development of a range of new e-learning packages such as Mental Capacity Act training and Bladder Scanning to provide greater access to training to all staff
- Utilisation of the library and knowledge services literature searching services to support improvements in infection control priorities
- Expansion of the resuscitation training portfolio to include the delivery of the first enhanced paediatric life support course held at the Trust
- Successful external funding bids secured as part of a national Department of Health pilot to employ newly qualified nurses to complete their preceptorship training
- Continued recognition by the Royal College of Physicians Edinburgh to become a regional centre to host the prestigious PACES course on clinical training
- 100% compliance with professional standards of Trust mentors for nursing students
- Continued success of the Trust's preceptorship support programme to support newly qualified nurses
- All Training, Education and Development policies received full compliance awards for meeting all NHSLA standards

1.1.7 Sustainability and the Environment

The new PFI hospital facilities and associated developments have been fully opened for nearly two years and this has allowed the Trust to build upon and develop its sustainability, environmental and climate change strategies. As part of these developing strategies, and to meet the challenges of climate change, the Trust has been refining a number of its objectives and activity streams:

- Imposed reduction targets
- Energy/utilities and waste – management and procurement
- Design and upgrade of new works
- Contract partners and stakeholders
- Procurement and supply chain management
- Transformational change
- Governance and communications
- Strategic approach to carbon management

The objectives are currently being incorporated into the latest version of the Trust's Carbon Reduction Management Plan (CRMP), Sustainability Development Management Plan (SDMP) and Green Travel Plan.

We are also committed to achieve Version 2 of the Good Corporate Citizenship (GCC) registration in the financial year 2012/13.

NHS Carbon Footprint

First calculated in 2008, the carbon footprint accounts for 25% of UK Public Sector Emissions and 3.2% of Total UK Carbon Emissions.

These are divided into three key sectors: travel, building/energy and procurement, at 18%, 22% and 60% respectively.

With the opening of the new hospital, and its energy targeted performance of 55 GJ/100m^3 per year, analysis of the Trust's energy usage and carbon emission indicates, as shown in Figure 1, a substantial improvement in our travel and building performance. This reflects the important work being undertaken by our procurement team.

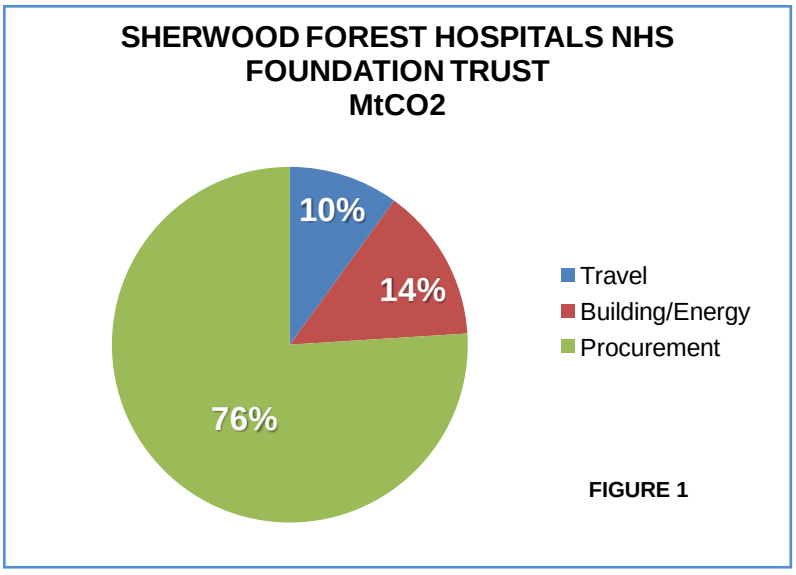


FIGURE 1

Climate Change and the Estate

With such a diverse mix of buildings across the Trust's three hospital sites, the approach to the climate change agenda has been split into two different activity streams.

The first of these, the *operational activity stream*, is targeted on achieving increases in operational performance by doing things differently and/or better.

To help support this process the Trust has adopted the following performance indicators:

- Energy tracker
- Energy champions
- Staff booklet and web based messages
- Awareness days
- Quick wins
- Survey works – plant and facilities technical reviews
- Heating and cooling controls and PCs
- Increased sub-metering
- DEC/CRC
- Design guide
- Standardisation

As an illustration, choosing and expanding upon two of the above items (survey works and increased sub-metering), the hospital and its PFI partners has undertaken a major review of the building, plant and engineering systems within the retained estate. This is allowing focused investment in key areas and systems to deliver real improvement in terms of the energy performance and the working environment.

The second activity stream relates to understanding how the legacy sites are performing. This is allowing targeted investment to achieve higher levels of performance and, where necessary, vacating the older estate and either mothballing buildings, or where practical, demolishing them.

The Trust recently undertook a post project evaluation of the first 12-month performance of the Geothermal (closed loop heat pump) system. This process has provided invaluable information to the designers and operators of the system, and a number of upgrades and refinements to the system are being made to further increase its effectiveness. The Geothermal system has been extended into parts of the King's Mill Hospital retained estate, further improving its overall utilisation and bringing increased reduction on CO2 emissions.

The Trust has also devised a sustainability and environmental dashboard of key performance indicators. This monitoring tool is used to provide monthly updates on environmental performance to the wider Trust and the executive management team.

1.2 GOVERNANCE REPORT

1.2.1 Trust Board of Directors

The Board of Directors directs the business of our Trust and, with participation from the Council of Governors, sets the strategic direction of the Trust.

The Board of Directors comprises executive and non-executive directors who manage the Trust. Our non-executive directors were appointed because of their business and commercial skills and their wider private and public sector knowledge and experience. Our executive directors were appointed because of their business focus and management experience of health services.

The Council of Governors appoints the Chairman and non-executive directors. During the year the governors re-appointed Tracy Doucét for a second term as Chairman and extended Stuart Grasar's term of office as a non-executive director on an ongoing temporary basis until a successor is appointed in autumn 2012.

Our executive directors are appointed in accordance with the Trust's recruitment and selection policies and procedures. Directors' record of attendance at Board of Director meetings is detailed alongside their names in the profiles below (meetings attended/meetings possible).

Profiles of the Board of Directors

Tracy Doucét, Chairman (12/13 Board meetings attended)

Tracy was appointed Chairman of the Trust and Board of Directors from April 2008 and was reappointed for a second term from April 2011.

As well as chairing meetings of the Board of Directors and the Council of Governors, Tracy also chairs the Board of Directors' Remuneration, Nomination and Investments Committees and the Council of Governors Nomination Committee and Performance and Strategy Committee.

Tracy joined the Board as a non-executive director when the Trust was granted its Foundation Trust licence in February 2007, bringing with her 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, improve communication, governance, customer focus, leadership and performance.

Tracy's work on corporate communication strategies, stakeholder engagement, effective governance, partnership working, board 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.

Martin Wakeley, Chief Executive (6/6 Board meetings attended)

Martin was appointed to the Board of Directors on 1 October 2011.

He first joined the NHS in 1995 and worked as a scientist in hospitals for ten years before moving into a number of hospital general management roles in large teaching hospitals before joining PriceWaterhouseCoopers as a management consultant.

He returned to the NHS, joining Trafford General Hospital in Manchester as director of operations and deputy Chief Executive, opening the first ISTC in the country, before becoming chief executive at Royal Hampshire County Hospital, Winchester and Eastleigh NHS Trust.

Martin has previously worked as the National Operations Director at Circle Healthcare, an independent health company, where he led the early part of the acquisition of Hinchingbrooke Hospital, the first takeover of an NHS hospital by a private provider in addition to opening their first private hospital in Bath.

Martin has also been a Non-Executive Director and chair of Choices Housing Association who specialise in providing 24/7 support for people with learning disabilities.

Carolyn White, Deputy Chief Executive (13/13 Board meetings attended)

Carolyn was appointed interim Chief Executive from December 2009. During the last year, together with Board colleagues, Carolyn has led the organisation during its first challenging year of turnaround ensuring both a high level of engagement of staff and a continued focus on quality and performance. Carolyn joined the Trust as Executive Nurse Director in July 2001, having 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. She 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.

Fran Steele, Chief Financial Officer (4/4 Board meetings attended)

Fran was appointed as Chief Financial Officer on 1 January 2012. She is responsible for financial management and strategic financial planning and provides expert advice to the Board of Directors on financial matters.

Fran joined the Trust from PA Consulting Group, where she was a partner in the government Practice leading transformational work in health and across the wider public sector.

Fran started her career as a graduate on the NHS Financial Management Training Scheme in the West Midlands and went on to work in organisations across east and west Midlands including Central Nottinghamshire Healthcare NHS Trust.

More recently Fran has had experience in shaping and delivering large scale commercial, operational and strategic change to drive excellence across the public sector.

Nabeel Ali, Executive Medical Director (11/13 Board meetings attended)

Whilst continuing to provide clinical care, as Executive Medical Director Nabeel provides dynamic leadership of the Trust's medical profession, plays a key part in developing policies and strategies, and provides a valuable medical perspective on all matters to the Board of Directors.

Nabeel is a general and respiratory consultant. He was appointed to the Trust in 1994, having worked in various capacities including Associate Clinical Sub-Dean for the University of Nottingham Medical School.

Nabeel was the Divisional Director for Emergency Care and Medicine at the Trust for three years before being appointed Executive Medical Director, firstly on an interim basis in July 2010, and then substantively in October 2010.

Susan Bowler, Executive Director of Nursing & Quality (11/13 Board meetings attended)

Susan was appointed interim Executive Director of Nursing and Quality in May 2010 on secondment from Nottingham University Hospitals NHS Trust and was subsequently appointed to the Board as Executive Director of Nursing & Quality on 1 July 2011.

Susan has worked within the NHS for 28 years in a variety of senior nursing, service improvement and patient experience roles. Her responsibilities include infection control, nursing and midwifery, clinical governance, quality and patient safety.

Initially trained as a Critical Care Nurse, Susan has held roles in senior nurse management, education, planning and hotel services. She has also worked as part of specialist networks, national inspection teams and has worked on a number of projects for the NHS Institute of Innovation and Improvement.

Susan has a strong professional drive for improving and enhancing patient care and ensuring that staff are supported and developed, to influence quality and patient safety.

Lucy Dadge, Commercial Director (3/3 Board meetings attended) (non-voting executive)

Lucy joined the Trust in December 2010 and joined the Board of Directors as an Executive Director in January 2012.

Lucy is responsible for the wider commercial operations of the Trust, including managing the relationship with the Private Finance Initiative (PFI) partnership that built and now runs the facilities management services for the hospital buildings. Lucy is also responsible for creating a commercial strategy for the Trust that delivers investments in new buildings and services and identifies new partnership opportunities for the Trust.

Lucy has spent her recent career working at Nottingham University Hospitals NHS Trust, Her Majesty's Revenue and Customs (HMRC) and East Midlands Strategic Health Authority; latterly focusing particularly on Public Finance Initiatives (PFIs) and other forms of public/private sector partnership.

Lucy initially trained as an architect and subsequently qualified as a Chartered Surveyor. She is a Fellow of the Royal Institution of Chartered Surveyors (FRICS).

Lucy has also worked in the private sector and currently holds non-executive director roles and company directorships in the social housing and further education sectors.

Karen Fisher, Executive Director of Human Resources (12/13 Board meetings attended)

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

She has worked for the NHS for over 30 years and has significant experience in human resources, partnership working and workforce transformation/change management programmes. She has held senior management positions within both strategic and acute sectors within the NHS.

Karen holds an MSc in Leadership through Effective HR Management.

Jane Warder, Chief Operating Officer

Jane was appointed as Chief Operating Officer in February 2010, having initially joined the Board of Directors as Executive Director of Strategy and Improvement in 2007.

Jane held a number of Director level and senior management positions across the NHS prior to joining the Trust Board. She has worked nationally and regionally with senior clinical teams and boards to improve and re-configure clinical services to truly transform patient experience.

Jane has worked in the NHS for over 25 years, having initially qualified as a nurse.
Jane left the Trust on 29 February 2012.

Lee Bond, Executive Director of Finance (1/2 Board meetings attended)

Lee joined the Board of Directors in August 2007, and also led the Trust's information and procurement functions. Lee was previously Executive Director of Finance at Sheffield Children's Hospital NHS Foundation Trust and has worked in the NHS since 1993. He is qualified with the Chartered Institute of Management Accountants (CIMA) and acted as the Trust's principal advisor on all financial matters.

Lee left the Trust on 19 June 2011.

Alastair Marshall, Interim Finance Director (5/6 Board meetings attended)

Alastair Marshall worked with the Trust as interim Director of Finance from 20 June to 30 November 2011. Alastair qualified as a Chartered Accountant with Price Waterhouse Coopers and has significant professional, financial, turnaround and NHS experience.

Elaine Konieczny, Acting Finance Director (1 Board meeting attended)

Elaine is a qualified member of the Chartered Institute of Management Accountants (CIMA), with over 25 years NHS experience across a wide variety of roles, including both Primary and Acute Trusts.

Elaine has previously covered a Director of Finance role in a local PCT, and has fulfilled two previous periods as Acting Director of Finance at Sherwood Forest Hospitals NHS Foundation Trust.

In this instance, Elaine worked in the acting capacity from 1 December to 31 December 2011.

Non-Executive Directors

Bonnie Jones, Non-Executive Director (Vice Chairman) (13/13 Board meetings attended)

Bonnie joined the Board of Directors in February 2008 and was appointed Vice Chairman in January 2009, being appointed for a second term in February 2011.

Bonnie is a member of the Audit Committee, the Remuneration Committee, Nominations Committee, the Finance Committee and is Chair of the Organ Donation Committee. She is also the non-executive director representative on the Trust's Infection Control Committee, and non-executive lead for safeguarding.

Bonnie was formerly an investigator with HM Customs & Excise, specialising in common agricultural policy fraud. Bonnie was Chair of Newark and Sherwood Primary Care Trust from 2000 to 2006. During this time the Trust developed as a lead commissioning organisation working closely with Sherwood Forest Hospitals NHS Trust.

Since 2007, Bonnie has been a non-executive director with Nottinghamshire Probation Trust where she is also the chair of the Audit Committee.

David Heathcote, Non-Executive Director (SID) (12/13 Board meetings attended)

David joined the Board of Directors in February 2008 and was appointed Senior Independent Director in November 2008. He was re-appointed for a second term in February 2011.

David is a member of the Audit Committee, the Finance Committee, the Nominations Committee, and the Remuneration Committee. He is also the lead non-executive director for the Trust's whistle-blowing policy and is non-executive lead for equality and diversity.

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 (13/13 Board meetings attended)

David joined the Trust in November 2005 and was appointed to the Board of Directors in February 2007. David was subsequently reappointed for a further 3 year term in November 2009, and he is the Chair of the Audit Committee.

David is a Chartered Certified Accountant by profession and has worked in 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 (small and medium enterprise) clients. David supports Young Enterprise UK as a business advisor to student companies.

Iain Younger, Non-Executive Director (11/13 Board meetings attended)

Iain joined the Board of Directors in December 2009 and is a member of the Audit Committee and the Finance 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.

Stuart Grasar, Non-Executive Director (13/13 Board meetings attended)

Stuart joined the Board of Directors in 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 Public Services at North Nottinghamshire College in Worksop.

Stuart has held both non-executive and executive positions operating in a boardroom capacity since 1984. Stuart worked with the Ilkeston Consumer Co-operative Society, becoming chairman between 2003 and 2006.

Stuart is an associate member of Healthcare Financial Management Association. His achievements include the development and motivation of people to move onto successful careers and his commercial experience has contributed to successful business trading.

1.2.2 Responsibilities of the Board of Directors

During the year ended 31 March 2012, the Board of Directors comprised 12 voting directors, equal numbers of non-executives and executives including the Chairman. The Board has a voting structure, set out in our constitution and authorised by Monitor such that the Chairman has a casting vote and Non-Executive Directors, including the Chairman have majority control.

The Chairman and Chief Executive work together to provide visible, effective leadership of the Trust. The division of responsibilities between the Chairman and the Chief Executive is set out in writing in governance documents, and has been approved by the Board.

The Chairman:

- Leads the Board in developing the Trust's vision and strategies
- Holds the Chief Executive to account for delivery of the strategy
- Provides visible leadership in developing a positive culture for the Trust
- Ensures that board committees which support accountability are properly constituted
- Has the responsibility for appointing and removing the Chief Executive with Non-Executive Directors
- Chairs the committees responsible for agreeing remuneration, the appointment and removal of the Chief Executive and Executive Directors
- Ensures regular reviews of performance of all Board member.

The Chief Executive:

- Leads the executive and provides visible day-to-day leadership of the Trust;
- Leads the executive in developing and delivering the strategy and agreed objectives
- Leads the operational delivery of the Trust
- Is the Officer accountable to Parliament
- Is accountable via the Chairman to the Board of Directors for the operational management and performance of the Trust and for the delivery of the Trust's strategy
- Reviews the performance of executive directors, with input from the Chairman in terms of wider board contribution

The Board of Directors have individual and collective responsibility for:

- Setting strategic direction, ensuring management capacity and capability
- Adding value to, and promoting the success of the Trust
- Providing leadership of the Trust within a framework of prudent and effective controls
- Monitoring and managing performance
- Safeguarding values and ensuring the Trust's obligations to its key stakeholders are met

All Directors, Executive and Non-Executive, have responsibility to constructively challenge the decisions of the Board, to ensure that the Trust continues to comply with its Terms of Authorisation, and to develop proposals on priorities, risk mitigation, values, standards and strategy.

The Board of Directors met 13 times during the year. The Board of Directors meets monthly in confidential private session and holds a public Board meeting each quarter, (April, July, October and January). Extra-ordinary meetings were held in February 2011 and March 2011.

1.2.3 Sub-Committees of the Trust Board

The Board of Directors has four sub-committees:

- Audit Committee
- Finance Committee
- Nominations Committee
- Remuneration Committee

The membership and role of each of these committees at 31 March 2012 is summarised below.

Audit Committee

The Audit Committee meets regularly throughout the year. Chaired by David Leah, membership of the committee comprises four non-executive directors (including the committee chair) all considered by the Trust to be independent.

The chair is a suitably experienced non-executive director with financial expertise. The committee has been supported by regular attendance from the internal and external auditors and Trust officers including the Chief Executive, Chief Financial Officer and Company Secretary. Other executive directors attend by invitation. The committee met on 8 occasions during the year.

The committee assists the Board in ensuring that effective internal control arrangements are in place across the Trust. The Audit Committee is also the governance committee, providing assurance to the Board on a wide spectrum of control issues, and in recent years has widened its scope to include other areas of non-financial governance – particularly clinical governance and information governance.

Members' attendance at Audit Committee meetings during 2011/12 was as follows:

David Leah - Chairman	8 of 8
David Heathcote	8 of 8
Bonnie Jones	8 of 8
Iain Younger	5 of 8

Finance Committee

The Finance Committee is chaired by the Trust Chairman, Tracy Doucét. The committee supports the Board in undertaking more detailed monitoring of financial performance; approving business cases within delegated limits for both revenue and capital expenditure; and in ensuring the effective implementation of the Trust's investment and borrowing strategy.

Members' attendance at Finance Committee meetings during 2011/12 was as follows:

Tracy Doucét – Chairman	10 of 10
David Heathcote	9 of 10
Bonnie Jones	9 of 10
Iain Younger	8 of 10

Nominations Committees

Two separate Committees exist – a Nominations Committee for the appointment of executive directors and their direct reports, and a Nominations Committee for the appointment of non-executive directors.

The Nominations Committee for executive directors and their direct reports is chaired by the Trust Chairman, Tracy Doucét. The committee ensures that there is a formal, rigorous and transparent procedure for the appointment of new executive directors to the Board and ensure that systems and processes are in place for the development, succession planning and regular performance assessment of the Chief Executive and Executive Directors.

The committee is supported by the Executive Director of Human Resources and Company Secretary and by external advisers where required. Neither the Chief Executive, nor the Executive Director of Human Resources are present for any discussion relating to their own role.

The Nominations Committee (for the appointment of executive directors) met twice during 2011/12. Attendance was as follows:

Tracy Doucét - Chairman	2 of 2
David Heathcote	2 of 2
Bonnie Jones	2 of 2

The Nominations Committee for non-executive directors is a committee of the Council of Governors, chaired by the Trust Chairman and supported by the Senior Independent Director. The committee ensures there is a formal and comprehensive process and procedure in place for the appointment of non-executive directors to the Board.

During 2011/12 the committee also focused on agreeing a protocol for handling any breaches of the Council of Governors' Code of Conduct. The committee is supported by the Executive Director of Human Resources and the Company Secretary.

The Nominations Committee (for the appointment of non-executive directors) met 5 times during 2011/12. Attendance was as follows:

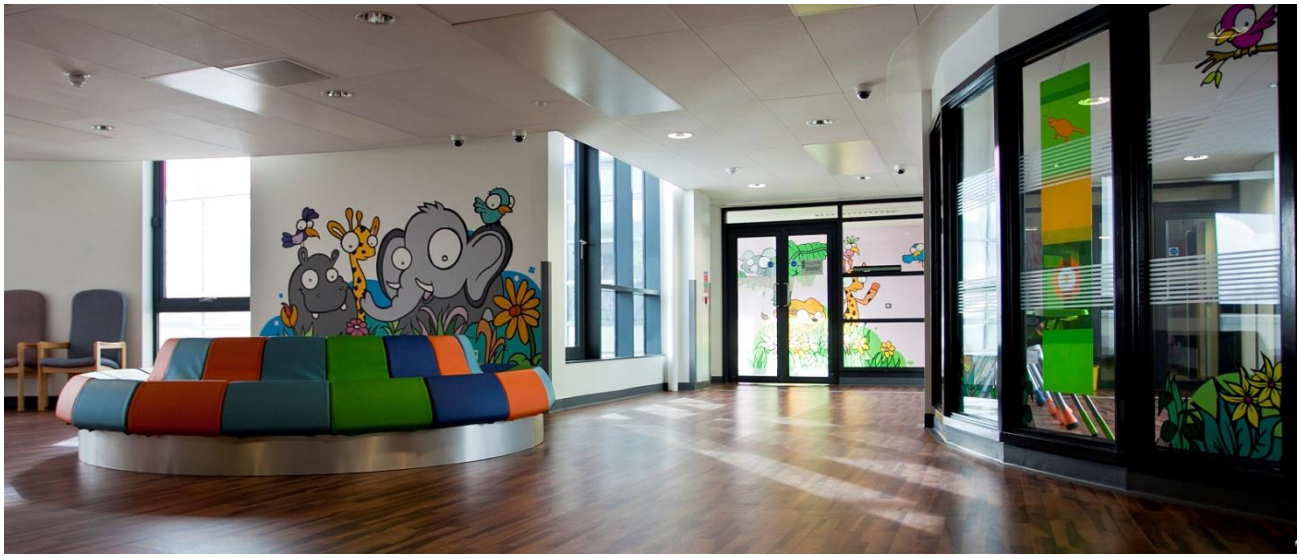
Tracy Doucét	2 of 5
David Heathcote	5 of 5
Eve Booker	5 of 5
John Marsh	5 of 5
Margaret Ralls	4 of 5
Alison Luke	3 of 5
Nigel Mellors	2 of 5
Barry Answer	2 of 5
Davina Fordham	2 of 5

Remuneration Committee

The Board of Directors appoints the Remuneration Committee and its membership comprises only non-executive directors. The Committee is chaired by the Trust Chairman and meets regularly to determine on behalf of the Board the remuneration strategy for the organisation, including the framework of executive and senior manager remuneration.

The Remuneration Committee met 5 times during 2011/12. Attendance is detailed below. The committee receives advice and is supported by the Chief Executive, the Company Secretary and the Executive Director of Human Resources. None of these individuals and no other executive or senior manager participated in any decision relating to their own remuneration during the year. At the end of March 2012, the members of the Remuneration Committee were:

Tracy Doucét – Chairman	5 of 5
David Heathcote	5 of 5
Bonnie Jones	5 of 5
Stuart Grasar	4 of 5



1.2.4 Corporate Governance

Compliance with the Code of Governance during 2011/12

The Foundation Trust Code of Governance (the Code) is published by Monitor the Foundation Trust Regulator. The Code was first published in 2006 and was last updated in March 2010, taking account of more recent developments in governance practices specific to NHS Foundation Trusts.

The purpose of the Code is to assist NHS Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

The Code is issued as best practice advice, but imposes some disclosure requirements. NHS Boards are expected to observe the code or to explain where they do not comply. It includes a number of ***Main & Supporting Principles*** and ***Provisions*** and Foundation Trusts are required to publish a two-part statement in their Annual Report confirming how these have been applied.

Part one below explains how we have applied the main and supporting principles of the Code Part two highlights those areas where the Board of Directors feels that compliance with the Code had not been fully achieved together with an explanation for this assessment.

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

Directors

We accept the principles described within the Code in relation to our directors and we are 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 Council of 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 delegated to the Chief Executive and other staff by the Board of Directors, as well as those powers that have been reserved for decisions by the Board. Amendments to the Scheme of Delegation were approved during 2011/12. The Chief Executive is the Accounting Officer for the Foundation Trust and confirms whether we comply with the provisions of the Code.

The Board of Directors is confident that its composition, skills and experience were appropriate during 2011/12 and the two Nominations Committees reviewed the composition of the Board of Directors, and its collective skills and expertise during the year.

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

A register of directors' interests is maintained by the Company Secretary, and can be obtained by writing to the Trust's Headquarters. With the exception of the Commercial Director, all board members exercise one full vote, with the Chairman having a casting vote.

Governors

The Trust has accepted the principles described within the Code in relation to its governors and has established a Council of Governors in accordance with the 2006 Act. The Council of Governors met on six occasions during 2011/12 (including the Annual General Meeting in September 2011) and has adopted the Trust's key governance documents. A Code of Conduct for Governors is issued to all governors on appointment.

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

Regular development sessions are arranged for governors, and a lead governor is in post.

Appointments and Terms of Office

We have applied the principles of the Code relating to appointment of Board Directors and their terms of office, and we undertake a formal, rigorous and transparent procedure for the appointment or re-appointment of directors.

A separate Nominations Committee for Non-Executive Directors has been established together with the Nominations Committee for Executive Directors. Both Committees are chaired by the Chairman. The Nominations Committee for Non-Executive Directors includes the Lead Governor and is chaired by the Senior Independent Director or Vice Chairman whenever the chair's remuneration, appointment or performance is discussed.

Information Development and Evaluation

During 2011/12, both the Board of Directors and the Council of Governors received information in a timely manner to enable them to discharge their respective duties. Performance evaluation and appraisals were undertaken for each member of the Board of Directors during 2011/12. The Chairman has 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.

Assessment of the effectiveness of the Board of Directors' key committees, including the Audit Committee was undertaken during 2011/12. The assessment process will be used again in 2012/13 and consideration will be given to further developing self-assessment and external assessment mechanisms.

Directors and governors joining the Board of Directors and Council of Governors respectively, also receive induction and ongoing training.

Developmental sessions for directors and governors and joint meeting sessions for the Council of Governor and Board of Directors have been held during the year. Action plans to address further developmental needs identified from these sessions have been prepared and implemented.

Directors' Remuneration

The Board of Directors and the Council of Governors accept that levels of remuneration for Board Directors should be sufficient to attract, retain and motivate people of a high calibre, whilst being independently benchmarked in relation to both the NHS and wider recruitment market.

The Remuneration Committee reviewed levels of Executive Directors' pay in 2011/12 and the Council of Governors considered the remuneration of the Chair and Non-Executive Directors during the year, following recommendations from the Nominations Committee for Non-Executive Directors.

Accountability and Audit

The Board of Directors accepts its responsibility to present a balanced and understandable assessment of its performance and endeavours, and 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 work of 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 re-appointed in November 2010, for a further two years following an assessment of their work considered by the Council of Governors.

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 joint developmental sessions and directors are members and / or regularly attend Council of Governor meetings and meetings of its committees to ensure that they understand Governors' views. The lead governor and a second public governor (the Chairman of the Patient Quality & Experience Committee) are also routinely invited to attend 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 with the Code had not been fully achieved in year, together with an explanation for this assessment.

Principle A3.2 The Board of Directors has carried a Non-Executive Director vacancy during 2011/12 and as a result did not have a majority of independent Non-Executive Directors. The Chairman, however, has a casting vote and as such the Non-Executive Directors retain majority control as required by the Constitution.

1.2.5 Council of Governors

The Trust's first Council of Governors was formally established in February 2007 following its authorisation as an NHS Foundation Trust. A second round of elections was held between October and December 2009, and further by-elections were held in May 2010.

As a Foundation Trust, the Trust Chairman chairs both the Council of Governors and Board of Directors. The Council of Governors currently comprises 36 Governors:

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, Newark Hospital, Mansfield Community Hospital and Ashfield Health Village staff and volunteers, all of whom are elected by our staff and volunteer 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
- Receiving the Annual Report and Accounts
- Providing views on the Trust's forwards plans and Annual Plan
- Developing a representative and active membership
- Representing the interests of members

All meetings of the Council of Governors are public meetings and in 2011/12, six meetings were held, including our Annual General Meeting in September 2011.

The Council of Governors is supported in discharging its statutory duties by the Nominations Committee (which oversees the appointment, remuneration and appraisal of Non-Executive Directors) and by 3 additional working sub-committees.

Governor Sub-Committees

Performance & Strategy Sub-Committee – involved in:

- Monitoring in-year performance, forward risks and compliance with the Trust's Terms of Authorisation
- Discussing and developing forward plans
- Discussing wider aspects of the Trust's Strategy and providing a view on behalf of members on consultations and on emerging National Policy & the NHS Act 2011

Patient Quality & Experience Sub-Committee – involved in:

- Setting and monitoring quality priorities
- Establishing patient views and experience
- Agreeing and reviewing the internal and clinical audit programmes
- Developing the Trust's Quality Accounts

Membership & Engagement Sub-Committee – involved in:

- Gathering views of patients, carers and staff to inform our plans and improve our services
- Recruitment and engagement with our members and wider community

The Board of Directors works closely with the Council of Governors, reporting performance and delivery against plans and regulatory targets throughout the year.

During the year, the Council of Governors and its sub-committees continued to engage in the development of the Trust's plans for the period 2012/13. The Governors continued to represent the interests of their members in the development of the Foundation Trust and the local health community.

During 2011/12, the Board of Directors ensured that Governors continued to be informed of developments at the Trust and across the wider NHS. 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 additional actions to engage further with Governors during the year:

- All Board Directors are encouraged to attend Council of Governor meetings
- Board Directors attend Governors' induction meetings and developmental sessions
- Two Public Governors, including the Lead Governor and Chair of the Patient Quality & Experience Committee have been invited by the Chairman to attend each of the confidential private session of Board of Directors meetings held during the year
- Non-Executive Directors and Executive Directors attend Council of Governor committee meetings in order to assist with the committees' work and each sub-committee has a minimum of one Non-Executive Director member to ensure effective joint working between the Board of Directors and Council of Governors throughout the year

The Council of Governors organised a large number of activities and events during 2011/12 to enable them to meet with and to listen to the views of our members.

A number of member events were also held focusing on issues that our members have indicated are their priority areas of interest.

Our Governors receive no remuneration, although they are able to claim expenses. The expense rates paid to Governors in 2011/12 reflected those paid to other service user representatives at the Trust and across the county.

A register of Governors' interests is maintained and information regarding this can be obtained by contacting the Company Secretary at the Trust's main headquarters.

Composition & Attendance of Governors at 31 March 2012

Governor	Constituency	Elected or Appointed	Attendance (6 maximum)
Eve Booker	Ashfield	E	6
Mary Wilde	Ashfield	E	5
Beryl Perrin	Ashfield	E	6
Craig Gunton-Day	Ashfield	E	5
[Richard Webster] resigned	Ashfield	E	2
Loris Lester	Ashfield	E	2
Yvette Price-Mear	Mansfield	E	5
Christine Smith	Mansfield	E	3
Davina Fordom	Mansfield	E	3
Geoff Stafford	Mansfield	E	6
John Marsh – Lead Governor	Mansfield	E	6
Frank Shields	Mansfield	E	5
Hilda Tagg (died Jan 2012)	Newark & Sherwood	E	0
Margaret Ralls	Newark & Sherwood	E	4
Patricia Richards	Newark & Sherwood	E	5
Jim Barrie	Newark & Sherwood	E	2
Elaine Ellison	Newark & Sherwood	E	2
[Tim Wright] resigned	Newark & Sherwood	E	3 of 4
Dorothy Platts	Derbyshire	E	5
Walter Satterthwaite	Derbyshire	E	6
Nigel Mellors	Staff – King's Mill Hospital	E	5
Alison Beal	Staff – King's Mill Hospital	E	5
Simon Beshir	Staff – King's Mill Hospital	E	3
Alison Whitham	Staff – King's Mill Hospital	E	5
Angie Emmott	Staff – Newark Hospital	E	5
Alison Luke	Staff – Newark Hospital	E	6
Ron Tansley	Staff – Volunteers KMH	E	5
Nicola Juden	Staff – Volunteers NH	E	2
Barry Answer (to May 2011)	Mansfield District Council	A	1 of 1
Councillor Paul Henshaw	Mansfield District Council	A	0 of 5
Mark Avis (to September 2011)	Nottingham University	A	0 of 3
Mick Parker (to May 2011)	Ashfield District Council	A	0
Councillor David Kirkham	Ashfield District Council	A	2 of 5
David Payne	Newark & Sherwood District Council	A	5
Amanda Sullivan	NHS Nottinghamshire County	A	3
Patricia Harman	West Notts. College	A	5
Councillor Stuart Wallace	Nottinghamshire County Council	A	3 of 3

Board Director attendance at Board of Governor meetings during 2011/12

Director	Position	Attendance (6 Maximum)
Tracy Doucét	Chairman (Board of Directors & Council of Governors)	6
Bonnie Jones	Vice-Chairman	6
Stuart Grasar	Non-Executive Director	5
David Heathcote	Non-Executive Director & SID	6
David Leah	Non-Executive Director	6
Iain Younger	Non-Executive Director	5
Carolyn White	Deputy Chief Executive	6
Nabeel Ali	Executive Medical Director	2
Lee Bond (left June 2011)	Executive Director, Finance	0
Susan Bowler	Executive Director of Nursing and Quality	4
Karen Fisher	Executive Director, Human Resources	5
Martin Wakeley (joined Oct 2011)	Chief Executive	1 of 2
Jane Warder (left March 2012)	Chief Operating Officer	2
Fran Steele (joined 3 Jan 2012)	Chief Financial Officer	1 of 1
Alastair Marshall (left Dec 2011)	Interim Finance Director	2 of 2
Lucy Dadge (joined Jan 2012)	Commercial Director	0 of 1

Trust Governors Eve Booker and Craig Gunton-Day meet Tim Farron MP (President of the Liberal Democrats) outside the Palace of Westminster following a Foundation Trust event.

1.2 6 Trust Membership

Almost 5% of the local population have chosen to support Sherwood Forest Hospitals through becoming a member of the Foundation Trust. We have the largest membership base in the East Midlands, and one of the largest in the country.

Our public membership continued to grow steadily during 2011/12, increasing by 2.58% from 20,294 at the end of March 2011 to 20,818 at the end of March 2012. In addition to the public and staff members, we listed 1,181 affiliate members at the end of March 2012. This positive, yet reduced growth rate on previous years is a reflection of our agreed focus on membership *engagement* as much as recruitment, and we have actively increased the number of opportunities to engage with our members over the past 12 months.

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

Staff constituency

The Trust has 5,317 employees and volunteers who are classed as staff members. The staff constituency is divided into four classes:

- King's Mill Hospital
- Newark Hospital
- Volunteers at King's Mill Hospital
- Volunteers at Newark Hospital

During May 2011, the transfer of community services took place (under TCS) and staff working for Ashfield and Mansfield Community hospitals became members of the King's Mill Hospital class.

We also encourage membership from organisations that work with or on behalf of the Trust, including our PFI partners. Less than 1% of our workforce has chosen to opt-out from being a member.

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 16 years of age or over and meet other eligibility criteria as described in the Trust's Constitution.

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

Public membership breakdown at 31 March 2012:

	Number of members	Membership profile %	Population Profile %	Index
Age (years)				
0-16	57	0.27%	1.3%	21
17-21	979	4.7%	5.4%	87
22+	19,782	95.0%	93.3%	102
Ethnicity				
White	20,628	99.1%	98.7%	100
Mixed	37	0.18%	0.46%	39
Asian	93	0.45%	0.41%	110
Black	45	0.22%	0.19%	116
Other	15	0.07%	0.22%	32
Socio-economic groupings				
ABC1	7,509	36.1%	42.6%	85
C2	9,767	46.9%	18.1%	259
D	1,130	5.4%	21.3%	25
E	2,273	10.9%	17.8%	61
Gender				
Male	7,854	37.7%	48.9%	77
Female	12,964	62.3%	51.1%	122
Constituency				
Ashfield	6,377	30.6%	28.2%	109
Mansfield	6,775	32.5%	23.8%	137
Derbyshire	2,272	10.9%	16.3%	67
Newark & Sherwood	5,396	26.0%	31.7%	82

Notes: for the purpose of the membership analysis the 'unknown' figures have been pro-rated across the 'known'.

Membership Recruitment

The Trust's Marketing and Membership Manager has played a significant part in driving forward membership by recruiting new members and enhancing our engagement programme. The profile of the membership has increased across the Trust and the community with the Council of Governors being actively involved in the recruitment and engagement of the members throughout 2011/12.

During the year, the principal means of membership recruitment was through face-to-face contact at local events, community and voluntary group meetings, and also within the hospitals. We have targeted all facets of our catchment area with a particular focus on those groups who are under-represented such as 16-21 year olds, males and the D socio-economic class.

The Membership and Engagement Sub-Committee has reviewed the membership recruitment target for 2012/13 based on the number of public members recruited during 2011/12 (1,716 new

members), on the number of members lost, and considered the emerging emphasis on better engagement with existing members. The sub-committee has recommended to the Board of Directors that the target should continue to be 21,000 public members by the end of March 2013. This replenishment of lost members will enable the list to be maintained whilst introducing a new focus on quality engagement rather than numerical growth. We are committed to keeping our data cleansed, which means that membership recruitment will need to attract 6-7% in order to maintain the status quo.

We will continue to use targeted recruitment methods to ensure that our public membership is representative of those eligible to join. Our recruitment events will focus on quality of membership over quantity, with involvement and engagement being significant factors.

Engagement with members

Positive engagement with our members is extremely important and we are constantly improving and increasing the level of this. There is evidence that there has been an increase in the number of members responding to surveys and attending member events. This is monitored regularly at the Membership and Engagement sub-committee and new, innovative methods of engagement are discussed.

Membership highlights:

- The Trust magazine, 'Best' is distributed three times a year to all members. The magazine has proved to be very popular, and with 3,862 members having been encouraged to receive it via email this has helped to reduce our printing costs whilst also creating a more interactive communications channel. The email list has increased by 412 members since March 2011 and we are actively encouraging members to receive the magazine via email instead of post. Members said in the member survey they found the magazine:

  "Very informative and enjoyable to read and look forward to receiving it"

- Monthly member events take place to engage members with different areas of interest. A member survey is included with all welcome packs asking them what interests they have. Events are arranged based on the most popular choices, as well as feedback from member events. Those members who have registered their interests can now be targeted with more appropriate information, surveys and invitations based on their areas of interest; this is extremely useful and valuable to our membership

  Feedback from member events:

  "The member events are always very worthwhile and informative"
  "Excellent speakers which helped me to understand dementia more"
  "Very well run and the content perfectly understood and appreciated"

- Over 800 members completed the Member Survey in December 2011 which asked members their opinions on our membership, how they would like to get involved and what they were interested in. We also collected 361 new email addresses from members who previously received Best magazine via post. Over 50% of members indicated they would prefer to receive the magazine only, with the majority also indicating that they would be happy to receive email updates and be contacted about their areas of interest

- Regular ‘meet your governor’ sessions are combined with member events in order for members to raise issues and concerns with their local governors. There are 64 members who have expressed an interest in elections or standing as a governor. They will be contacted for the upcoming elections

- There are regular articles in the magazine regarding membership and governors exchanges. Staff governor drop-in sessions have taken place at Newark Hospital which have raised the profile of the staff governors and enabled their constituents to contact them when necessary

- The Marketing and Membership Manager and individual governors have attended various community groups and events to inform the public about membership and also to engage with the members. Events include NHS Community in Unity events (Newark and King’s Mill hospitals), Careers Fair at West Notts College, Learning Disability Locality event, Nottinghamshire Pride Festival, the Ashfield Show and local supermarkets

- Members have influenced the Trust’s strategy and helped to shape services by completing a survey regarding what priorities the Trust should focus on for the Annual Plan and the Quality Report. Over 480 members completed the surveys and played an active role in shaping the Trust’s future

Future membership recruitment and engagement

Whilst the Trust is satisfied that its membership profile was broadly representative of its local population at the end of 2011/12, actions will be taken during 2012/13 to ensure that it continues to be even more representative of the local population in the future. We will also improve and increase the level of engagement with our members – both public and staff.

The key priorities in 2012/13 are to:

- Work closely with our governors and members to ensure that our services meet their needs and reflect their ambitions; and being open and more transparent with governors and members
- Engage with members, in line with the Equality Delivery System objectives, ensuring that all groups are appropriately represented and that we continue to build productive relationships with our members, including an increasing proportion who would recommend our services
- Influence key policy areas followed by feedback to members on how they have made a difference, for example involvement in the service redesign for healthcare of the elderly patients
- Ensure that the membership continues to be representative of our local population and that the number of members is sustained

The Trust will also be developing further innovative ways in which it can engage with members including:

- Increasing opportunities for members to get more involved with service redesign and the Trust’s Annual Plan by arranging focus groups, workshops and online surveys
- Hosting an Open Day at Newark Hospital to enable Newark and Sherwood members to have a behind-the-scenes tour and enable the Trust to listen to their priorities for Newark Hospital in the future

- Improving new member welcome packs and implementing a new look monthly membership e-bulletin
- Continuing and improving the Trust magazine and the quality and range of stories
- Continuing the rolling programme of member events based on the most popular areas of interest as indicated in the member survey
- Increasing the opportunities for governors to engage with their members at meet your governor sessions
- Enhancing the use of social media to engage with members and increasing the number of members who would like to communicate via email
- Stimulating greater attendance at the AGM by introducing talks on popular topics and featuring key service 'spotlights' to demonstrate new developments and ground-breaking achievements

The recruitment of members has increased at a slower rate in 2011/12 compared to the previous year. Consequently, it has been decided to consolidate at 21,000, recruiting enough new members to replace those who will be lost over the year. The Trust will re-focus its efforts on quality engagement with members to ensure it has a more active and involved membership based on the quality of members and not the quantity.

To contact your local governor

All governors can be contacted by emailing governors@sfh-tr.nhs.uk or telephoning 01623 622515 ext. 3509.

Find out more about our Council of Governors and look up individual governors on our website www.sfh-tr.nhs.uk . You can also follow us on Twitter at www.twitter.com/SFHFT or Facebook by searching for Sherwood Forest Hospitals at www.facebook.com

1.2.7 Annual Governance Statement

Scope of Responsibility

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

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

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than 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 Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.

The system of internal control is based upon a risk management framework consisting of policies and procedures covering key business, staff management and clinical activities, Standing Orders, Standing Financial Instructions and Scheme of Delegation, the checks inherent within internal and external audits and reviews, independently commissioned assessments, the Board Assurance Framework (BAF), the Corporate Risk Register (CRR) and Executive Management Committee (EMC) and Trust Board oversight.

Capacity to Handle Risk

Leadership

The Board of Directors
The Board of Directors is responsible for the overall governance of the Trust, including the recently transferred community services and is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. As Accounting Officer I have overall accountability for ensuring and providing robust assurance on the effective risk management in the Trust.

The control and management of risk is also a fundamental responsibility of all Executive Directors and it is embedded within the job roles of all senior managers - underpinning their responsibility for the delivery of safe and effective patient care and good governance.

The Chief Executive, as Accounting Officer, has delegated specific responsibility for risk management throughout the Trust to Executive Directors who are the Trust's Senior Responsible Officers.

Director's specific responsibilities in relation to risk management include ensuring:

- Effective systems for identifying risks
- Appropriate processes for eliminating reducing or mitigating risks
- Compliance with internal policies, procedures and protocols
- Compliance with statutory requirements

The Board of Directors receives details of key risks on a monthly basis through board reports and through its discussions at Board meetings, the agenda having been set to reflect the Board Assurance Framework and the risk management and escalation processes in operation within the organisation. Throughout the year the adequacy of the BAF (Board Assurance Framework) has been reviewed in response to external audit opinion that further refinement of the process was required, resulting in a clearer articulation of the Trust's key risks in addition to further refinement work of the BAF itself.

The monthly executive performance reports record material financial, clinical, and operational risks and these are supported by detailed quarterly reports recording performance against key performance indicators and progress against annual planning objectives.

This process is further supplemented when the Board undertakes its quarterly assessment of service, financial and activity risks and discusses as part of its submission to Monitor, the NHS Foundation Trust Regulator.

Together, these arrangements serve to ensure the Board's effective ownership, leadership and ultimate accountability for the effective management of its key business risks in the context of its strategic direction and key objectives.

Training and Guiding Staff on the Management of Risk

Staff are supported and equipped to manage risk relevant to their workplace in a variety of ways this includes:

- Comprehensive staff induction in Trust policies and procedures
- Mandatory annual training for all staff eg fire safety, health and safety, information governance, moving and handling, infection control
- Ongoing training and specifically identified training needs as part of annual appraisals, service changes and performance management systems

Staff are trained to manage risk in ways which are commensurate with their specific roles and duties e.g. incident reporting and investigation training. Mandatory training is a critical part of the Trust's clinical governance, risk management and patient and staff safety strategies. The Board has required an improvement in attendance at mandatory training. The training, education and development annual report received by the Board of directors at its board meeting in September 2011 provided positive assurance that attendance at Mandatory training had increased from 39% to 60% during the year; further board updates have seen sustained improvement with a continued rise in attendance. In addition the department has undertaken a fundamental review of both statutory and mandatory training requirements to ensure that we can continue to provide the best training and support to our staff and patients. As a result of a gap analysis and recognition of the

need to strengthen operational performance we have also commissioned and delivered the first cohort of a management and leadership development programme to better prepare our clinical leaders for the challenge of operational management.

Continuous Improvement Through Learning
The Board is committed to a culture of continual learning and quality improvement.

The Trust routinely uses learning from incidents, root cause analysis, complaints and patient and staff feedback to review the effectiveness of our underlying policies, processes and controls. The Trust uploads anonymised data on all incidents reported on its online system to the National Patient Safety Agency.

In line with an active patient safety culture, the Trust has actively developed a campaign and objective to encourage an increase in incident and near miss incident reporting in order that learning from such events can be maximised.

Lessons learned are routinely cascaded to staff across the organisation to improve the quality, safety and effectiveness of the care provided for patients.

Reports from Healthcare Regulators, internal and external assessment, best practice and lessons learned from major incidents elsewhere, are also used as an important tool to drive continuous improvements in patient safety and good governance.

Monitor Compliance Targets
As a Foundation Trust we have considered carefully our ability to achieve compliance against the targets issued by our regulator Monitor. The Board of directors took considerable time to assess risk of achievement of the targets at the beginning of the financial year and declared a risk against achievement of C. difficile and cancer targets. Recognising the implications for patients and our governance risk rating, the Trust worked hard during the year to mitigate against the risks.

Significant success in reducing health care related infections in previous years gave the Board confidence that this could be achieved again and it was disappointing therefore to narrowly miss the C. difficile reduction target by 2 cases. As a consequence of this breech, which resulted in a red risk rating (subsequently considered and reduced to Red/Amber by Monitor), the Trust undertook a corporate Root Cause Analysis (RCA) to ensure that we had discharged our duties effectively. Lessons learned from this RCA have been incorporated into our plans for the coming year.

Successful achievement of all other key performance indicators underpinned by the fact that we were one of only a small number of hospitals in the country to achieve zero MRSA bacteraemias over a two year period and one of only two Trusts in the East Midlands to achieve the A&E target gives the Board of Directors significant assurance that appropriate controls were in place in year.

Care Quality Commission (CQC)
During the early part of 2011 the Trust received a planned visit from the CQC at King's Mill Hospital, following two planned visits at Newark Hospital.

During these visits it was identified that improvements were required to meet 7 of 16 outcomes (detailed within the annual Quality Report). It was recognised at this time that the shortcomings

identified did not constitute a risk to patient care but that systems and processes required strengthening.

The Trust instigated many improvements to meet the standards and strengthened both our auditing arrangements and reporting from ward to board. As a consequence 5 out of 7 concerns were found to be addressed when the CQC undertook a follow-up visit in October 2011.

Concerns remained regarding outcomes 2 and 21 and as a consequence the Board of Directors commissioned an action plan to ensure that compliance would be demonstrated before the end of the year and to review why the Trust's governance systems failed to recognise the repeated failure of the two highlighted outcomes. Following on from this a period of comprehensive work was undertaken which culminated in the Board being satisfied that full compliance had been achieved during March 2012, but recognised that a programme of continuous improvement would need to be maintained to ensure sustained improvement. A review visit was requested which took place on 27 April. The CQC reported that the Trust had made massive progress and was compliant against all outcomes.

The Developing Organisation

During 2011/12 the Trust successfully assimilated community patient services, acquired following competitive dialogue as part of the Transforming Community Services process. In value the services were relatively modest (£14.2m) however, this transfer reflects the Trust's ambition to transform and develop new patient pathways and to working with our local health partners in truly transforming local healthcare services. Consequently, in order to ensure that we robustly assure ourselves and manage the risks of an enlarged organisation, our Board Assurance Framework, risk registers and quality metrics (effectiveness, safety and experience), as well as our operational reporting structures have been reviewed to provide assurance that risks to community services are managed effectively.

Risk & Control Framework

Risk Appetite and Risk Tolerance

The board is responsible for determining the nature and extent of our risk appetite and approach to risk tolerance. Overall the Board considers the degree of risks it is willing to take in achieving different levels and types of risk (strategic, tactical and operational) by considering our willingness and propensity to take risks, our ability to exercise effective control and our ability to measure performance and identify deviations. This Board intends to undertake further work during the year ahead.

Risk Management Framework & Strategy (Assurance Framework)

The Trust has a Risk Management Framework which is approved by the Board. It outlines:

- The Risk Management Framework and underlying systems and processes of risk management, control and governance
- The ways in which risks, or changes in risks are identified, evaluated and controlled
- The key committees
- Individual and collective responsibilities

The Risk Management Policy & Framework has been distributed throughout the Trust, and is also available via the Trust's intranet and internet sites.

Risk evaluation is based on a grading matrix of likelihood and consequence. This produces a risk score to enable the risk to be prioritised against other risks and evaluated against the organisations assessment of risk appetite. Risk scoring is also then used to determine the level within the organisation responsible for its management and mitigation.

Risks are recorded on the Trust's divisional, clinical, non-clinical and corporate risk registers.

Clinical and non-clinical risks are reported using Datix the Trust's online risk management system.

The Trust is cognisant of its responsibilities to ensure safe systems for the management of patient and staff data and has met its obligations as determined by the Data Protection Act and Information Governance regulations.

The Trust has improved its systems of management and control in year and has achieved Level 2 of the Information Governance toolkit. Any breaches of information security are investigated and reported through the Information Governance Group to Risk Management committee and where appropriate reported to the Information Services Ombudsman in accordance with national requirements.

A fundamental and thorough review of patient record security has been undertaken during 2011/12 improving systems of control in and between clinical and administrative departments.

In line with NHS policy, the Trust has also developed and implemented a Board Assurance Framework (BAF) as a mechanism for assessing risk and control at the very highest level.

The BAF is a key part of the Trust's risk & control framework. Work has been undertaken in year to strengthen the BAF recognising the significant risks facing the organisation and the need to have a robust system of risk management to ensure effective mitigation. Despite limitations at the start of the year the Board has sought to develop and strengthen this work in year seeking external support to do so, this has not compromised Board assurance in overall terms.

As part of our good governance and leadership and as an essential part of our overarching risk management and control framework, the Trust identifies its key strategic aims, corporate objectives and its operational objectives, which are aligned and cascaded throughout the organisation. The Board Assurance Framework considers the risks which might prevent the achievement of these objectives together with the associated controls in place and sources of assurance, which can be identified, through which the controls can be evidenced to be working effectively.

Where gaps in controls exist, these are identified and evaluated and are considered by both the Executive Management Committee and Board of Directors. Additional measures are considered to mitigate risks (where appropriate or required) in order to reduce the identified risks. Action plans are then prepared and used to assist the Trust to mitigate residual risks.

As outlined above, this process is informed and supplemented by a review of the most significant risks facing the Trust from the risk register, all risks being subjected to the application of the same risk grading matrix and evaluation criteria.

Structure & Accountabilities

The Trust has in place a formal structure to ensure that clear, unambiguous lines of accountability and communication exist in respect of, and in to order to, facilitate a robust approach to risk management. Roles and responsibilities are clearly defined in section 5 and appendix 1 of the Trust's Risk Management Framework.

During 2011/12, and operating within that framework with the specific remit to manage risk, there were:

Divisional Management Teams & Governance Committees (As defined in appendix 2 of the Trust's Risk Management Framework). These report to:

Risk Management Committee (RMC)
Responsible for the development of risk policies and monthly review of strategic and operational risks.

Clinical Governance Committee (CGC)
Provides assurance to the Board that governance arrangements are regularly reviewed in all areas of clinical activity. This reports to:

Executive Management Committee (EMC)
The operational management of the Trust is delegated to the Trust Executive Committee which reports directly to the Board of Directors via the Chief Executive. Decisions taken by the Trust Executive Group are informed by risk management principles.

The delegation of responsibilities to Executive Directors is detailed within the Trust's Risk Management Policy and Scheme of Delegation and is summarised below:

- Clinical & Quality Governance - Executive Nurse and Medical Directors
- Corporate Risk Management including major incident planning - Deputy Chief Executive
- Commercial, Property & Estate related risks – Executive Commercial Director
- Financial and Information Governance Risks – Chief Financial Officer

EMC brings together all key financial, clinical and corporate risks providing an organisational overview, which in turn populates the Board Assurance Framework. The Executive Management Committee (EMC) has specific responsibility for developing and monitoring the BAF and for regular routine reporting to the Audit Committee. EMC are responsible for ensuring that BAF is reported and discussed by the Board (at least quarterly), hence ensuring that the Board of Directors are fully sighted on and able to effectively manage significant risks.

The Board of Directors is supported by a number of formal sub-committees, each with a role in managing risks. These comprise the following:

Audit Committee
Board sub-committee comprising Non Executives, with responsibility for providing assurance on the effectiveness and robustness of the Trust's overall and underlying systems for integrated financial, clinical and operational risk management and governance.

Finance Committee
Responsible for gaining assurance on financial performance and on risks to the delivery of financial objectives and plans.

Nominations Committee
Oversees the process of appointing and removing Executive Directors and their direct reports. Ensures effective Board succession planning and performance management of Executive Directors via the Chief Executive.

Remuneration Committee
Determines remuneration of Executive Directors and those staff reporting directly to them.

The Risk Management Framework and the underpinning committees and structures have been reviewed in year by the Executive Management Committee, Audit Committee and Board of Directors.

Quality Governance Arrangements

The Trust Board ensures that there are robust arrangements for the management and continuous improvement of quality governance and performance and has made a clear commitment to its patients to the delivery of high quality of care.

Safeguarding and improving quality whilst driving costs down is the responsibility of all Directors.

During 2011/12, a set of nursing metrics has been introduced across the organisation. These metrics measure a broad range of core nursing activities, providing a robust basis for monitoring and measurement against a baseline, also allowing for direct patient feedback. Monthly assessment is undertaken with regular feedback to ward teams and managers, facilitating early identification of any concerns in the consistent delivery of high quality and safe care. The basis of the metrics is now being considered for a similar set to measure performance of doctors.

Quality is the subject of regular monthly discussion by the Board of Directors. Further detailed quality reports are provided each quarter providing assurance on performance against key quality objectives. Assurance on the delivery of consistent quality of care is provided through both internal controls and external independent peer review.

The quality of performance information is regularly assessed and discussed.

Each year the Board formally considers its performance against Monitor's Quality Governance Framework. This is supported by quarterly Board discussion of ongoing performance prior to the submission of the Board's quarterly declarations and returns.

Specifically the Board considers its performance and effectiveness in respect of the 4 key domains:

- Strategy
- Capabilities & Structures
- Processes & Structures
- Measurement

In addition to internal assessment and continuous improvement programmes, the Trust actively commissions external assessments of services from high performing peers, external review bodies and professional advisers to provide independent external assurance and where identified uses the recommendations to develop actions to drive further improvement.

During 2011/12 independent assessment of the following Trust services has been undertaken:

- Laboratory services
- Stroke care
- Trauma care
- Acute heart failure
- Cancer pathway management

Principal Risks & Controls

At 31 March 2012, the Board reviewed the Trust's major risks (both prior and future) and the Board Assurance Framework was updated and discussed by the Board of Directors in April 2012.

Principle risks in relation to the achievement of the Trust's strategic objectives are summarised below:

Objective: To protect and improve the quality, safety & effectiveness of our services and enhance the quality reputation of the Trust;

> ***Risk:*** The scale and pace of cost reductions as a result of financial challenge may result in clinical services failing to achieve the required level of quality and/or safety. *(In-Year & Ongoing)*
>
> ***Management & Mitigation:*** Existing controls and sources of assurance include the development of, and robust monitoring against, clear quality objectives and service line quality metrics, including assessment of the risks arising from the delivery of both in year and future CIPs. During the year, Nursing metrics were developed to provide early warning systems and performance is regularly monitored at all levels of the organisation. The Trust has established a Patient Safety Board and has robust PMO arrangements in place to ensure that the pace of cost reductions can be delivered safely and sustainably. Actions are underway to further mitigate these risks and to strengthen the PMO in respect of quality governance and monitoring is detailed in the BAF and has been the subject of Board discussion during April 2012.

Objective: Excellent financial and business management (economy, efficient and effective use of resources);

> ***Risk:*** Deteriorating underlying financial performance, resulting in risks to long term financial sustainability and a consequential failure to remain compliant with our Terms of Authorisation. This is caused principally as a result of being unable to deliver cost reductions quickly enough to outpace future reductions in income as a consequence of national and local efficiency requirements and commissioning plans.

Risk: High and increasing fixed and semi fixed costs (including PFI – Private Finance Initiative) and inability to flex our PFI estate and asset base in response to commissioning intentions which result in deteriorating asset utilisation.

Risk: Failure to secure larger NHS market share in our core business and/or secure business opportunities to diversify. Failure to mitigate risks to our core business as a result of choice, competition and to respond accordingly as a result of failure to identify risks and respond effectively leading to loss of existing revenue streams threatens short term financial viability. Securing increased revenue from diversification is a key contributor to longer term sustainability.

Risk: Cash position declining to negative levels resulting in a loss of going concern status.

Management & Mitigation: Robust financial reporting and governance processes are in place. Performance is reported monthly in detail to Finance Committee and risks escalated to Board. The Trust worked with external advisers between December 2010 and September 2011 to ensure that an effective PMO was in place. A number of gaps in assurance were identified by the Trust's Finance Committee and Board in January, as a result of which a further external review was commissioned. This has resulted in actions being agreed to further strengthen and embed robust CIP monitoring and delivery.

The Trust has a £19m WCF facility in place, the terms of which allow the Trust to draw down against this, if required, even if in breach of terms of authorisation. At year end, the Trust successfully achieved its principle financial objectives resulting in a financial risk rating of 3 against a plan of 2. This reflects the effective management and mitigation of these risks during 2011/12.

Additional Actions to mitigate risks during the Year Ahead: The 2012/13 to 2014/15 LTFM and Annual Plans are supported by robust underlying assumptions and a high level of Executive and Board confirm and challenge. The Trust has appointed a Chief Restructuring Officer and Cost Improvement Plan Director, and strengthened CIP development, delivery and monitoring. Additional actions are being taken to ensure that an effective PMO is in place during12/13 to support the Board's commitment to delivery of its plans, ensuring efficient, effective and economic use of resources and continuing good governance.

Recognising the requirement for significant cost improvements over the next three years, and the recommendations of the Head of Internal Audit, the Trust has reviewed its PMO arrangements to provide additional project management, financial, organisational development and human resource capacity and expertise. Fundamental to our cost improvement programme is assessment of the quality impact of any service changes as a consequence of cost reduction; the quality impact assessment framework developed during 2011 will continue to be used, supported by specialist clinical expertise within the PMO.

Effectively managing the Trust's declining cash position is critical with regard to its future financial security and its ability to declare itself as a 'going concern' in future years. Consequently, in year, we established a Cash Committee with a specific remit to examine ways in which our cash can be protected and ensure effective controls are in place for robust cash management. The Cash Committee reports to the Finance Committee, a sub-committee of the Board of Directors. Our

improved cash position against plan this year is evidence of work undertaken. As we move forward into the new financial year our cost reduction plans are focused on achieving an improved EBITDA and reducing 'cash burn'. An enhanced PMO has been implemented to provide assurance regarding delivery of CIPs.

The BAF provides a comprehensive and detailed assessment of all principle risks, identifying the causes and assessing the consequences and gross impact/severity of risks. It details existing key controls, sources of assurance (internal and external) and identifies residual gaps assessing the net impact/severity. Where required, further actions are then agreed and are delegated to identified senior responsible officers. Progress and outcomes are then monitored against all agreed milestones and timescales by the Trust's principal risk committees, including the Board of Directors.

Work is currently underway to ensure that the BAF continues to clearly identify, articulate and assess the Trust's forward risks against our 2012/13 corporate objectives to ensure strengthened and embedded risk management.

The Trust is ensuring an ongoing dialogue with Monitor regarding its forward financial risks and the actions being taken

Public Involvement in Risk Management

The views of our patients, commissioners and wider stakeholders are very important to us. Learning from the experiences of many varied sources external to the Trust enables the organisation to learn and improve. In addition it enables us to develop and improve services which are responsive to the views and needs of our stakeholders.

As a Foundation Trust, we are committed to being open and transparent in our reporting and to listening to the views of our members and Council of Governors.

The Council of Governors is engaged at every opportunity to ensure that we meet this commitment.

Examples of where public stakeholders were actively engaged by the Trust during 2011/12 in managing risks which impact on them and assisting us to manage risks include:

- Continued use of real time patient experience surveys to highlight risks and identify areas for improvement
- Engagement of and reporting to the Council of Governors, Council of Governors' Performance & Strategy and Patient Quality & Experience Sub Committees
- Engagement of Governors and attendance at Clinical Governance Committee and confidential Board Meetings
- PALS contacts, members events & constituency meetings

CQC Compliance

During the year, following CQC inspections in both May and October 2011, we have worked with external advisers to improve and strengthen our policies, procedures and governance processes to ensure improvements in our assurance processes in relation to CQC compliance. During the

period May to October we were unable to declare compliance against 7 of the 16 standards, however following the CQC visit in October this was reduced to 2. During October to March we implemented our action plan and were able to declare compliance against the final 2 outcomes on March 15th 2012.

To provide assurance in relation to compliance with CQC registration requirements we sought evidence from a number of sources.

This included:

- Strengthened Governance processes as a result of engaging external specialists to support us to improve policies and practice, resulting in the development of improvement actions
- Regular assessment by clearly identified 'guardians' each with responsibility for monitoring compliance against specific CQC standards, and identifying and implementing the actions required to ensure ongoing compliance
- Routine reporting of compliance against each standard to Executive Management Committee, supported by risk assessment and action plans (where necessary)
- Regular reports to the Audit Committee and the Board of Directors

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

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

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

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

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Board of Directors regularly reviews its performance and ensures it continues to exercise its functions effectively, efficiently and economically, in line with its general duties and Condition 2 of its Terms of Authorisation.

Throughout the year, the Trust Board has ensured that proper and effective arrangements are in place and that it clearly understands the financial challenges and risks facing the organisation and that it is taking appropriate action to secure a stable financial position.

Principally this has been achieved through:

- Ensuring that detailed performance dashboards have been developed in year which facilitate rapid assessment of key performance issues, and that they are fully embedded and used effectively throughout the organisation
- Receiving detailed integrated monthly financial and performance reports to support the robust monitoring, management and mitigation of risks
- Delivery of 6% cost improvements in year, exceeding plan and driving further efficiencies throughout the organisation, albeit full year recurrent effect was only £11.6m
- Maximising opportunities to use external benchmarking, where available to provide comparative information and identify areas for improvement
- Commissioning of independent external assessment of its financial plans and long term PFI affordability and current efficiency to identify risks and agree further mitigating actions
- Considering internal audit reports, reports from external audit in relation to the effectiveness of its systems of controls to gain external assurance that the Trust's mechanisms for effectively managing resources are sound and effective

The Foundation Trust currently has a financial risk rating of 3 and exceeded or achieved its in-year financial objectives and was fully compliant with the CQC at the end of the year.

Annual Quality Report

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

The Board of Directors have taken a number of actions to gain assurance that the Quality Report presents a balanced view of the quality within the organisation. At the heart of the Trust's commitment to quality is a clearly defined clinical quality strategy, a system of quality performance management, and a clear risk management process. In addition to gaining assurance as part of the routine governance, leadership and risk management/control framework described previously, the Board have taken a number of additional steps specifically in relation to the Quality Account.

The Board appointed the Executive Director of Nursing and Quality to lead the production of the Trust's 2011/12 Quality Report. The draft report has been widely consulted upon to ensure balance and accuracy. Details of consultation are contained within the Quality Report.

The performance information within the report has been prepared and validated by clinical governance staff and information management teams. The data reflects that which has generally been available in summary to the Trust Board, Executive Management Committee (EMC), Risk Management Committee (RMC), Clinical Governance Committee (CGC) and in relation to our 2011/12 priorities the Council of Governors Patient Quality & Experience Committee.

A framework exists for the management and accountability of data quality, supported by the Data Quality Policy. In addition, the Board and Audit Committee have both reviewed the performance data against key in year reports and have validated the data.

The Trust has a comprehensive clinical audit work plan covering both national and local audits. Regular updates on clinical audit are reported to the CGC. A system of routine audits and point prevalence studies ensure compliance with essential clinical policies such as infection control, medicines management and fundamental nursing care.

During March, executive and non-executive directors have been involved in undertaking audits in clinical areas and have commenced patient-safety walkabouts.

Additional assurance on the accuracy and robustness of reporting has been provided as a result of an unqualified opinion following a limited scope of work by our external auditors. Full details of assurance and any recommendations for improvements will be reported by the end of June in their separate assurance report on the quality account.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audits and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by 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, the Executive Management Committee, the Risk Management Committee and the Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- Reports from Clinical Governance Committee and Risk Management Committee
- The views of the Trust Board
- The views and reports of the Audit Committee
- In year compliance assessments, evidence and assurance provided with regard to CQC compliance
- The views of our commissioners, governors and wider stakeholders
- The published results of the quarterly in year performance assessments undertaken and published by Monitor as well as the learning from other Trusts
- The views of external advisers commissioned during the year including PWC, KPMG, McKinsey's and Ariotti & Doe Associates
- Audit reports prepared independently by both internal and external audit and the reports of independent regulatory bodies

The BAF (Board Assurance Framework) was revised at the beginning of the year in line with our revised strategic objectives and high level risks. The Risk Management Committee has received the BAF for review and comment, and regular reports on its status have been received at Audit Committee and at Board meetings through the year. The 2010-11 Head of Internal Audit Opinion Statement highlighted that the Trust needed to take action to ensure that the BAF is used as an embedded strategic management tool. During the year, both the Board and Audit Committee have

requested that actions be followed up to strengthen the use of the BAF and as a result, the Board commissioned support from KPMG to undertake a Board development session in November 2011.

Further support was subsequently commissioned from Ariotti & Doe Associates to support improved risk management and reporting procedures.

Our Internal Auditors' 2011-12 opinion, whilst providing significant assurance, has highlighted that the BAF had not been updated to reflect the recommendations made in May 2010/11, and therefore action is still required to progress this recommendation.

The Executive Management Committee (EMC) Terms of Reference refer specifically to their role for developing and monitoring the BAF and reporting to the Board at least quarterly, however, this was not completed between October and January. Instead reports focused on the organisation's top 12 risks and the actions being taken to mitigate risks. This was reported regularly to the Risk Management Committee, Audit Committee and the Board.

The BAF was presented to the Board in February and March. The Board and its sub-committees continue to discuss risk management and recognise that further embedding of risk management arrangements is required for moving forward. An updated and strengthened BAF was presented to the Board in April and the further work required to fully embed will be taken over the coming months. Progress will be regularly assessed against agreed timescales and will be formally reviewed by our Internal Auditors at mid-year.

The recommendations contained within the Annual Report from our Internal Auditors, when issued, will support us to further develop the organisation's Assurance Framework during 2012/13.

Conclusion

No significant internal control issues have been identified.

Martin Wakeley
Chief Executive
29 May 2012

2. QUALITY REPORT

QUALITY REPORT CONTENTS PAGE

2.1 INTRODUCTION

2.1.1 Foreword

Our vision is simple yet passionate: ". . . to provide the best care, with the best people, in the best place."

We have some of the best hospital facilities in the UK at present, following the massive investment and opening of the new Kings Mill hospital earlier last year. Additionally, further investments have been made in our other facilities to further improve the environments available for our patients and to provide our staff with the best possible working environment.

Having great facilities is only one part of the patient experience, however. It is the care and empathy that our staff provide to our patients that we are most proud of. We aspire to being one of the safest hospital Trusts in the country and have commenced a programme of reducing our Summary Hospital-level Mortality Indicator (SHMI) to become one of the top 10% performers, ensuring that our patients can be confident that everything we do is grounded in a patient safety culture.

We have already invested in additional clinical staff to ensure that our patients receive high quality and consistent care 7 days a week, an issue receiving national attention last summer and one which we had already recognised as needing attention . . . and have acted upon.

We have appointed a senior clinician responsible for patient safety who coordinates our many service improvement activities to ensure they all contribute to improved patient outcomes

We have commenced with an innovative scheme which enables us to return frail elderly patients back home from hospital with care cover for up to 48 hours to ensure that when patients are discharged from our hospitals their basic needs are supported and that they do not go back to a home without food or heating. This programme has already received fantastic feedback from our patients and reflects our ambition to see patients as individuals, requiring more than just professional medical and nursing care but also practical support to help get their lives back to normal.

Our focus on patient safety and quality has ensured that we are one of only 2 hospitals across the (previously defined) East Midlands SHA region that delivered the 95% A&E target throughout the year, providing additional capacity where necessary and ensuring that patients flowed through our hospital optimally, reflecting the ongoing success of our ABC (Achieving Best Care) programme that we commenced over a year ago.

There are very few hospitals in the country that can report the elimination of hospital acquired MRSA from their organisations - but Sherwood Forest has now gone for over 2 years since its last infection, an outstanding achievement and one which reflects the adoption of our zero tolerance policy.

We are naturally disappointed therefore to have only reduced our C. difficile rates by 17% during the last 12 months, reporting 45 cases against a trajectory of 43. This disappointment has, however, spurred the Trust to make further investments in its surveillance programme with additional consultant microbiologist appointments in addition to further strengthening our pharmacy

and infection control nursing resource. Our ambitions warrant such a response and over the course of the last 6 months our infection rate continues to decline to one of the lowest rates in the country.

Quality, however, is not only about the care that patients receive; it is also about how they are able to access it and how they feel supported throughout their care.

We have changed the way in which our administration systems work by adopting a ‘patient pathway coordinator model’ which more closely aligns our patient administration systems to how our consultants actually work. This will enable patients to phone a single point in order to access information about their care, rather than being transferred to different departments, a key frustration often highlighted in patient feedback.

We have changed how we manage patient complaints by inviting patients and their relatives to meet up with senior management and the clinicians involved in their care in order to directly respond to their concerns, and in some instances we have invited patients and their relatives to share their experiences with the Trust Board in order to strengthen the Board's links to the experiences of our patients.

In reflecting back on the previous year I am confident that, to the best of my knowledge, the information in this report accurately reflects our actual performance and provides an honest and consistent appraisal of where our plans were delivered, where they were exceeded and where we failed in our ambition.

Our objectives for next year reflect the ambitions of the Trust Board and our staff, and the areas of priority have been agreed with our governors.

We will continue to strive for excellence as 'good enough' never is.

Martin Wakeley
Chief Executive
Sherwood Forest Hospitals NHS Foundation Trust

2.1.2 What is a Quality Report

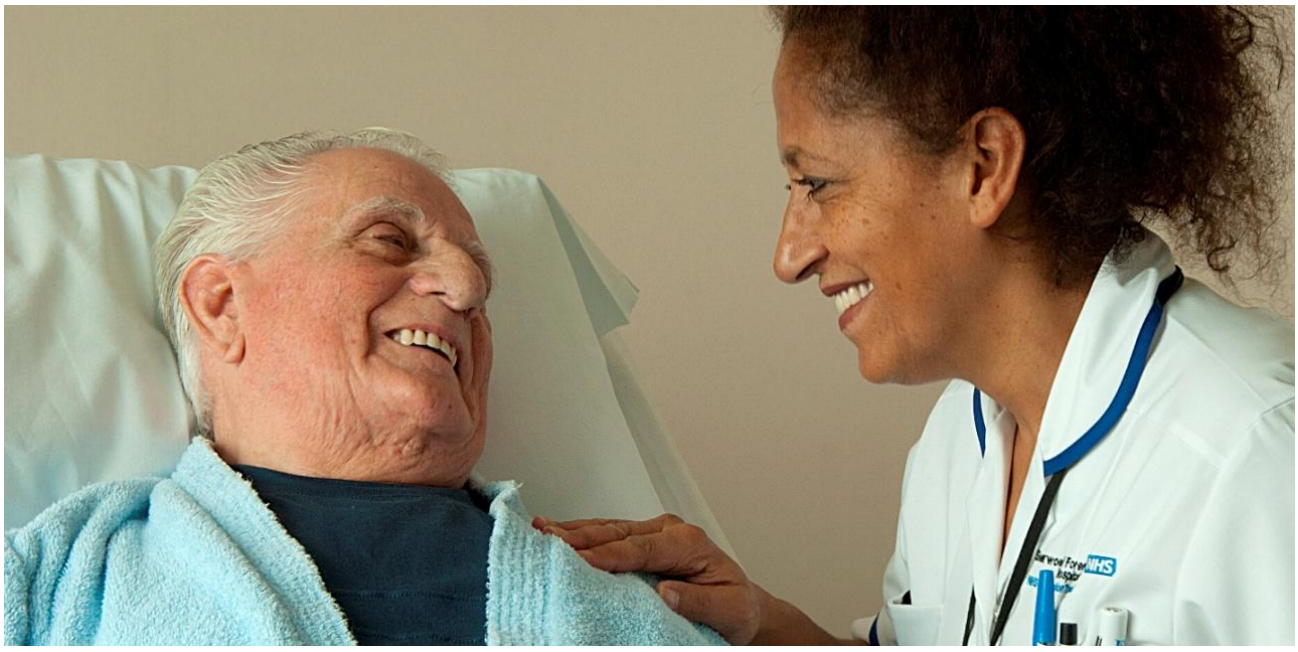
A Quality Report is an account about the quality of services provided by an NHS healthcare provider. The report is published annually by each provider and made available to the public on NHS Choices website (www.nhs.uk) as well as on each provider's website. The report for Sherwood Forest Hospitals is available at www.sfh-tr.nhs.uk, where a downloadable file is available. A paper copy may be requested from e.communications@sfh-tr.nhs.uk.

In addition to publishing the Quality Report document, Foundations Trusts such as Sherwood Forest Hospitals include the Quality Report within their Annual Report & Accounts.

In a Quality Report we share information on the quality of the services we provide by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- Patient feedback about the care provided

The report will enable you to determine if you think we are providing you with the best care and treatment.



What is covered in this report

This report includes:

- An overview of our services
- Our performance against the priorities set in last year's Quality Report
- Our priorities for further improvement for the coming year
- What others say about our Quality Report
- A statement from the Chief Executive summarising the Trust's view of the quality of the NHS services that it provides, which confirms that to the best of his knowledge the information contained in the report is accurate

Who is involved in writing this report

Many of our staff have been involved in the compilation of this report. These people are experts in their field and are best placed to advise on the best care for our patients and more significantly what our patents tell them is important. Our staff have also helped to measure the quality of care that we have delivered over the last 12 months and have been instrumental in delivering service improvements and quality enhancements for our patients.

Our Council of Governors has received regular reports regarding the quality of care we have provided over the last year. There are three sub committees of the governors involved in reviewing quality: Performance & Strategy, Patient Quality & Experience, and Membership & Engagement. The Trust's Board of Directors also receives monthly quality reports in addition to a detailed quarterly quality report.

We have engaged with members of the public, including a considerable number of our 20,000 members, throughout the year by running various events to ensure we truly listen to their needs and requirements. These events have also helped us shape our priorities for the coming year.

We have worked with the ambulance service and other organisations during the past two years through events called 'Community in Unity'. These events are aimed at groups of people who are seldom heard and often find it difficult to get their views across. We ran a very successful event in November where people told us what mattered to them. We have also asked people on a daily basis what matters to them through the use of face-to-face surveys, which means we get a real understanding of what concerns people and, if they have any problems, we can more efficiently resolve them.

In addition to the above, views have been sought from:

- Our commissioners, NHS Nottinghamshire County Primary Care Trust
- Nottinghamshire Local Involvement Network (LINk)
- Nottinghamshire County Council Overview and Scrutiny Committee
- Our Council of Governors

2.2 OVERVIEW OF PRIORITIES

2.2.1 Priorities and Achievements for 2011/12

Under the three dimensions of quality, 'Patient Safety', 'Clinical Effectiveness' and 'Patient Experience', we identified three key areas for improvement. The following section will report our performance against those key areas. All the other quality priorities for 2011/12 have been reported on from section 2.3 onwards.

Patient Safety - Priority 1

To reduce hospital mortality

Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. Like all statistics, HSMR's are not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it is a warning sign that certain aspects of care require further interrogation.

Our Trust HSMR was 113 for the period 2010/11, which is significantly above expectation. Just prior to the reporting of this indicator we had investigated and implemented changes to address this concern and learnt lessons from the way we collect data. The appointment of an Associate Medical Director for Patient Safety and a dedicated Mortality Group were developed to gain an understanding of the contributory factors.

Following the recommendations of the Hospital Standardised Mortality Ratios (HSMR) review, the Department of Health committed to implementing the SHMI (Summary Hospital-level Mortality Indicator) as the single hospital-level indicator for the NHS.

The SHMI has been developed by the Department of Health as one indicator of healthcare quality. It measures whether the death rate of patients admitted to a particular hospital is above or below expected, taking into account the nature of their condition and factors such as their age and the presence of other illnesses. As with many statistics, the SHMI should not be used in isolation but is one of a number of indicators to assess how a hospital is performing.

The average Hospital Trust has a SHMI score of 100. The SHMI for our organisation for the year 2010/11 was 103, which is not significantly different from the expected rate for English hospitals and deemed to be average. The data is taken from Dr Foster intelligence http://drfosterintelligence.co.uk/ and is governed by standard national definitions enabling comparisons to be made with other hospitals

We are ambitious to be one of the safest Hospital Trusts in the country and have therefore examined our services to identify how we can improve further in order to deliver better, safer care. As with many hospitals, we have identified that the outcomes of patients admitted as an emergency at weekends has not been as good as those admitted during the week. This is reflected in a higher mortality of patients admitted at a weekend compared to weekdays. We have therefore started to reorganise our services with the aim of providing the same high standard of care throughout the whole week.

In response to this we have:

- Introduced weekend ward rounds by consultants and junior doctors in many parts of our hospitals with an aim to extend this to all wards by summer 2012
- Appointed four new acute physicians (doctors) to the Trust. This will improve the quality and timeliness of assessment of patients when they are first admitted, and means that once admitted they will be assessed by the relevant specialists on a daily basis
- Increased the availability of radiological investigations at weekends so that there will be less waiting for the relevant tests
- Appointed an Associate Medical Director for Patient Safety. The role includes examination of all in-hospital deaths and serious incidents so that lessons are learnt and changes made to improve our service

We will continue to closely monitor our SHMI to ensure that we deliver our ambition to be one of the best and safest hospitals in the country, aspiring to a SHMI of 97 for 2012/13, and falling to 89 in future years.

Clinical Effectiveness - Priority 1

To reduce the time ambulance staff wait to handover patients

We aim to admit patients arriving by ambulance to the Emergency Department promptly, taking all the details from the ambulance staff, swiftly making the ambulance ready for the next 999 call.

All hospitals have a national target to achieve a 15 minute 'turnaround' (this is a 15 minute target from arrival to departure of every emergency vehicle). We are achieving this target at Sherwood Forest Hospitals. However, it remains a significant challenge as we have seen a substantial increase in ambulances attending the emergency department in the last part of the year. We are working closely with the ambulance service to ensure that the patient pathway, clinical handover and information recording processes are made more robust, and we have been selected as a flagship site for the East Midlands to pilot new ways of working with ambulance crews to improve the clinical handover processes.

In order to ensure our most skilled staff are available to see the sickest patients we have introduced medical support workers. They are based in the department to take the patient's blood and record heart tracings, so freeing-up nursing time. We are in the process of recruiting 6 or 7 additional support workers.

We are committed to working with the ambulance service to ensure vehicles are released on time and together we have implemented the following:

- A generic worker has been introduced to book patients into the department, preventing ambulance staff from having to book in at reception, saving time
- The ambulance service has introduced a Hospital Ambulance Liaison Officer based in the Emergency Department to further reduce the handover times
- The team are also piloting time stamping bleeps, which automatically book the ambulance staff in and out of the department as a possible time saver

Year on year we are seeing an increase in the number of patients attending our emergency department. Despite this huge increase we were one of only three hospitals in the East Midlands to have achieved the national Accident and Emergency four hours wait target.

The 15 minute target data is collected by the East Midlands Ambulance service as part of the national Urgent care standard.

Patient Experience - Priority 1

Ensure nutritional screening is undertaken for every patient

One of our primary patient experience aims is to ensure that significant improvements are made in screening all adult inpatients for risk of malnutrition. Over the past year our nursing staff have concentrated on ensuring our patients' nutritional needs are adequately assessed and supported through the use of MUST (Malnutrition Universal Screen Tool). As a consequence we have met the local and regional Commissioning for Quality and Innovation (CQUIN) targets for nutrition screening for each of the first three quarters of 2011/12 and narrowly missed the fourth quarter by 1%, even though we are able to demonstrate a continuous improvement.

This means that over 90% of our patients have received a nutritional assessment during 2011/12. Our audit results for quarter 3, which involved auditing case notes of all adult inpatients across our four hospitals, showed that 93% of patients had been screened using the MUST. The audit for quarter 4 shows a further improvement to 94%, leaving us 1% short of the 95% target. Further work will be completed in 12/13 to address this. The data is governed by local and regional definitions.

These improvements have been achieved by raising awareness and providing training to ward based staff on the use of MUST. A training programme was delivered across the Trust which involved MUST workshops as well as ward-based teaching sessions. This gave all relevant staff the opportunity to attend.

The Essence of Care Nutrition Benchmark was re-audited during December 2011. Ten factors were assessed using three different tools as shown below:

- Staff questionnaire
- Patient questionnaire
- Observations and check records

The results for the Trust gave an overall score of 93%, which is well above the agreed minimal level of 70%. These results give an excellent picture of the improved quality of patient care and work that has been carried out since the previous benchmark in 2010.

Quotes from staff questionnaires are as follows:

- Attention has been excellent
- Quality meals - very good
- Good meals - and able to give individual patients the portion sizes they require
- A good service to patients and their family

To strengthen our nutrition guidelines we launched a Nutrition Operational Policy and a Protected Mealtimes Policy throughout our hospitals in December 2011. This means that we continue to protect patient meal times, to avoid patients being disturbed unnecessarily by any member of staff or by visitors.

We have also continued to improve the red tray system, which means that people who either need help or need their food intake monitoring are served their meals on a red tray. This ensures that all staff are aware of the nutritional needs of the patients. For those patients who need assistance with eating and drinking we actively encourage the input of relatives and carers.

For the next year we plan to build upon this excellent work by:

- Promoting and embedding the Nutrition Operational Policy and Protected Mealtime Policy into the ward culture throughout the hospitals. The implementation of these policies demonstrates our commitment in ensuring that all of our patients have their nutritional needs assessed, catered for and evaluated as required. Adhering to these policies ensures that the patients are provided with meals that are free of unnecessary interruptions and allows staff to be free to concentrate on helping people to eat. The nutrition team will continue to support staff with the completion of MUST for all adult inpatients. This will ensure that patients who are at risk of malnutrition receive appropriate care and support for their nutritional needs. Further training workshops have been arranged each month for staff

- Focused work will be carried out to ensure that patients who require it have an appropriate nutritional care plan, instigated in a timely manner and reviewed at recommended intervals to safeguard the quality of care they receive

2.2.2 Priorities for 2012/13

Priorities for improvement

The Trust has established several mechanisms and sources for determining its key priorities for quality improvement. These include, but are not restricted to:

- Patient Surveys
- Trust Risk Register and Board Assurance Framework
- Outcomes of Clinical Audit
- Care Quality Commission Assessments
- Outcomes of Complaints and Incidences
- Performance information contained within the Integrated Performance Report
- The Trust's CQUINs, and quality performance indicators as contained within the Acute Services contract agreed with our commissioners
- Dialogue with Council of Governors, staff, members, local public, Trust Board and our patients

From these sources the Trust was able to identify a series of key themes and concerns mapped against its core strategic objectives. Each of these priorities had been cross-referenced against the two corporate aims that relate to the delivery of quality of care:

> Aim 1: Protect and further develop the quality, safety and effectiveness of our services and enhance the quality reputation of the Trust.
>
> Aim 2: Build and strengthen the confidence of our patients, staff, governors and the wider community in the services we provide.

The Trust believes that the monitoring and implementation of the priorities chosen for 2012/13 will have the following impact:

- Increase our transparency and lead to further engagement with our patients, members and the public
- Demonstrate to our patients that we have refocused our activities on ensuring that we provide the best care, adopting zero tolerance as a principle of driving improvement
- Make our services more efficient and better value

Our top priority under each of the headings of Clinical Effectiveness, Patient Experience and Patient Safety, respectively are:

- To reduce our SHMI to 97
- To increase the net promoter score
- To reduce Hospital Acquired C. difficile infections

Our top priorities together with our other clinical objectives for 2012/13 are described in more detail below.

Clinical and Quality Objectives for 2012/13

Key Objectives / Main Quality Goals	Milestones	Key Actions	Key milestones the Trust Board will use to evaluate progress against the Goals	Risks & Mitigation
Clinical Effectiveness				
To reduce our SHMI to 97 Lead : Executive Medical Director	2011/12 SHMI 101 Y1. To reduce SHMI to 97	1. Implement acute Physician Rota 2. Weekend ward rounds by all consultants to all medical wards 3. Rollout Orthogeriatric Service to the orthopaedic wards 4. Implement upper GI Rota 5. Increase availability of emergency radiology test at weekends 6. Improve the number of patients who access emergency surgery at week-ends 7. Increase the availability of planned emergency surgical lists at weekends to reduce waiting.	1% fall in SHMI per quarter Implementation of all actions	Risk- Failure to implement actions against agreed timescales Mitigation- Executive Medical Director is to withdraw from clinical duties for 6 months from June to focus on delivering the SHMI action plan
To reduce avoidable emergency re-admissions to hospital within 28 days of discharge	2011/12 avoidable readmissions were 2% Y1 To reduce to 1.75 %	1. Implement GP telephone access to senior clinical opinion scheme 2. Introduce Clinical Decision Unit to enable patients to be seen, treated and discharged without being admitted to a general ward 3. Strengthen surgical admissions unit to enable direct access to surgical specialist, timely decisions and where appropriate discharge home 4. Introduce increased range of ambulatory care services at the front door (geriatrics, cardiology, diabetes	Commence new ways of working in summer 2012 Fully operational by October 2012	Risk- Need to agree clinical and information governance protocols Mitigation- Funding agreed for acute physicians and ED consultants. Acute physicians commence in post in August 2012 to allow service to commence. ED consultants being recruited – will assume

Lead : Deputy Chief Executive		and respiratory medicine		responsibility for the CDU in October 2012. Risk- Increased diagnostic capacity required Mitigation- Funding bid to Reablement Funds Risk- Need to agree local tariff for ambulatory care with CCGs Mitigation- Funding to pump-prime service capacity requested from Reablement Funds
To eliminate unnecessary deaths due to Venous Thrombo-embolism (VTE) by increasing the number of patients receiving a VTE Risk Assessment within 24 hrs of admission from 92% to 95% Lead : Executive Medical Director	Baseline April 2012 – 92% Y1 To increase VTE Risks Assessment to 95%	1.Implementation of Electronic prescribing with mandatory VTE risk Assessment	Monthly reports to the Trust Board via the Integrated performance report, which will detail weekly results. In-depth reporting via the quarterly quality report	Risk- Failure to implement electronic prescribing as per schedule Mitigation- PAS investment agreed and funded via transformation fund. Implementation of PAS to be reported to Exec Team on a fortnightly basis
To improve inpatient diabetes management by non-specialist teams and improve access to diabetes care by the full implementation of 'Think Glucose'	Baseline 4 wards have been involved with pilot-data compiled from National Diabetes inpatient audit which prompted the department to review Diabetes inpatient services.	1.Diabetes team to implement and strengthen inpatient diabetes service 2.Phased roll out for patients to be seen and assessed using 'Think Glucose' across KMH to include EAU 3. All staff to refer appropriate patients using Jonah 4. Daily review of emergency admissions by Diabetes Team		

Patient Experience				
To understand and respond to the experiences and feedback of patients leading to improved services for NHS customers. We aim to increase the net promoter score meaning more people would recommend the hospital to friend and family Lead : Director of Customer Experience	Baseline April 2012 – 95.41 To achieve a ten point improvement or top quartile (national) performance	1. To survey 10% of inpatients at discharge face to face or within 48 hours. This equates to approximately 60 patients per month 2. Collate the results into a dashboard which reports from ward to board 3. To interrogate qualitative and quantitative results to provide greater understanding of the concerns / issues 4. Triangulate the results with other quality metrics 5. Formulate action plans to address specific themes / concerns	Monthly reports to the Trust Board via the Integrated performance report, which will detail weekly results. In-depth reporting via the quarterly quality report	Risk 1- Weekly numbers and narrative reported to the board per ward will be very small. It will be difficult to compare ward to ward and make an informed judgement. Mitigation- Trends will be observed through quarterly quality reports Risk 2- face to face surveys may elicit 'false' positive responses Mitigation- Undertake postal audit x 2 per year
To improve specific elements of care which are known to be important to patients We aim to increase responsiveness to patients personal needs by improving: 1. Involvement in decisions about treatment/care 2. Hospital staff being available to talk about worries / concerns 3. Privacy when discussion condition / treatment 4. Being informed of medication side effects	Y1 To achieve a 80% composite score in 5 indicators	1. To survey inpatients at discharge face to face. The sample size of 60 will be used 2. Collate the results into a dashboard which reports from ward to board 3. To interrogate the results and formulate action plans 4. Triangulate the results with other quality metrics and qualitative information, including complaints, incidents, litigation, PAL's and near misses 5. To formulate action plans to address specific themes / concerns 6. Increase patient counselling on medication side-effects by Pharmacy and other healthcare professionals	Monthly board reports and in depth quarterly reports	Risk – Weekly numbers and narrative reported to the board per ward will be very small. It will be difficult to compare ward to ward and make an informed judgement Mitigation- Trends will be observed through quarterly quality reports

5. Being informed who to contact if worried about condition after leaving hospital Lead : Director of Customer Experience				
To increase the percentage of staff who would recommend our hospitals to a family or friends Lead : Executive Director of Human Resources	Yr 1 OD plan sets out what organisational development and improvement is needed, and uses communications support	1. Use team brief /website /intranet and bulletin to share 2011 staff survey results with Board and all staff 2. Engage with existing Trust groups, EMC and workforce committee to share 2011 staff survey results and understand what the patient survey results are telling us about staff 3. Using annual results groups and Divisions identify 3 top improvements for 2012/13, 4. Develop and agree OD plan 5. Maintain regular series of staff engagement workshops and focus groups to listen and move views forward, reinforce messages and the 'you said-we did 'approach 6. Share progress with Board and staff regularly	1. 2012/3 staff survey staff increase in response rate and maintain engagement score Patient survey demonstrates improvement in overall impression score	Risk 1- -Difficult to predict what staff survey results will be given level of organisational change in progress Risk 2- Overall impression of Trust dependent on range of variable factors not just staff Risk 3–This is not viewed as a high priority by the Executive Management Committee and the focus on CIPs outweighs effect of developmental work
To improve the quality of care and outcomes for patients experiencing dementia 1. 90% of all emergency patients (exclusion criteria in CQUIN) aged > 75 will be screened for dementia 2. 90% of all emergency patients (exclusion criteria in CQUIN), who have been screened as at risk of dementia, have had a	To individualise dementia patients experiences across all specialities	1. To introduce a Dementia Specialist nurse who will act as a knowledgeable practitioner and resource for referrals and to bridge the interface between primary and secondary care 2. The Dementia Risk Assessment tool is not yet in place nationally; once this has been developed the Trust will implement this tool across all specialities 3. Introduction of training on orientation and mandatory training events to	1. Quarterly report against the CQUIN targets 2. Quarterly quality report to update on progress to date with identified actions	Risk 1- Financial support of dementia business case. Mitigation- Business case currently being re-validating for presentation to finance committee Risk 2- Lack of investment into resources such as Acute Care Mental Liaison due to increased referral rate

dementia risk assessment prior to discharge 3. 90% of all relevant staff are trained in dementia care and the mental capacity act every 2 years Lead : Executive Nurse Director & Executive Medical Director		ensure maximum coverage of all disciplines 4. Target specific areas in level 2 training to further advance staff awareness of dementia patients requirements 5. Collaboration work with regional team to develop University based academic level 5 course 6. Rolling training programme across Trust and disciplines to embed assessment of capacity to consent and to close theory practice gap by implementing a scenario based training framework 7. Appropriate diagnosis of patients and referral to specialist services 8. Individualised documentation for patients so that their lifestyle is mapped 9. Greater involvement in carer contribution to patient management		which affects the delivery of the CQUIN target. Mitigation- To agree a joint strategy for referral management and escalate via PCT commissioners. Risk 3- Risk of delays for Mental Liaison could increase LOS across specialities. Mitigation- As above
Patient Safety				
To deliver harm free care by reducing the risk of patients receiving a hospital acquired infection We aim to reduce Hospital Acquired C. difficile year on year Lead : Executive Nurse Director	2011/12 Baseline 45 cases Y1 To reduce to < 36 cases per year	1. Continue delivery of C. difficile action plan 2. Improve antimicrobial prescribing (increase all HAPPI domains > 90%) 3. Implement new antibiotic guidance 4. Implement external peer review recommendations 5. Continue programme of education and sustained improvement 6. Continue delivery of rapid actions, root cause analysis and interrogation of individual cases/ lessons learnt	1. Monthly / quarterly trajectories reported to Trust board (3 per month / 9 per quarter)	Risk 1- Norovirus outbreaks which potentially lead to increased incidence of C. difficile Mitigation- Demonstrable evidence of improved response and management of norovirus 2011/12 Risk 2- Increased emergency activity (2011/12) and increased

				population of > 65 year old patients (higher risk pats) Mitigation- C. difficile action plan - Improved practice and guidance on antibiotic and bowel management
To deliver harm free care by eliminating avoidable Grade 2,3, and 4 pressure ulcers Lead : Executive Nurse Director	Baseline 2011/12 Grade 2 – 219 Grade 3 – 36 Grade 4 - 0 Y1 100% reduction in incidence of avoidable category 2, 3 & 4	1. Implement safety thermometer as tool for scoring / assessment 2. Develop and implement Pressure Ulcer Reduction Strategy 3. Implement the Safe SKIN prevention bundle 4. Strengthen Pressure Ulcer Steering Group 5. Attend all engagement events 6. Work alongside SHA Expert and Intensive support teams	1. Pressure Ulcer Strategy agreed by June 2012 *Based upon March 2012 baseline .* 2. Q1 25% reduction 3. Q2 50% reduction 4. Q3 75% reduction 5. Q4 100% reduction	Risk- Current work has resulted in 23% reduction in Grade 3 (11/12) and 0 Grade 4 pressure ulcers for 22 months –reduction targets more challenging Mitigation- Implementation of Pressure Ulcer Strategy & improved Root Cause Analysis Process to improve lessons learnt and changes in practice
To reduce the rate of patient safety incidents and percentage resulting in severe harm or death Lead : Associate Medical Director for Patient Safety	Y1 Baseline position using tools from Institute of Health Improvement= Leadership in Patient Safety training (LiPS),	1. Use incident reporting, Global Trigger Tool (GTT) and mortality case reviews to triangulate data for baseline 2. Implement safety walk-rounds 3. Continue work on current patient safety projects 4. Undertake new patient safety improvement projects in the priority areas identified from case reviews. Ensure sustainability and system capability in projects in order to	Monthly reports to Patient Safety Steering Group and quarterly onwards to board	Risk- Current capacity on jobs plans to undertake patient safety projects. Mitigation- Workforce review of governance and assurance department

		enable implementation in relevant services		
To deliver high quality, harm-free, safe use of medicines Lead : Chief Pharmacist & Associate Medical Director for Patient Safety	Missed/delayed doses – Y1 50% Medicines reconciliation Y1 – 70% Other specific measures under development via LIPS programme.	1. Support the safe use and treatment of patients via introduction of weekend clinical ward Pharmacy services 2. Reduce the number of delayed and missed doses of critical medicines by 95% by April 2015. 3. Improve the quality and safety of prescribing to minimise risk and improve patient outcomes 4. Maximise safety gains achieved with the introduction of e-prescribing 5. Achieve 95% reconciliation of medicines within 24 hours by April 2013 6. Minimise risk to patients by ensuring medicines are stored securely throughout the Trust 7. Minimise number of patients sent home without discharge medicines.	Monthly report to Patient Safety Steering group and quarterly onwards to the Board.	Risk- Medicines reconciliation target dependent on 7 day working and implementation of e-prescribing Mitigation- Monthly monitoring is in place, other options for increased input to admissions could be explored. Risk- Minimisation of patients sent home without medicines dependent on other factors including improved discharge planning, 7 day working Mitigation- Some improvement likely to be achieved but to lower level if 7 day working not achieved.

2.2.3 Quality Overview

A review of our services

During 2011/12 we provided services across three clinical divisions on four hospital sites equating to 51 mandated services. The Board of Directors has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2011/12 represents 78% of the total income generated from the provision of services by the Trust for 2011/12.

How many people do we treat?

How many people did we treat in 2011/12?	Plan	Actual
Elective (planned)	**36,750**	**36,580**
Non elective (emergencies)	**35,030**	**39,137**
Outpatients (appointments)	**326,990**	**334,438**
Emergency Care (A&E)	**101,400**	**111,940**
Total	**491,104**	**525,622**

The significant increase in A&E attendances and emergency admissions to the hospital placed considerable pressure on the Trust, not only in relation to meeting its A&E target but also requiring it to increase variable capacity to accommodate the additional patients. In both instances the Board sought assurance that quality was not being compromised through reviews of patient complaints, reports detailing reducing HSMR figures and regular director visits to key clinical areas.

Our participation in national clinical audit

Clinical audit is a simple tool to review clinical practice against best evidence standards; identifying actions to improve the quality of patient care and treatment.

During 2011/12, 41 national clinical audits and four national confidential enquiries covered NHS services that we provide. We participated in 80% (33/41) of the national clinical audits and 100% (4/4) national confidential enquiries of the National Clinical Audits and National Confidential Enquiries which we were eligible to participate in.

Since April 2011 the National Clinical Audit and Patient Outcomes Programme (NCAPOP) part of the National Clinical Audit (NCA) programme has become mandatory for all acute hospital Trusts. During this time we participated in 17/19 (89%) of the mandatory NCAPOP audits applicable to us.

The national clinical audits and confidential enquiries we were eligible to participate in during 2011/12 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of registered cases required by the terms of that audit or enquiry.

Name of audit	**Mandatory NCAPOP audit?**	**Did we participate?**	Cases submitted as % of cases required
Peri-and Neo-natal			
Peri-natal mortality	No	Yes	100%
Neonatal intensive & special care	Yes	Yes	100%
Children			
Paediatric pneumonia	No	No	
Paediatric asthma	No	No	
Pain management **CEM**	No	Yes	100%
Childhood Epilepsy Audit	Yes	Yes	100%
Paediatric Diabetes	Yes	Yes	100%
Acute care			
Emergency use of oxygen	No	Yes	100%
Adult community acquired pneumonia	No	Yes	100%
Non invasive ventilation -adults	No	Yes	100%
Pleural procedures	No	No	
National Cardiac Arrest Audit	No	Yes	100%
Severe sepsis & septic shock CEM	No	No	
Adult critical care -ICNARC	No	Yes	100%
Potential donor audit	No	Yes	100%
National Audit of Seizure Management	No	Yes	100%
Long term conditions			
National Adult Diabetes Audit	Yes	No[1]	
Heavy Menstrual bleeding	Yes	Yes	99%[3]
National Pain Audit	Yes	Yes	100%
Ulcerative Colitis & Crohn's Disease	Yes	Yes	100%
Adult Asthma	No	Yes	100%
Bronchiectasis	No	No	
Elective procedures			
National Joint Registry	Yes	Yes	100%
Elective surgery National PROMs programme	No	Yes	87%[4]
Adult cardiac interventions PCI / Coronary	Yes	Yes	100%

angioplasty			
Vascular Surgery Database	No	Yes	100%
Carotid Intervention Audit	Yes	Yes	100%
Cardiovascular disease			
Acute Myocardial Infarction	Yes	Yes	100%
Heart failure	Yes	Yes	100%
Acute stroke (SINAP)	Yes	No[2]	
Cardiac Rhythm Management	Yes	Yes	100%
Cancer			
National Lung Cancer	Yes	Yes	100%
National Bowel Cancer	Yes	Yes	100%
Head & neck cancer (joint audit with NUH)	Yes	Yes	100%
Oesophago-gastric cancer (joint audit with NUH)	Yes	Yes	100%
Trauma			
National Hip Fracture Database	Yes	Yes	100%
Trauma Audit & Research Network	No	Yes	100%
Blood transfusion			
Bedside transfusion	No	No	
Medical use of blood	No	No	
Health promotion			
National Health Promotion in Hospitals Audit	No	Yes	100%
End of life			
Care of dying in hospital (NCDAH)	No	Yes	100%

Source of list: http://www.hqip.org.uk/national-clinical-audits-for-inclusion-in-quality-accounts/

Commentary notes relating to the table above:

1. **National Adult Diabetes Audit** – The Trust is unable to participate in the National Diabetes Audit as it does not have an electronic medical record for the extraction of required diabetes data. This will depend on how soon the Trust's computer system, SystmOne is operational but we are working to be able to implement this audit.

2. **Stroke Implementation National Audit SINAP** – There are issues with the database used by all of the hospitals in the East Midlands region and the SINAP database. A regional solution is currently being sought and until that time we will continue to collect the relevant data and continuously review and act upon it locally.

3. **Heavy Menstrual Bleeding (HMB) Audit - ** This audit/survey required us to ask patients if they wish to participate and to be contacted at a later stage. This figure therefore represents a recruitment rate rather than participation rate.

4. **Patient Reported Outcome Measures (PROMs)** – This is a recruitment rate, as it is voluntary for patients to take part in these surveys . We are in the top percentage of achievement for PROMs participation rates for acute hospitals.

	Pre Operative Participation rates for 2011-12	England average participation rates for 2011-12
All Procedures	**87.0%**	**68.4%**
Groin Hernias	**85.6%**	**57.1%**
Hip Replacements	**100.0%**	**78.6%**
Knee Replacements	**89.0%**	**76.6%**
Varicose veins	**54.2%** (low numbers of operations so not always statistically relevant)	**47.2%**

Participation in NCEPOD (National Confidential Enquiry into Patient Outcome and Death) studies

These national confidential enquiries review potentially avoidable factors associated with poor outcomes and provide NHS organisations with key recommendations for the provision of safer patient care.

The Trust is currently participating in all NCEPOD studies that relate to services at our hospitals and the Best Practice policy has recently been updated to improve the monitoring and implementation of advice/recommendations from these reports.

The national confidential enquiries we were required to participate in are listed below:

Study Title	**Did we participate?**	**Number of cases submitted as a percentage of the number of cases required**
Bariatric Surgery	Yes	**N/A** – We do not undertake Bariatric surgery therefore we did not submit any clinical cases– however we did submit an organisational questionnaire to cover the service we do provide.
Cardiac Arrest Procedures	Yes	100% 3/3
Peri-operative Care	Yes	100% 6/6
Surgery in Children	Yes	**N/A** No clinical cases requested but organisational data supplied as required.

Review on National Clinical Audit

The report of 1 National Clinical Audit was reviewed by ourselves in 2011/12 and we intend to take the following action to improve the quality of healthcare provided.

Community Acquired Pneumonia (CAP)

- To reduce the delay in patients receiving antibiotics
- To reduce the amount of intravenous antibiotics used
- To ensure improved use of the CURB-65 system (CURB-65 is a clinical prediction rule that has been validated for predicting mortality in community acquired pneumonia and infection of any site)
- Participate in the British Thoracic Society re-audit in 2012

Local Clinical Audits

The reports of 29 local Clinical Audits were reviewed in 2011/12 and we intend to take the following action to improve the quality of healthcare provided. Re audits will be carried out throughout the year were required.

Local Clinical Audit TITLE	Actions planned / Implemented
NICE guidelines on pre-operative tests (Inguinal hernia grade 2 surgery)	• Increase awareness of NICE guidelines
Bortezomib and lenalidomide in patients with myeloma	• Results 100%. Actions - no cause for concern identified
Patient cancellations from theatre lists (elective patients)	• Continuous Detailed Audit implemented • Planned Improved Pre-operative Information
HIV testing - offer and uptake 2010	• Offering and Acceptance of HIV Testing in our Department is still well above the recommended standards.
Review of specimens within genitourinary (GU) medicine processed as medico legal samples	• Senior GUM doctor discussions
Clinical care of under 16 yrs in GU medicine for Nov 2009 to Nov 2010	• Highlight in clinical area that 2 Registered Nurses must always check medication for <16s DONE
Timing of intravesical mitomycin C for treatment of superficial bladder cancer	• Clear documentation in the post-op note of those who require Mitomycin C. • Training more people in administering Mitomycin C (especially junior doctors),
Oxytocin for labour dystocia / augmentation	• Staff, both midwifery and medical, are reminded of the required assessments prior to commencing oxytocin.
Record keeping for removal of third molar against NICE guidance	• Ensure consent form are filled in the notes
Screening for coeliac disease in iron deficiency anaemia (Trust-wide audit)	• All Patients with iron deficiency anaemia should be screened for Coeliac Disease.
Heparin usage at SFH 2010/2011	• Education with Doctors regarding appropriate prescribing, and ensuring patients are weighed wherever possible.
Lying and standing blood pressure	• Provision of a ready reckoner • Individual Action Plan from Ward leaders
Management of early syphilis in GU medicine	• Episode is coded and entered correctly.
Availability of paper blood results on orion against guideline written to decide which paper results should be destroyed - Rheumatology	• Continue to sort paper blood results as per 'store/ destroy' protocol.
Cannulation and intravenous line documentation - compliance with NPSA and NICE	• The auditor will discuss the audit results with appropriate managers and actions identified
Are medics documented in medical notes that patients have a urinary catheter (UC) inserted and reason for insertion?	• Present results to medical division meeting with a view to rolling out catheter-sticker across the division

Excessive reporting of haemolysis in neonates blood samples	• Documenting this concern within a risk assessment
Audit of investigation of suspected deep vein thrombosis at Newark Hospital	• Improve recording of Wells score (70%) • Improve proportion of patients undergoing D-dimer testing (85%)
Acitretin use in women of child bearing age (14yrs to 50yrs) in dermatology	• New initiation of acitretin sticker. Implemented
To ensure the correct storage and labelling of insulin at ward level	• Feedback results to service line clinical governance forums for each Division. • Discuss with pharmacy staff the importance of checking stock levels of insulin before ordering more.
Ward based epidural monitoring	• Wards 31, 21, 32 trained Oct 2011
Documentation of safeguarding children alerts within the midwifery services at SFHFT	• Review filing instructions for safeguarding children documentation done Nov 2011
Child protection supervision process audit	• Meet with supervisors to discuss findings and review changes that may be necessary to improve the process Jan 2012
Compliance of 'store/ destroy paper blood results guideline' and availability of the 'store/destroy' results on 'Orion' and 'ICE' 'Re-audit	• There was an improvement in correctly selecting blood results for destruction.
Rivaroxaban prescription and complications following total hip and total knee replacement	• Pharmacy to print and disseminate 'continued VTE prophylaxis' reminder stickers in progress
Midwifery and Health Visitor communication	• Meet with Health Visiting Team Leaders
Re-audit of Antibiotic Prophylaxis in Orthopaedic Surgery (emergency cases only)	• Pocket card guidelines implemented
Patient property audit	• The results of the audits have been disseminated
Audit of ISOTRETINOIN use in the Dermatology department	• Initiation of isotretinoin sticker to include space for pregnancy test result - by May 2012

The table above denotes the principle actions. More detailed actions are available on request. Regular reports on the progress made in all national and local clinical audits are submitted to the Clinical Governance Committee from the Clinical Audit Committee. In addition to this, each Speciality Clinical Governance Forum will review reports on any national/local clinical audit applicable to them. There are robust action plans for each of the audits.

There was an internal audit review during June to December 2011 reviewing national clinical audit participation and outcomes. This report concluded that significant assurance could be provided that a generally sound central system of control has been established for ensuring that clinical audits are registered for inclusion on the annual clinical audit programme. It also concluded that appropriate support is provided by clinical audit staff and that the level of participation in national clinical audits on the Department of Health list is monitored.

Patients participating in clinical research

We are really proud of our recruitment of patients into clinical research trials. We have seen a huge uptake in people recruited to the trials, see table following:

	2011	2010	2009	2008
Numbers recruited	1,008	250	135	64

The number of patients receiving NHS services provided or sub-contracted by us that were recruited to participate in research approved by the Research and Ethics Committee was 1,008.

The quality goals we agreed with our commissioners

A proportion of our income, £2.6m in 2011/12, was conditional upon us achieving quality, improvement and innovation goals (CQUIN – Commissioning for Quality and Innovation), agreed between commissioners (NHS Nottinghamshire County PCT) and ourselves. We received 100% of this income.

The proportion of our income for the year before (2010/11) was £2.7m and we achieved 75% of this income.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on line at http://www.monitor-nhsft.gov.uk/

Our registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of all health and social care services in England. Their role is to make sure that care provided by hospitals, dentists, ambulance, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

The government standards cover all aspects of care, including:

- Treating people with dignity and respect
- Making sure food and drink meets people's needs
- Making sure that that the environment is clean and safe
- Managing and staffing services

There are 16 government standards of quality and safety. Full details are on the CQC website at **www.cqc.org.uk**. The CQC registers health and adult social care services across England and inspects them to check whether or not standards are being met. During their inspections they ask people about their experiences of care, talk to care staff, and check that the right systems and processes are in place. They judge whether the standards are being met or not and publish reports of their findings on their website.

We are required to register with the Care Quality Commission and our current registration status is registered.

During 2011/12 we received 4 visits by the CQC:

- One unannounced visit to Newark Hospital to assess standards of dignity and nutrition inspections (DANI)
- One planned visit to Newark Hospital to assess the 14 standards of quality and safety (2 had been assessed as part of DANI)
- One planned visit to King's Mill Hospital to assess the 15 standards of quality and safety. Outcome 16 (Clinical Governance) had been assessed as compliant within the previous 12 months so was not reassessed
- One unannounced visit to assess our progress in relation to the findings from visit 3

During these visits it was identified that improvements were required to meet 7 of the 16 outcomes:

- Outcome 1 Respecting and involving people who use services
- Outcome 2 Consent and care to treatment
- Outcome 5 Nutrition
- Outcome 9 Management of medicines
- Outcome 12 Requirements relating to workers
- Outcome 17 Complaints
- Outcome 21 Records

We instigated many improvements to meet the standards; including improving the way we managed our complaints service, improving our consent procedures and improving the management of medicines in our Emergency Admissions Unit. When the CQC re-visited us in October 2011, they assessed that much progress had been made and assessed that we had achieved the required standard in 5 out of the 7 outcomes.

Following the October visit from the CQC and their concerns relating to outcome 2 and outcome 21, the Trust Board commissioned an action plan to ensure that compliance would be demonstrated before the end of the year and also wished to review why the Trust's governance systems failed to recognise the repeated failure of the two highlighted outcomes.

The action plan to deliver compliance was commenced towards the end of November after having been reviewed to ensure that it would deliver compliance. Additional external support was commissioned to further strengthen the work and towards the end of March the Board felt confident that the action plan had been thoroughly and successfully implemented.

A recent Board sub-committee concluded:

- The sub-committee recommend that in regard to Outcome 21, records that the issues identified have been addressed
- In regard to Outcome 2, consent issues where patients lack capacity, whilst the Board can gain positive assurance from the significant improvements that have been made and recognise that the Trust is on the right trajectory, further work is required to ensure recent changes in practice and learning are fully embedded and can be sustained in the longer term
- The Board should consider how it will continue to gain assurance of progress as we move forward.

In relation to strengthening our internal governance arrangements the Trust commissioned an improvement review from external advisors in order to provide additional assurance to all Board

members that our systems and processes in relation to the CQC were effective and resilient, and that evidence was available on an ongoing basis of compliance against all outcome measures. This work has commenced and is being implemented.

A CQC review visit was requested which took place on 27 April. The CQC reported that the Trust had made massive progress and was compliant against all outcomes. The Care Quality Commission has not taken enforcement action against us during 2011/12.

The quality of our data

We submitted records during 2011/12 to the secondary uses service (for inclusion in the Hospital Episode Statistics) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was as follows:

	Valid NHS number	Valid general Medical Practice Code
For admitted patients care	100% where NHS No present	94.4%
For out-patients care	100%	93.1%
For emergency care (A&E)	100%	94.5%

Other important quality factors

Performance against the Information Governance Tool Kit

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information.

Our Information Governance (IG) assessment report overall score for the previous year 2010/11 was 62% and was graded as Red – 'Not Satisfactory'. Consequently, an action plan was devised to address the aspects that fell short of achieving Information Governance Toolkit Level 2 standards during 2011/12. The action plan has been progressed within the appropriate service areas/divisions with full support from the information governance team. Monitoring of the action plan is undertaken via the Information Governance Group, with regular escalation reports provided to the Risk Management Committee and Audit Committee. The main areas addressed are:

- Ensured IG is a mandatory training requirement for staff
- Established information asset owners and administrators throughout divisions' and provided training
- Sourced a tool to enable the Trust to pseudonymise (people who don't have a right to see data do not see the data) patient data
- Documented and implemented the procedures for the effective management of corporate records as part of this we have undertaken corporate records audit in at least 5 areas of the Trust and have subsequent action plan

Green for governance

Our Information Governance (IG) assessment report overall score for 2011/12 was 72%. This was graded as 'Green' – 'Satisfactory'. There is a requirement for all IG Toolkit standards to achieve Level 2 or above in order for the Trust to be graded as green. We have achieved this.

We have taken the following actions to improve data quality:

- Developed a data quality dashboard which helps to monitor external data quality reports
- There are now procedures in place for using both local and national benchmarking to identify data quality issues
- Procedures are now in place that ensure clinical staff are involved in validating medical information regarding clinical activity
- We have 2 different external auditors who will perform a 200 finished consultant episode clinical coding audit each tear
- We have an internal data quality audit procedure which has a 12 month cycle for auditing specialties covering out patients and spell data
- We also work with our commissioners in terms of ensuring any queries that are received regarding data quality are resolved
- Routine daily, weekly and monthly reports are run from our PAS system
- Any new member of staff or existing staff receives data quality awareness
- There are also monthly data quality meetings which will discuss forthcoming information standards notices, data recording, secondary users' dashboard and training documentation

Clinical coding

We were subject to the payment-by-results clinical coding audit during the reporting period by the Audit Commission (payment-by-results refers to the payments given for each patient based on their episode of care). The error rates are related to the errors in coding which will affect the amount of money paid for the episode of care. The audit showed that our overall error rate was 4.7% based on episodes that affect the payment compared to a national average of 9.1%. Our data was audited in March, April and May of 2011. The error rate for coding of treatments was 2.1% and for diagnostic tests was 4.8%. These results are based on a sample of case notes and should not be extrapolated further. The services reviewed within the survey were respiratory and a random sample of all specialties.

Never events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Unfortunately, there have been two never events during the quarter October to December 2011. Both of these were relating to retained swabs following delivery of a baby. The first occurred following a procedure undertaken in theatre where systems and processes were not followed. The second occurred in a birthing room where the systems were not fully in place.

In both cases we identified the pack from which the swab originated and have reviewed all packs that could be used during the course of a birth and changed all swabs available to larger ones with ties. All policies have been amended to reflect best practice and reinforced to staff.

A visit by NHS East Midlands and Nottinghamshire County PCT was hosted to demonstrate the changes the service has implemented. Detailed action plans from the lessons learnt have been completed, with remedial action being taken. The Primary Care Trust visited the Trust and commented that the visit provided the assurance that the Sherwood Forest Hospitals Foundation Trust Maternity Service based at King's Mill Hospital is safe and that it has learnt lessons following the Never Events.

NHSLA (NHS Litigation Authority)

The NHSLA handles negligence claims (CNST : Clinical Negligence Scheme for Trusts) and works to improve risk management practices in the NHS. The Trust pays a premium to the NHSLA which is similar to an insurance premium. The NHSLA sets standards to determine if the Trust can be part of their scheme.

The acute standards were assessed on 8 February 2012 with a top score of 50/50, which means we successfully achieved Level 1 and our premiums will be discounted by 10% for two years. Level 1 means that the process for managing risks has been described and documented. The Level 1 assessment requires all minimum standards for each criterion to be described. However, the quality of the processes will not be rigorously tested until the Level 2 assessment takes place. It is important to note therefore that compliance at Level 1 is not an indication that the organisation will be able to demonstrate compliance at Level 2 or that it is effectively managing risks.

The maternity standards were assessed in October 2011 and scored 49/50 at Level 1.

The table below explains why the standards are set. As an organisation we are working hard to become a Level 2 organisation and if successful it will mean our premiums will be discounted by a further 10% for two years.

The standards and assessment process are designed to:

- Improve the safety of patients, staff and others
- Provide a framework within which to focus risk management activities in order to support the delivery of quality improvements in patient care, organisational governance, and the safety of patients
- Assist in the identification of risk
- Contribute to embedding risk management into the organisation's culture
- Focus organisations on increasing incident reporting whilst decreasing the overall severity of incidents
- Encourage awareness of and learning from claims
- Reflect risk exposure and enable organisations to determine how to manage their own risks
- Encourage and support organisations in taking a proactive approach to improvement
- Provide information to the organisation, other inspecting bodies and stakeholders on how areas of risk covered by the standards are being managed at the time of the assessment

During 2010/11 we settled clinical negligence claims at £1,864,580. This is comparable with neighbouring NHS Hospital Trusts of a similar size. One hospital paid out £2,770,301 and another £3,539,536 during the same time period.

2.3 OTHER PRIORITIES AND ACHIEVEMENTS FOR 2011/12

2.3.1 Patient Safety - other priorities

Since 2005/06, when infection prevention and control became our number one priority, significant improvements have been made. A dramatic shift in the culture of the organisation has been achieved, changing to one in which staff acknowledge and accept their personal responsibility for protecting all patients, visitors and staff from acquiring healthcare associated infections (HCAI).

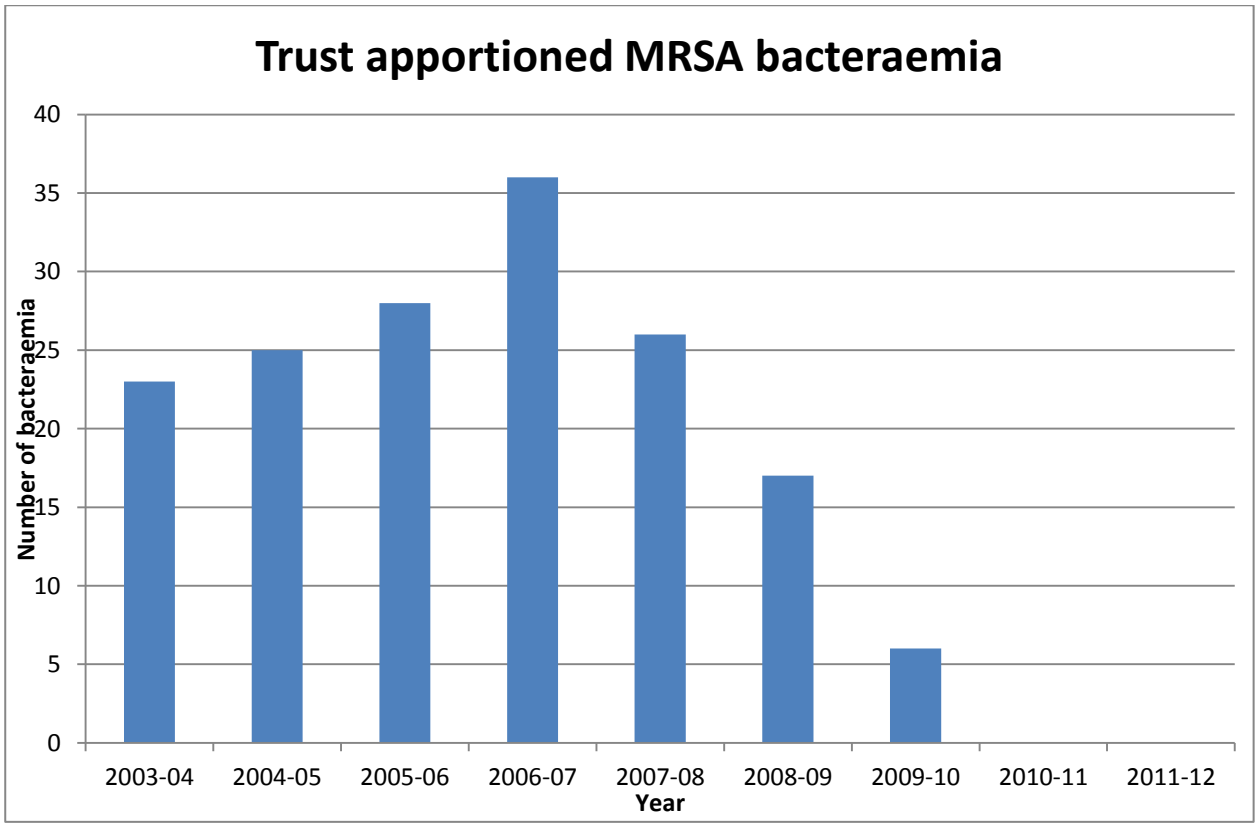
The data within this report is collected via internal mechanisms and is governed by standard national definitions.

There are two causes of HCAI that have external targets associated with them: Methicillin resistant *staphylococcus aureus* (MRSA) bacteraemias and *Clostridium difficile* infections (*C. difficile*).

Two years without a hospital acquired MRSA
(The only Trust in the East Midlands to have zero MRSA)

MRSA

The Department of Health mandatory MRSA bacteraemia surveillance scheme has been used to measure the effectiveness of infection prevention and control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.



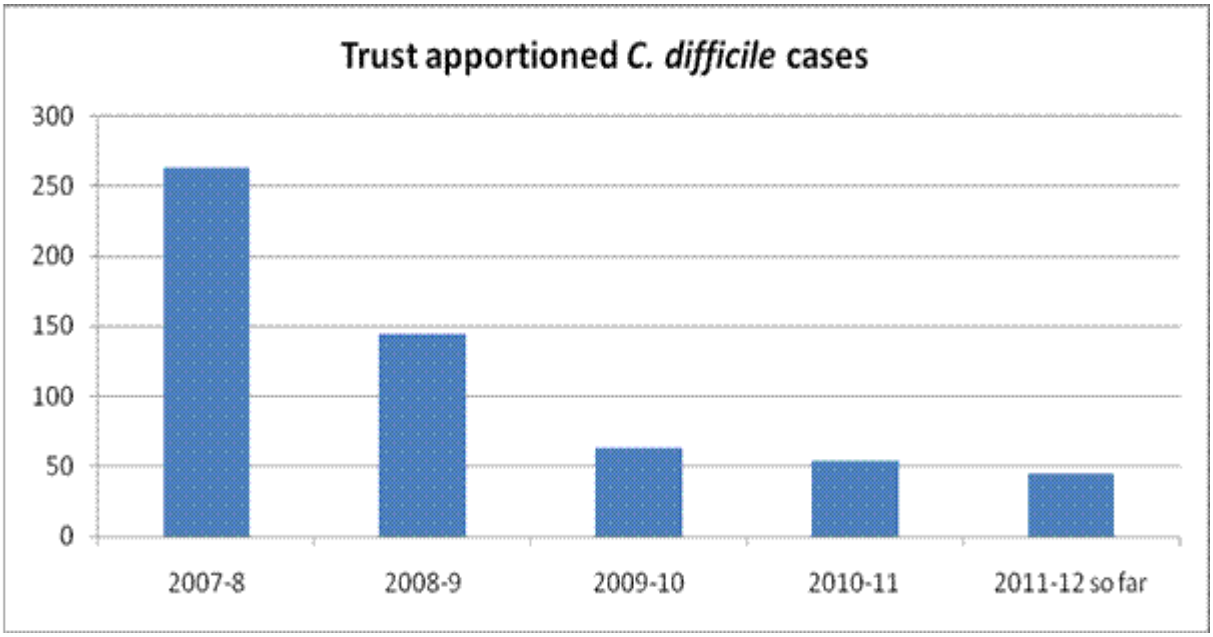
As of 30 April 2012, the Trust is able to report that it has been two years since any patient experienced a hospital acquired MRSA bacteraemia. This is a fantastic achievement and is the direct result of continuous high quality care delivered by our staff. The MRSA bacteraemia target of <3 was met for 2011/12. To put this into context and demonstrate the scale of the improvements made, in 2006/07 there were 36 reported cases of hospital acquired blood borne MRSA bacteraemias in the Trust.

The Trust is, however, not complacent and has further invested in its infection surveillance systems to ensure that this record continues along with reductions in other hospital acquired infections.

Clostridium difficile (C. difficile)

The target trajectories for *C. difficile* infection are set nationally by the Department of Health. During this year there have been 45 cases of *C. difficile* attributable to the Trust which has exceeded our target ceiling of 43.

The Trust is disappointed to have exceeded the target. There has been significant scrutiny and assessment as to why this has arisen and whilst the Trust can report a 17% reduction against the previous year's figures it is committed to zero tolerance of hospital acquired infection.



In response to this, the Trust Board commissioned root cause analysis of every case throughout the year which when considered as a whole indicated that the unexpected resignation of our two consultant microbiologists last summer and their replacement utilising locum consultant staff resulted in a subtle change in anti-microbial pharmaceutical prescribing along with changes in surveillance techniques.

Our response during the year provided an action plan which dramatically reduced the monthly run rate of infection from January onwards and has resulted in some of the lowest infection figures in the country during the last quarter.

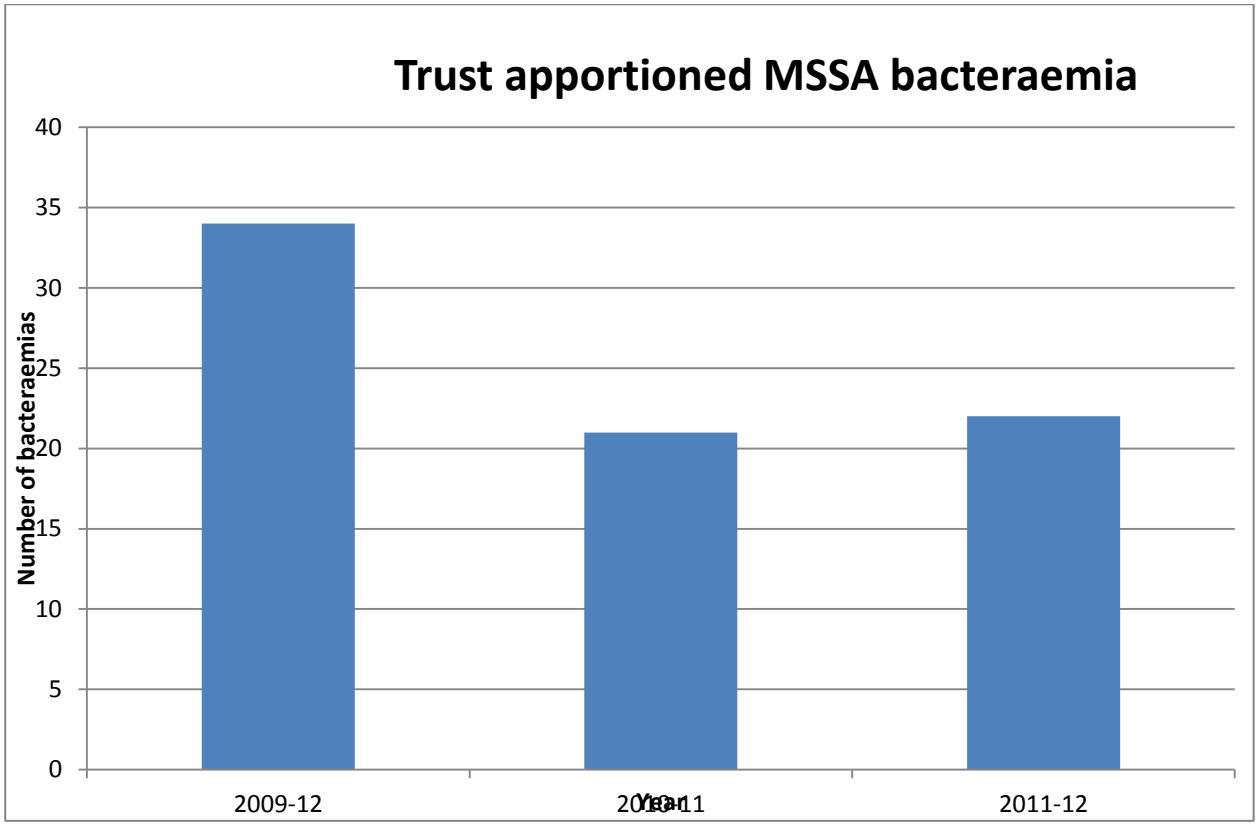
Our approach to C. difficile has since been modified and strengthened with the appointment of 2 substantive consultant microbiologists, investments in nursing staff and the use of external review to ensure that our policies and procedures mimic best in class.

Our ambition remains to eliminate all hospital acquired infection and for 2012/13 our Department of Health target is 36 requiring the Trust to have no more than 3 cases per month. During April and May 2012 we have hit this target and remain committed to further reductions.

Meticillin sensitive *staphylococcus aureus* (MSSA) bacteraemias

The Trust has monitored MSSA bacteraemias detected from blood cultures since 2006/07. Since April 2008 the Trust has participated in the voluntary surveillance of MSSA bacteraemia and reported figures to the Department of Health via the HCAI Data Capture System.

This became mandatory in January 2011. The graph below shows the annual number of MSSA bacteraemias in the Trust since 2006/07; this highlights that since 2009/10 there has been a year-on-year reduction in the number of MSSA bacteraemias.

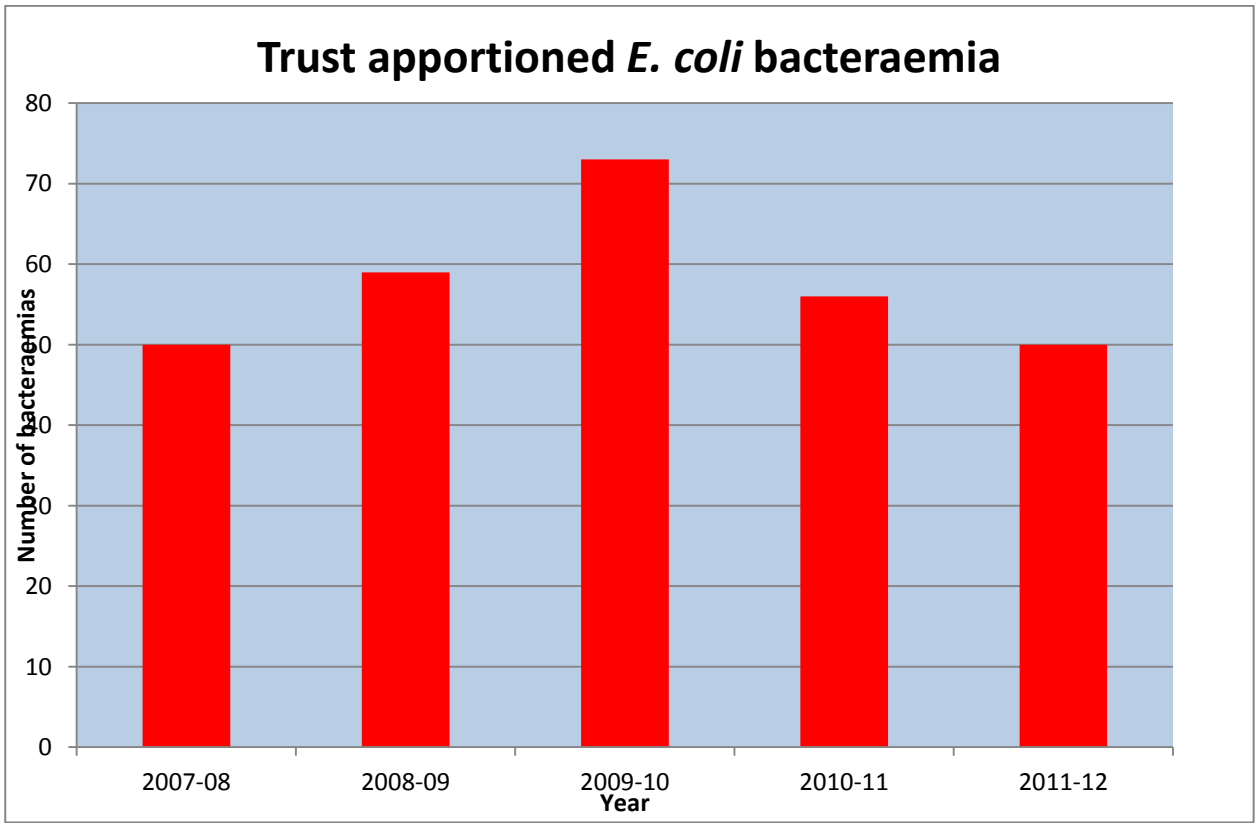


MSSA bacteraemia has the potential to become resistant and develop into MRSA bacteraemia; therefore the Trust treats these bacteraemias as 'near misses' for an MRSA bacteraemia. A Root Cause Analysis (RCA) is carried out for each intravenous line related MSSA bacteraemia, with analyses of the RCA's from these incidents resulting in action plans to enable further reduction in the numbers to be achieved. This process means that patients can be assured that as an organisation we actively investigate to help prevent them happening again.

A spacious 4 bedded bay

Escherichia coli (*E coli*) bacteraemia

Escherichia coli (E coli) is one of the most frequent causes of many common bacterial infections such as urinary tract infections, food poisoning and bacteraemia (when the bacteria gets into the bloodstream). Since June 2011, as part of ongoing information gathering we have submitted data on *E coli* bacteraemia to the Health Protection Agency, in a similar way to MRSA. As the graph below demonstrates, the Trust has had a year on year reduction since 2009/10.



Urethral catheter associated infections

Using the Commissioning for Quality and Innovation (CQUIN) the Trust's aim was to reduce the incidence rate of Trust apportioned urethral catheter associated bacteraemias (blood borne infections). The Trust's 2010/11 surveillance highlighted that there were 40 hospital-acquired urethral catheter associated bacteraemias. The Trust prioritised: reducing the number of catheterisations, applying best practice to those with a urethral catheter and to monitor patients with a catheter for episodes of urinary tract infection. This approach has seen a significant reduction in the number of Trust apportioned urethral catheter associated bacteraemias from 40 in 2010/11 to 12 in 2011/12.

Norovirus

Norovirus (winter vomiting disease) causes sporadic cases as well as outbreaks of gastroenteritis in people of all ages. Norovirus outbreaks are common and are predominantly, although not exclusively, a winter time pathogen, and Norovirus is highly contagious. During 2011/12 the Trust had 12 wards affected by Norovirus, with 139 patients and 86 staff affected overall. Several wards were closed during the outbreak, with an average closure of 11 days and a range of 9-17 days.

Ward staff swiftly reported suspected cases, which led to prompt assessment and implementation of control measures. The kinds of measures undertaken on all wards include:

- Close ward or bay immediately to prevent the spread of infection
- Segregate nursing and medical teams to care for affected and non affected patients
- Ensure enhanced cleaning takes place immediately
- Decontaminate the area with hydrogen peroxide vapour once patients have recovered.
- Restriction of visitors

Ongoing infection prevention and control includes the following:

- Managing Norovirus outbreaks to reduce the risk of the virus being transmitted across the organisation
- Supporting clinical staff during periods of increased incidents
- Development of patient information leaflets: norovirus, norovirus once discharged, C. difficile, mumps, influenza, influenza visitor guidance
- Continued mandatory surveillance: MRSA/MSSA/E coli/C. difficile
- Continued infection prevention and control audits: environmental, hand hygiene, commodes, raised toilet seats
- Working with estates in relation to water management: in particular related to legionella and pseudomonas
- Working with Medirest (our soft FM – Facilities Maintenance – providers eg cleaning and catering) in relation to 24/7 hydrogen peroxide vapour decontamination programme
- Working with microbiology in relation to provide *a* C. difficile testing 7 day service
- Providing infection prevention and control (IPC) service to Ashfield and Mansfield Community Hospitals
- Development and implementation of the C. difficile action plan
- Providing mandatory, introduction and ad hoc IPC training sessions – extended this to include human resources and voluntary services (plan to extend this into other areas during 2011/12 i.e. Medirest, estates)
- Identifying and replacing commodes that are not fit for purpose

- Working with an external company in the design of a bespoke raised toilet seat (ongoing)
- Working towards standardising sharps containers: improve compliance with disposal of sharps (ongoing)
- Working with health and safety in relation to implementation of the EU (European Union) directive for safety devices in relation to sharps (ongoing)
- Working towards the roll-out of using ATP for environmental and hand hygiene compliance: Standard Operation Procedures formalised, database designed, audit programme being formulised (ongoing)

PEAT (Patient Environment Action Teams) scores

The PEAT Audit is an annual assessment of inpatient healthcare sites in England and is undertaken on all sites with more than 10 beds. It is self assessed and measures standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors in all patient areas). The assessment was established in 2000 and is a benchmarking tool to ensure improvements are made in the non-clinical aspects of a patient's healthcare experience. PEAT highlights areas for improvement and shares best practice across the NHS.

NHS organisations are each given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. The NPSA (National Patient Safety Agency) publish these results every year to all NHS organisations, as well as stakeholders, the media and the general public.

We inspect a wide range of clinical areas and assess against best practice standard national definitions. The team of assessors is made up of hospital staff and our governors as well as members of the public.

One of our governors, included in the audit this year, said:

"I'm amazed at how well run the hospitals are. I'm delighted to be part of the audit process and also to be able to pass this on to my constituents in Derbyshire as well as to friends and Trust members via member events. As I also attend monthly meetings at the Trust I receive feedback on improvements to the patient experience that are being made throughout the year"

The scores for last year are shown below:

Site Name	Environment	Food Score	Privacy & Dignity Score
King's Mill Hospital	Good (4)	Excellent(5)	Good(4)
Newark Hospital	Good(4)	Good(4)	Excellent(5)
Mansfield and Ashfield Community Hospitals	Excellent(5)	Excellent(5)	Excellent(5)

Environment	**2010**	**2009**	**2008**	**2007**
KMH	5	4	3	4
Newark	4	4	3	4
Food	**2010**	**2009**	**2008**	**2007**
KMH	5	4	4	4
Newark	4	4	3	3
Privacy & Dignity	**2010**	**2009**	**2008**	**2007**
KMH	4	4	3	4
Newark	5	4	4	4

Our progress over the last year:

- The building works are now completed on the King's Mill site which has significantly reduced the amount of dust being generated on site. This has resulted in the cleanliness being maintained to a very high standard. This year's PEAT audit took place during February. The final ratified scores are not available until around June but we are very hopeful that we will achieve similar scores to last year
- We have seen an increase in the number of people smoking outside the hospital entrances despite our status as a Smoke Free site. As a result we have revised our policy and have agreed to provide some designated areas which will be away from the main doors, where smokers can be directed to if they wish to smoke
- The refurbishment of Newark Hospital outpatients department has commenced with a scheduled completion date of June 2012. This area was in need of modernisation and this will significantly improve the patient experience when visiting the hospital
- King's Mill introduced Steamplicity, individual plated meals which are cooked fresh at ward level. The menu consists of a choice of 24 main meals, 7 types of sandwiches and 15 deserts. They are free from artificial additives and preservatives. This service was introduced at King's Mill at the same time as the rollout of the ward hostess role. This has resulted in very positive feedback from our patients regarding the quality and variety of food available

- The food service is observed as part of the PEAT audit and includes food tasting. This is the first top score of 5 we have achieved. We are echoing this achievement by rolling out hostesses and Steamplicity at both Mansfield and Newark hospitals in the near future
- Our volunteers demonstrate helpfulness when directing patients and visitors around the site
- We will continue to undertake our own mini PEAT audits throughout the year to ensure that these high standards are maintained

How we have reduced the amount of people who fall

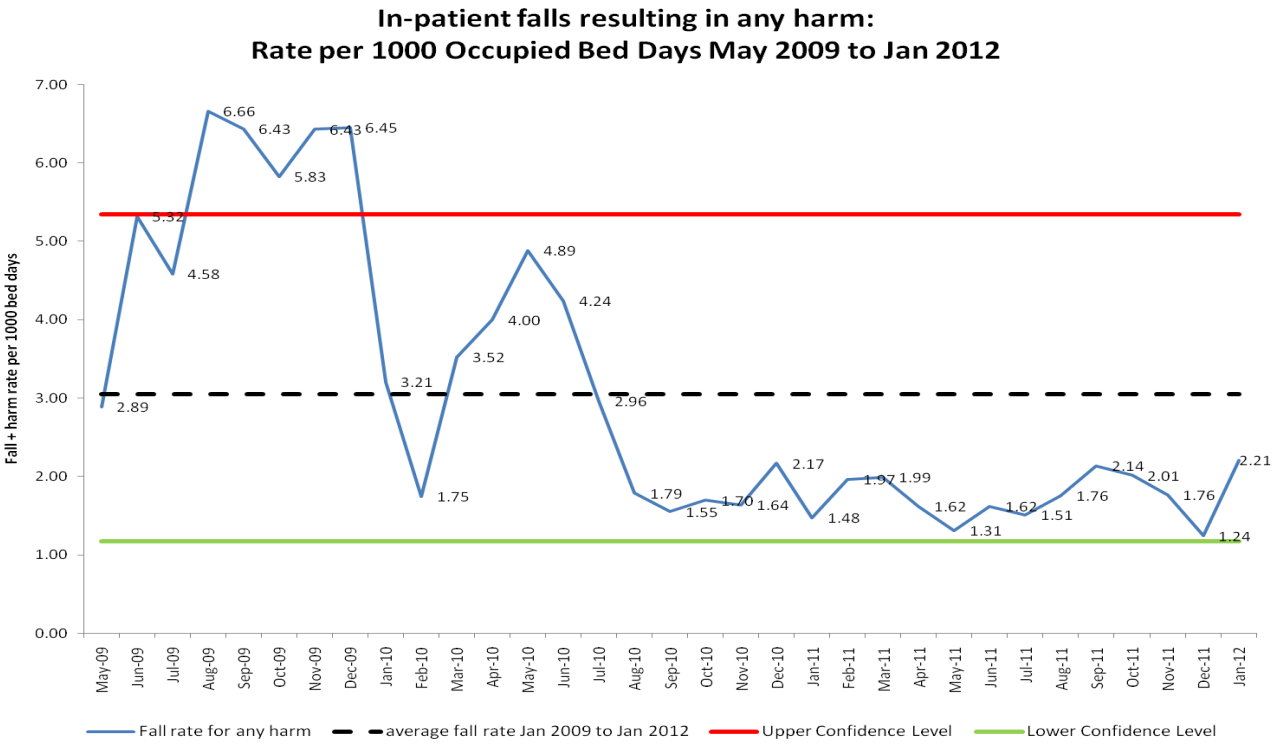
Reducing the amount of patients who fall whilst in hospital is vitally important to us. We know when patient's fall it could lead to a physical injury but it also leads to reduced confidence and a potential reduction in independence for the person. We have worked hard this year to reduce the amount of falls.

We have developed a group whose job it is to concentrate on falls and find ways of preventing them. The Falls and Safety Group continues its work, checking monthly that falls risk assessments are completed on all patients, that falls care plans are in use for people who need them and that people are assessed to see if they need a bed rail.

We have achieved a 6.9% reduction this year in the number of falls (per 1000 occupied bed days) by patients who are in hospital. We believe this reduction is due to improvements we have made such as an increase in dementia and delirium training for ward staff and the use of 1:1 nursing (one patient, one nurse) where indicated.

The data is calculated from incident forms and is governed by the National Patient Safety Agency national definitions.

The amount of people who fall causing harm continues to be below the national average.



This coming year we are going to launch a pilot of a specialist falls team that wards can contact when they have identified a patient with a high risk of falling. This team will provide additional assessments and support. We are also going to be developing a policy to prevent patients moving from one ward to another in the night, unless it is for medical reasons.

How we have reduced pressure ulcers

We want to ensure that our patients come to no harm when they are in our hospitals. Pressure ulcers are painful and debilitating and we aim to reduce the number of hospital acquired pressure ulcers, year on year. This year we have worked extremely hard to reduce the amount of pressure ulcers our patient experience.

Nationally it is recognised that pressure ulcers occur in 4 -10% of patients admitted to hospital. They cause pain and misery to patients, extend their hospital stay, and can be associated with an increased risk of secondary infection.

Pressure ulcers are graded from 1 - 4 and the more serious the ulcer the higher the score.

Grade 1	Reddening of the skin
Grade 2	Blister or superficial break in the skin
Grade 3	Full thickness of skin
Grade 4	Involving muscle or bones

"No grade 4 pressure ulcers for the last two years . . . and we are seeing a year on year reduction in all other pressure ulcers"

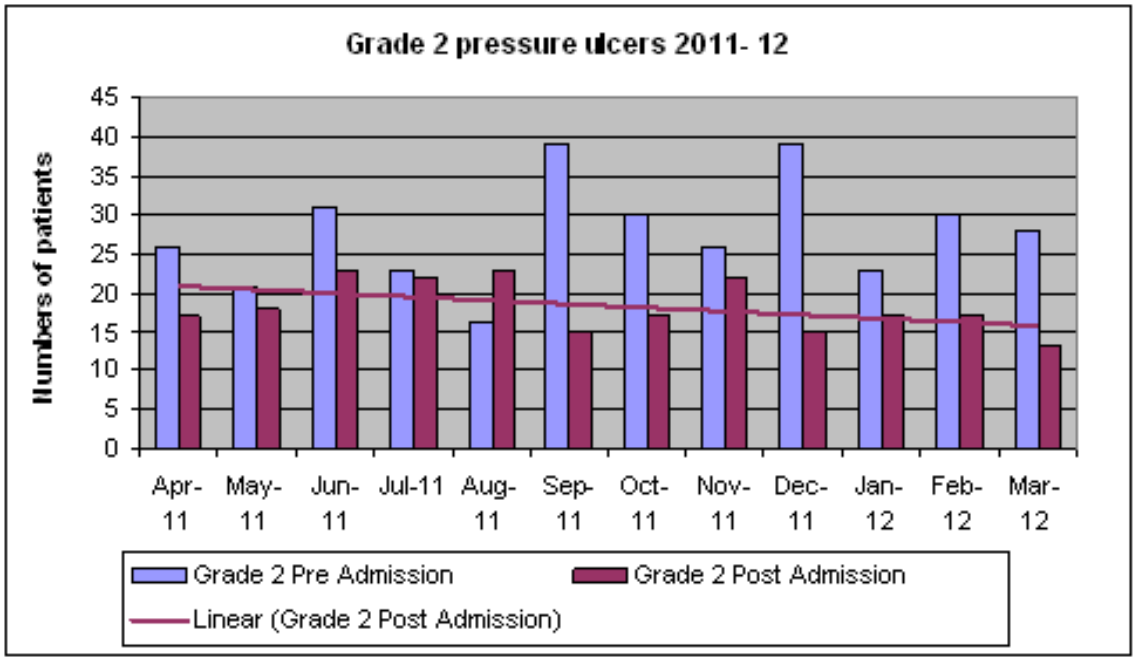
A national quality target, governed by standard national definitions, was introduced last year to increase the number of patients who are assessed for their risk of developing pressure ulcers. The second part of the target was set locally, and is to reduce the number of patients developing pressure ulcers whilst in our care.

We are pleased to report that there have been fantastic improvements on assessment, with 95- 97% of patients being risk assessed and the numbers of patients acquiring pressure ulcers in hospital has fallen to below the agreed target. We have instigated nursing metrics which measure the number of pressure ulcer assessments, increased the number of pressure relieving mattresses, implemented Root Cause Analysis investigations for all Grade 3 ulcers and plan to implement SSKIN Bundles (national best practice) to improve the documentation, assessment and evaluation of care.

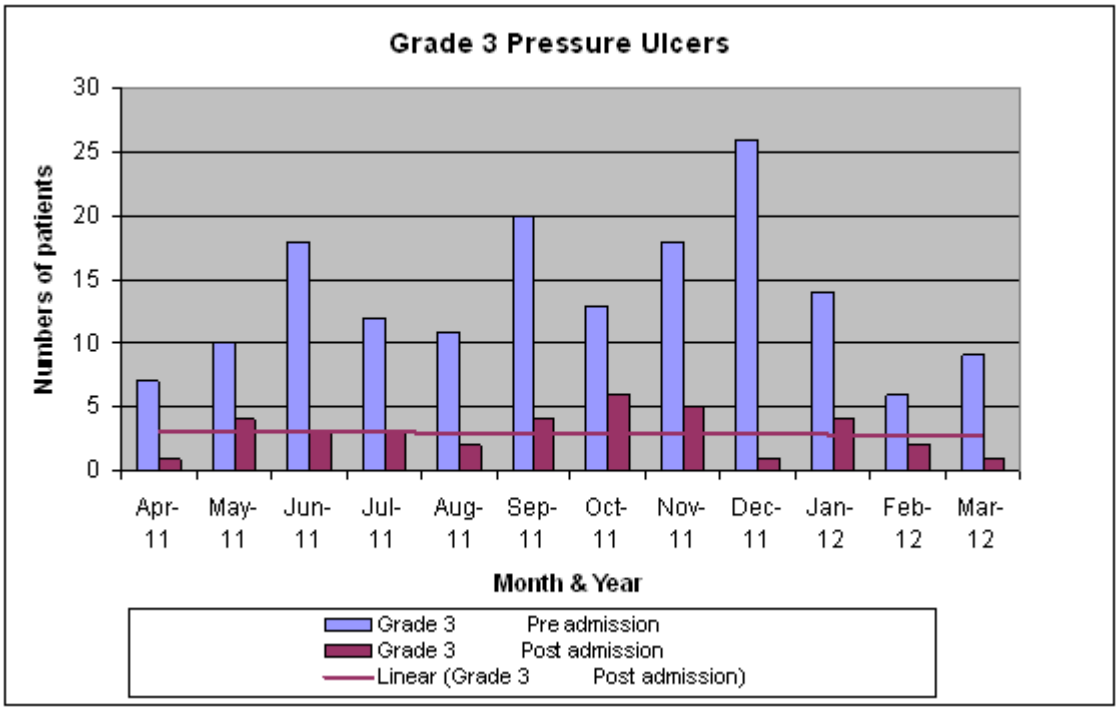
We will continue to drive this forward with an aim to meet the Pressure Ulcer Ambition project which is to have no avoidable grade 2 , 3 or 4 pressure ulcers within the Trust by March 2013.
Hospital acquired pressure ulcers are on a downward trend in line with the 5% CQUIN reduction target for 2011/12.

The graph below shows the total number of hospital acquired pressure ulcers (HAPU's) as a percentage against the total number of patients admitted that month.

Grade 2 Pressure Ulcers



Grade 3 Pressure Ulcers



Grade 4 Pressure Ulcers

There were no hospital acquired grade 4 pressure ulcers in 2010/11.

Pressure Ulcer Steering Group

Grade 3 and 4 hospital acquired pressure ulcers are investigated by Service Line Heads of Nursing, along with relevant members of the clinical team and a Tissue Viability Specialist Nurse, using root cause analysis (RCA). Findings from RCA's are presented at the pressure ulcer steering group

meetings by the relevant head of nursing. Subsequent action plans are developed and shared to promote improvement and good practice.

An intensive drive on education, tighter guidelines and a new fleet of top of the range mattresses are some of our initiatives, coupled with an increased profile around the Trust in order to help meet this important target. The tissue viability team will continue to review all patients with a grade 2,3 or 4 pressure ulceration and will also see those with grade 1 damage from May 2012.

How we have maintained high quality maternity services

Our maternity services have continued to be a popular choice for women during 2011/12 and we have given care to over 4,000 women and their families across North Nottinghamshire and surrounding areas.

We offer community based services, obstetric ante natal and post natal services from King's Mill and Newark hospitals, and childbirth facilities at King's Mill. Our services are complimented by the work of colleagues in the early pregnancy unit, sonographers, physiotherapists and other medical colleagues in paediatrics and anaesthetics.

We continue to monitor closely aspects of our services that help assess quality. Our aim is to have the same midwife working with the lady and her family throughout the pregnancy. During 2011/12 our audits showed that we maintained 95% continuity of midwife during the antenatal period and 93% during the postnatal period. This enables women to develop trusting relationships with the midwife and influences our birth outcomes.

Our birth outcomes are outlined in the table below and continue to place our maternity services as one of the best nationally.

	11/12	10/11	09/10
Birth Numbers	3499	3427	3281
% rise from previous year	2.1%	6%	4.4%
Midwife to birth Ratio	1:32.9	1:32.3	1:30
Caesarean Section Rate	17.92%	15.74%	15.68%
Vaginal Birth Rate	82.08	84.26%	84.32%
Home Birth Rate	5.5%	6.76%	7.75%

We are really proud of these outcomes which we achieve by the strong philosophy of care the maternity team share. They have also been enhanced by our fabulous new environment, the availability of facilities for water births and aromatherapy. These complement the traditional services available from midwives, obstetricians, paediatricians, anaesthetists and neonatal services.

Midwife to birth outcomes are measured quarterly in order to assess our services in comparison with others across the East Midlands and nationally.

This is work that supports evidence that midwifery staffing levels affect outcomes for patients. The data is governed by standard national definitions and the recommendation is a midwife birth ratio of 1:28 the chart below demonstrates our rates at Sherwood Forest Hospitals.

	Total Year 10/11	Quarter 1 11/12	Quarter 2 11/12	Quarter 3 11/12	Quarter 4 11/12	Total Year 11/12
Births	3427	898	914	889	798	3499
Midwifes	106.29	106.29	106.29	106.29	106.29	106.29
Ratio	1:32.3	1.33.8	1.34.3	1.33.4	1.31.7	1:32.9

We also value the views of our services users. We collate comments that women have made about their birth experience in their post natal records, monitor themes and trends of our incidents and complaints to inform service improvements.

We also ask women to share their experiences with us relating to their care in labour. It has been demonstrated that women who have a dedicated midwife available to them when they want one during their labour improves birth outcomes. Over the last year over 90% of our women reported a positive experience in relation to one to one midwifery care.

Our challenges are regarding broader public health targets such as breast feeding initiation rates and smoking cessation rates in pregnancy. Despite many initiatives, performance is still poor nationally. We continue to work to promote breast feeding and talk to women about smoking, encouraging them to stop and to accept the support of the local specialist stop smoking service.

How we aim to prevent acute kidney injury

Following on from the NCEPOD (National Confidential Enquiry into Patient Outcome and Death) 2009 report 'Adding Insult to Injury' the organisation established an Acute Kidney Injury (AKI) work group whose task it was to implement both the standard national NCEPOD recommendations based on national definitions and meet CQUIN indicators (as mentioned earlier in this report). The group has established a database of cases, a system to identify patients with AKI (Acute Kidney Injury) and flag them up to specialists' attention, and completed training to raise awareness of AKI in both acute admissions and patients on the wards. The data is extrapolated from the Orion system (internal information system)

Awareness and educational actions to date

- Information has been sent to all ward leaders regarding AKI and the importance of accurate fluid balance
- All inaccuracies/mistakes on fluid balance charts are addressed by the critical care outreach team
- Discussion with the training and development department to ensure that fluid balance is covered appropriately with the non registered nurses and that the department are aware of recurring problems
- Issues to be discussed at the Professional Advisory Group, a regular meeting of senior clinicians

Awareness and educational actions for the coming year

- From April 2012 AKI is to be covered on the nurse induction programme
- An ongoing rolling programme of education for all registered and non registered nurses is planned, exact details still under discussion
- Consider an AKI link nurse for each adult acute ward
- Continue to raise issues with the relevant people as they arise

How we safeguard children and young people

The safeguarding children and young people team set high targets to achieve for 2011/12 and are delighted to report, the majority of the developments and improvements in Safeguarding Children Work Plan for 2011/12 were completed and delivered on time with the completion of the remaining few anticipated in early 2012/13.

Key achievements for 2011/12

The development of a Child Protection Supervision Policy for Staff has increase the range and number of staff who undertake child protection supervision. This has contributed to an even greater awareness amongst key staff of the needs of vulnerable children and young people.

In addition, all staff employed by the Trust have a Safeguarding Children clause in their contracts to ensure they are aware of their responsibilities when safeguarding children.

At the beginning of 2011/12 the Trust Safeguarding Children Training Programme was reviewed and updated in response to new guidance. In addition to the core programme training on Domestic Violence, Multi-Agency Risk Assessment Conferences (MARAC) are provided for midwives and

Common Assessment Framework (CAF) Awareness sessions are provided for children and neonatal nurses. A new initiative to support and enhance the training programme was the development of Safeguarding Children Competency Packages for midwives and for registered nurses working in children's wards, neonatal care, emergency department and genito-urinary medicine.

A policy for children and young people who do not attend appointments was also developed. A Trust wide audit of this policy has now been initiated and will be completed in early 2012/13. A robust audit programme is an essential element in ensuring the quality of safeguarding work so as well as the DNA (Did Not Attend) audit, six other audits were undertaken and completed during 2011/12. These were on:

- Completion of Midwifery Safeguarding Documentation
- Effective Communication between Midwives and Health Visitors
- Midwifery Safeguarding Supervision
- Midwifery Routine antenatal and postnatal inquiry (domestic abuse)
- Completion of Paediatric & Neonatal Safeguarding Documentation
- Effective use of the Paediatric Liaison Criteria in the emergency department

In addition to planned work, a Paediatric Safeguarding Children Dashboard was also developed in late 2011/12 to provide quarterly monitoring of key paediatric and midwifery outcomes.

Key Priorities for 2012/3

- Maintain the Safeguarding Children audit programme
- Implement the Safeguarding Children Competency Packages
- Continue to maintain and develop the Paediatric Safeguarding Dashboard

How we safeguard adults

Safeguarding adults is fundamental to delivering quality healthcare. The Trust has developed a Safeguarding Adults Board and this continues to meet monthly, and is very well attended.

Key Achievements for 2011/12

- The organisation has appointed an additional safeguarding adults nurse to strengthen the service
- Mental Capacity Act training is ongoing, with the emphasis on embedding the mental capacity act into practice
- Vulnerable adults' study day developed and now runs three times each year. This includes real case examples and reflects the learning needing to take place. This is evaluated extremely well by staff
- The organisation collected themes from safeguarding concerns which were around transfer of care and discharge information. This had led to a review of our discharge/transfer information recommendations which started to be implemented from May 2012
- The organisation is now ensuring that leads in vulnerable patient groups (eg those with learning disabilities, dementia, domestic violence victims) work together more and feed back to one central place to safeguard vulnerable patient groups

Key Priorities for 2012/13

- Review safeguarding documentation
- Audit use of mental capacity in the organisation and learn from best practice
- Review safeguarding and Mental Capacity Act training
- E-learning package for safeguarding and learning disabilities to be introduced

The training programme of safeguarding adults and Mental Capacity Act (MCA) continues to raise awareness. This includes an intensive training programme for MCA to ensure it is used in practice. An MCA poster awareness campaign ran across all our hospitals in March. Lessons learnt from safeguarding have been used to change practice.

2.3.2 Clinical Effectiveness - other priorities

How we reduced the amount of people developing blood clots

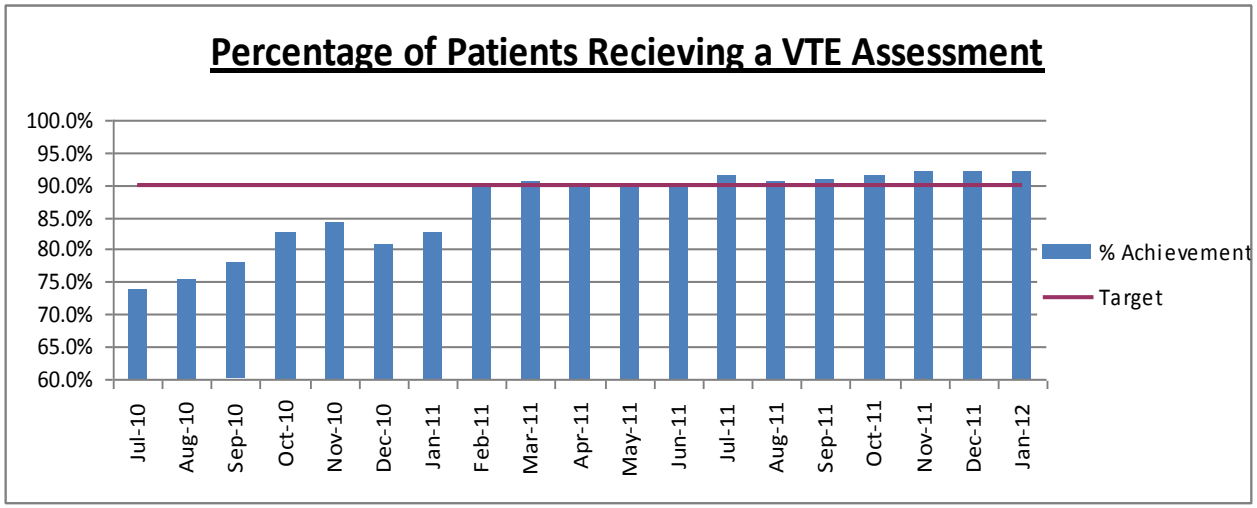
Over 90% of our patients should be assessed when they come into hospital to determine the chances of them getting a blood clot (venous thromboembolism). We are then able to treat those at risk and reduce their chance of developing a blood clot.

The data is taken from an audit of all assessment forms against a list of all admitted patients. The data is governed by standard national definitions.

We reached our target of 90% by February 2011, ahead of all the other Trusts in the region and have maintained an excellent performance.

The target for next year has increased to 95%, this includes a further requirement to measure the number of people where treatment has been started, which will be challenging. Currently we are at 93% and implementing improvement plans.

The graph shows a fantastic increase in the number of people being assessed therefore increasing the number of people who were prevented from developing a blood clot.



How we continue to improve the monitoring of very ill people

ACAT (Augmented Care Assessment Tool) is the organisation's early warning system that alerts us to the patients who are at risk, or who are actually deteriorating. If we intervene early in the course of their deterioration we may be able to instigate treatment that will prevent further deterioration or prevent the need for an intensive care admission.

The patient's vital observations are carried out, such as blood pressure, temperature, pulse, respiration, oxygen levels, urine output and consciousness levels (consciousness levels are recorded by the AVPU tool – Alert, Voice, Pain, Unresponsive). The results are then calculated and a score given. If the score is above a certain level a doctor is called. Audits are carried out throughout the year, in terms of assessing nursing notes and charts, to ensure this tool is being used effectively. The data is governed by local definitions.

Overall Trust compliance with all elements of the observation and ACAT audit was 95%. This represents an increase of 1% since the last audit in March 2011.

Good compliance (99-100%) was maintainedin five of the six mandatory vital signs. The target is to achieve 100% compliance with the recording of all 6 mandatory observations and the ACAT score thus increasing the opportunity for identifying the deteriorating patient early in the course of their deterioration

There was less compliance with recording of AVPU where there is still a need for further improvement (84%).

How we will continue to improve on ACAT?

- Attendance at LIPS course by the nurse consultant facilitated the prioritising of acutely ill patients as part of the improving patient safety agenda agreed at Board level
- Projects worked up in preparation for this using PDSA (Plan Do Study Act) methodology eg improving compliance with observations, monitoring unplanned admissions to intensive care using global trigger tool to identify (and learn from) events
- Strategy day planned for critical care outreach team for planning
- Audits are now carried out by the senior nurses and incorporated monthly into an audit tool known as nursing metrics. This is in a pilot phase and will be reported fully in next year's account.

A new support service for junior doctors and nursing staff has also been introduced to ensure that acutely ill patients whose condition worsens receive the fastest possible treatment by medical specialists. This is called the Acute Response Team and was introduced in December. The groundbreaking new service is based on models in use at Sydney, Australia and at Aintree Hospital in Liverpool. This service is available 24 hours a day, seven days a week. The Acute Response Team provides immediate assistance to ward staff for any acutely ill adult inpatients whose condition begins to deteriorate.

A memorable bleep number enables ward staff to call the team, which offers a new middle level of support in between calling the cardiac arrest team and the critical care outreach service, to get senior medical help to the sickest patients faster. Members of the new Acute Response Team include a medical registrar, intensive care registrar or consultant, critical care outreach nurse and resuscitation training officer.

How we provide privacy through same sex accommodation

"None of our patients have been cared for in mixed sex accommodation for at least 16 months"

We have made significant improvements to our environment and can report that we have had no same sex breaches. This means that where we have a bay of four or six patients they are either all women or all men. At King's Mill Hospital we also have 50% single ensuite bedrooms for our patients. You can rest assured that your privacy and dignity is maintained when admitted to one of our hospitals and King's Mill is the only hospital in the East Midlands offering this.

How we avoid readmitting people who do not need to be in hospital

When patients attend hospital they expect to be discharged home, well, and having received the correct treatment that enables them to return to their lives. For a small number of people they find themselves having to be readmitted to hospital either as a result of a recurrence of their original condition or as a complication or indeed a new condition.

We need to ensure that we do not discharge patients home if there is a risk that their original condition has not been successfully treated or that they have a complication. We, therefore, have systems and processes to ensure that this does not happen.

The hospital has a discharge team who identifies people who are readmitted within 28 days and look into the reasons why. People who are admitted to the hospital many times are identified by the Repeat Admission Patient Alert (RAPA) system. This enables these people to be seen quickly and to identify if the reasons for readmission are medical or social need or both. The integrated discharge team and other specialist nurses work with the multidisciplinary team, including community matrons and the community nursing team, to identify strategies to support patients in the community and, if admitted into acute care, have a care plan in place to assist prompt discharge home or to an appropriate destination.

There are many developments we have introduced over the last year to support a reduction in people being readmitted to hospital for the same condition. These are:

Reablement

- EDAASS (Emergency Department Admission Avoidance Support Scheme) launched in March 2011 and explained further in this report
- Urology outreach service (launched Sept 2011). This enables urology patients to be seen at home
- Dedicated geriatric support in Emergency Department (launched Dec 2011)
- End of Life support in the Emergency Department (launched Jan 2012)

Medical staffing

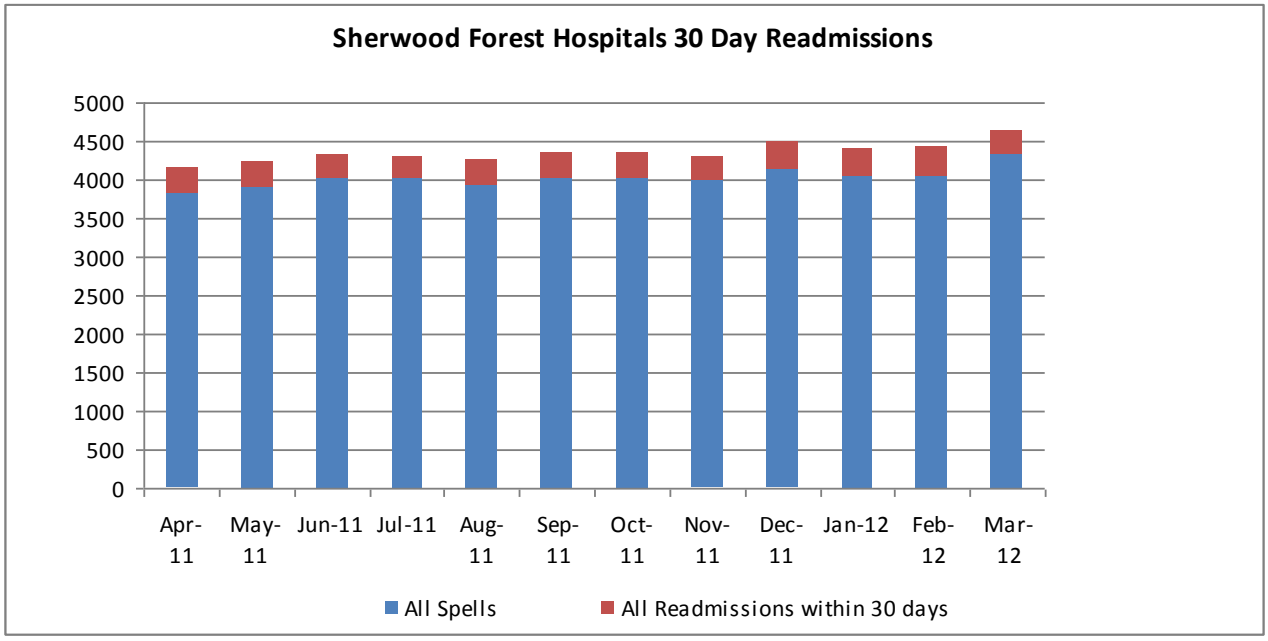
- Increasing the number of Emergency Department consultants from 6 to 11
- Establishing acute physician service (4 whole time equivalent doctors appointed to start between August and November 2012)

Emergency Care Service Innovation

- Single Point of Access – this means that all patients are seen in the Emergency Department and then treated according to their needs. Sometimes they do not need admitting (launched in December 2010). This has led to a significant reduction in GP admissions
- Develop a Clinical Decision Unit (estimated implementation summer 2012)
- Increased access to Radiology in the Emergency Department (in discussion and first development launched in April 2012)
- Develop Ambulatory Specialty services in Emergency Department.
- Community Geriatrician in Newark and Sherwood (interviews in April 2012)

This information provides a summary of the breadth of developments achieved and planned.

The data below is governed by standard national definitions and is generated by the hospital PAS (Patient Administration System) system.



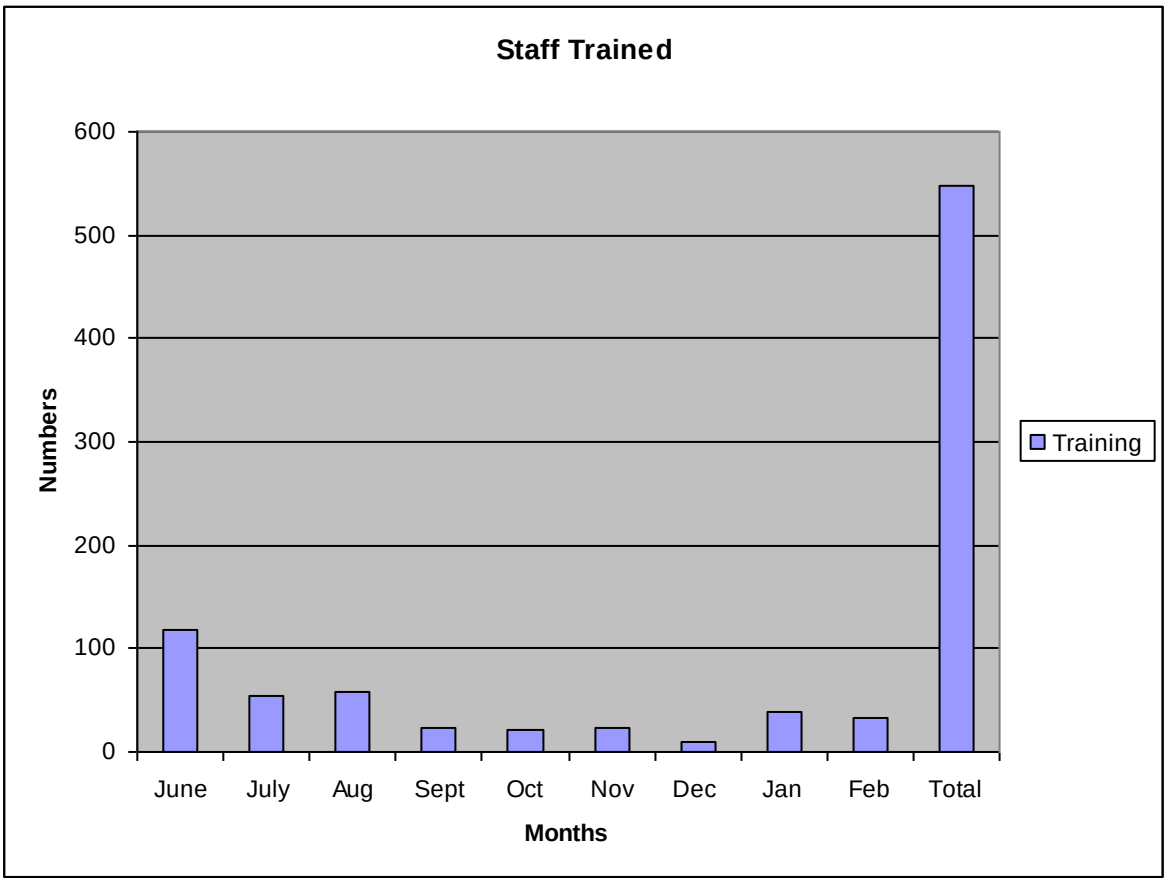
The blue bars above show how many people were admitted during that month. The red bars on the top show how many readmissions we had that month. As you can see the readmission rates are small when compared to the first admission rates.

How we actively support people to stop smoking

In line with both national and local quality improvement programmes, Sherwood Forest Hospitals has been working to implement a system which identifies people who smoke and provide Brief Advice about quitting and where appropriate refers to the Local Specialist Stop Smoking Services. This is based on research which shows that brief conversations between patients and clinicians on lifestyle issues such as smoking can stimulate change.

'Time for a QUIT chat' is a new scheme that has been training staff to identify patients who smoke and motivate them to accept a referral to stop smoking services. An in-house trainer was recruited.

Frontline staff attend one hour training sessions in Brief Advice skills from accredited trainers. The graph below shows how many staff have been trained each month.

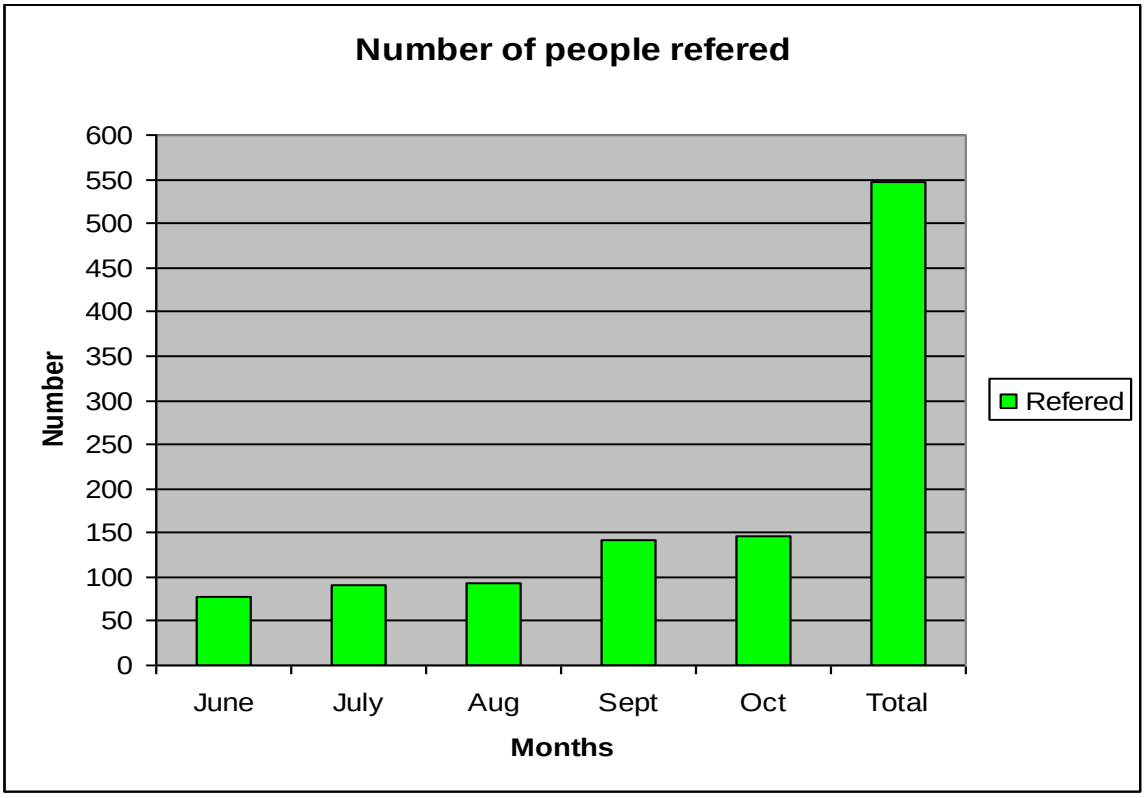


An electronic referral process to stop smoking services continues to work well in maternity services and has been extended for use within inpatient areas also.

Extensive research shows stopping smoking amongst more patients can reduce length of stay for patients. It also improves overall health and wellbeing and reduces post operative complications.

We monitor the number of referrals from the hospital to Local Specialist Stop Smoking Service and ensure feedback to staff through Time for A Quit Chat newsletters.

The graph below shows how many people have been referred each month.



Staff and patients have been involved in surveys to evaluate the effectiveness of the programme.

How we have improved outcomes for stroke patients

The hospital has worked hard to be able to provide a thrombolysis (clot busting drug) service to patients who have suffered a stroke caused by a blood clot in their brain. This means that when these patients are admitted they can be given this treatment to disperse the blood clot and in many cases the patients make a full recovery. Previously patients would have needed to travel to another hospital to receive this treatment.

A patient told us:

> ***"I was having a stroke, my wife called the ambulance, I came to King's Mill and received this new clot busting drug - my life is nearly back to normal"***

A recent accreditation visit proved to be positive and highlighted areas of good practice and areas that the stroke unit was required to continue to work towards. These areas are all being actioned proactively.

Since King's Mill Hospital gained accreditation as a primary stroke centre, work continues to further improve the service, using a structured stroke service improvement programme, including specific work streams for TIA (transient ischaemic attack or mini stroke), pathways and cross county partnership working.

The results from the ongoing measurement against the nine Sentinel Audit Key Performance Indicators, governed by standard national definitions are in the table below, and show continued improvement in almost all indicators.

Brain scan within 24 hours of stroke was previously identified as a risk, but there has been sustained performance above the top quartile.

	National Quartiles (Sentinel Audit 2010)						
Sentinel Indicators	**25% of sites score below**	**Median**	**25% of sites score above**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**
Patients treated for 90% of stay in a Stroke Unit (as calculated)	46.4%	62.2%	72.7%	95%	89%	95%	95%
Screened for swallowing disorders within first 24 hours of admission	75.5%	84.1%	94.2%	95%	98%	100%	99%
Brain scan within 24 hours of stroke	58.6%	70.5%	79.7%	96%	98%	100%	100%
Commenced aspirin by 48 hours after stroke	59.2%	94.1%	98.0%	98%	98%	100%	100%
Physiotherapy assessment within first 72 hours of admission	87.6%	93.0%	96.9%	89%	97%	95%	98%
Assessment by an Occupational Therapist within 4 working days of admission	72.7%	87.1%	96.2%	83%	87%	91%	94%
Weighed at least once during admission	78.2%	89.2%	96.3%	100%	100%	100%	100%
Mood assessed by discharge	68.8%	84.4%	94.1%	100%	100%	100%	100%
Rehabilitation goals agreed by the multi-disciplinary team by discharge	92.6%	97.3%	100.0%	99%	100%	100%	100%
Average for 9 indicators	71%	85%	92%	95%	96%	98%	98%

To ensure we deliver an excellent stroke service at Sherwood Forest Hospitals . . . we are planning to work towards implementing a 24 hour thrombolysis service at King's Mill Hospital. This will be supported by:

- Strengthening the partnership working with Nottingham University Hospitals NHS Trust
- Progressing towards implementing a 7 day high risk Transient Ischaemic Attack (TIA) service in partnership with Nottingham University Hospitals NHS Trust
- Continuing to familiarise staff with the telemedicine equipment and resolve connectivity issues
- Increasing the substantive stroke consultant establishment

We have during 2011/12 implemented:

- A 5 day high risk TIA service providing a one stop clinic where patients are assessed, investigated and treated
- A thrombolysis (clot busting) service at King's Mill Hospital, Monday to Friday 8am to 5pm, with patients being repatriated directly to Nottingham University Hospitals outside these times

To ensure we deliver the best possible care to our patients we continue to monitor stroke performance.

How we have improved the pathway in Emergency Department

The hospital achieved delivery of the national emergency access standard of 95% for patients being treated, admitted or discharged within four hours of their attendance. The score for the hospital was 96.21%. This is despite a significant increase in demand for services during 2011.

The Emergency Department has managed this increase within existing resources by re-profiling staff hours to better match peaks in demand and redesigning the workforce to shift from a dependency on high cost agency medical staff to substantively employed staff.

One example of this is the successful appointment to three new Advanced Nurse Practitioner roles which support the delivery of high quality patient care in the majors section of the Emergency Department.

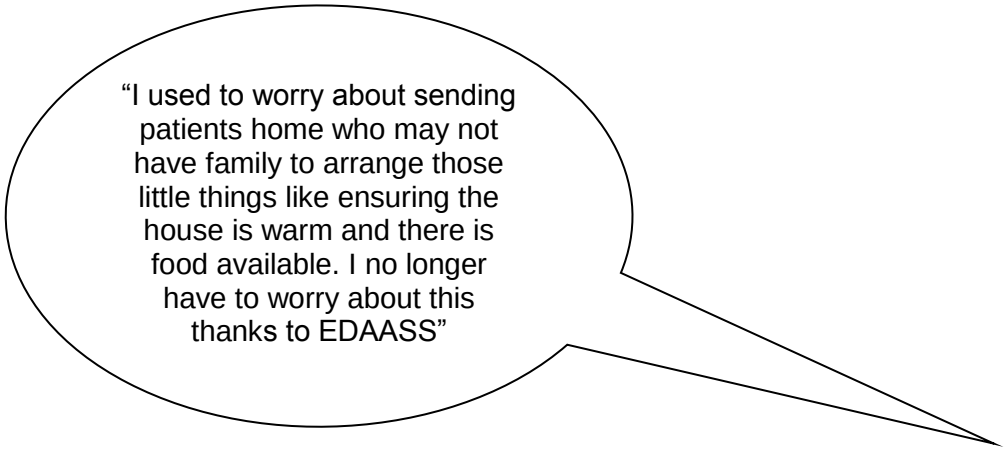
The next phase of the workforce strategy is to increase the number of consultants delivering the service from 6 to10. This is one of a number of actions being taken to improve our performance to improve the quality and speed with which patients are cared for.

During the last year we commenced EDAASS (Emergency Department Admission Avoidance Support Scheme). This was introduced for patients who attend the Emergency Department and Emergency Admissions Unit who do not require admission to a ward. This scheme avoids unnecessary admission and improves quality of care.

The scheme provides transport home and helps to settle in the patient at home. It may also include prescription collection and shopping and can provide 48 hour follow-up if necessary. The team initially consisted of five part time support workers who provide a 9am to 9pm service 7 days a week. Due to the success of the service the staffing levels have increased to 7 full time people. The aim is to extend the service to the wards, enabling people to be discharged even if their care package is not in place for 48 hours as the support workers can fulfil this role. The support workers will hand over the patient's care to the community team when the care package commences. This will ensure a seamless service for the patients.

The EDAASS team ensures that care packages are re commenced in the community. They can refer to intensive home support, rapid response, social services and the falls team.

During the last 12 months over 600 patients have been cared for by the EDAASS team.



EDAASS achievements

There has been a qualitative survey of a small sample of patients and carers between March and May 2011.

- 100% felt the service helped them to be discharged earlier from hospital
- 60% felt the service avoided the need for them to be admitted as they were provided with the necessary support in the community
- 100% said the service met their individual needs and wishes
- 100% said they would recommend the service to others
- There has been an increased number of referrals to the falls service
- Unnecessary admissions have been avoided
- Estimated savings in excess of £266k, as patients do not require a longer than necessary hospital stay
- The EDAASS team provide a valuable bridge between health and social care

A recent patient said:

"Excellent, excellent. It reassured me. The EDAASS support worker was remarkable. The two ladies that I met were so thoughtful – lovely ladies. They assisted me and I was grateful for it. I would definitely recommend the service to others; in fact I already have recommended it"

How we have improved access to contraception

In line with National Policy in reducing unplanned pregnancies, we have been working to improve access to and information about contraception across two key groups of patients. All patients who access the hospital for termination of pregnancy services are counselled regarding their choices for future contraception. They are signposted to appropriate services and if the patient chooses we initiate contraception at the time of the termination. We consistently deliver information to more than 95% of this group of patients.

We offer an emergency contraceptive service to complement the community services available on public holidays, which whilst use is small, is effective for those who use the service.

Within maternity services the post natal documentation available to our women has all the information regarding contraceptive choices post birth and signposts women to the appropriate services to access their choice. Our records demonstrate that between 80-90% of our women have this documentation and we will work on improving this uptake.

How we ask more people about their alcohol intake

Screening all hospital patients for alcohol misuse and providing brief interventions is well recognised as appropriate and supported by a significant evidence base. The data is governed by standard national definitions set out in the NICE (National Institute for Health and Clinical Excellence) guidance.

Standards	Quarter 2 2011/12 Baseline n=50	Q3 2011/12 N=100	Q4 2011/12 N=100
Standard 1 all patients admitted via the emergency admissions unit will be screened for alcohol problems using a recognised validated screening tool (target 65% of patients meeting this standard)	16/50 screened 32% compliance	78/104 75% compliance*	82% compliance overall
Standard 2 all patients identified via standard 1 as drinking to excess (but falling short of being potentially alcohol dependent) will be offered brief advice in relation to alcohol (target 90% of patients meeting this standard)	1/16 identified 0/1 offered BA or offer of referral 0% compliance	2/3 66% compliance	2 of 4 = 50%
Standard 3 all patients identified via standard 1 as drinking to excess (but falling short of being potentially alcohol dependent) will be offered a referral to the Alcohol and Drug Liaison Team (ADLT) (target 90% of patients meeting this standard)	Zero patients identified in this sample	0 /3 0% compliance	1 of 4 = 25%
Standard 4– for all patients identified via standard 3 and accepting a referral to ADLT, such a referral will be made (target 90% of patients meeting this standard)	Zero patients identified in this sample	Zero patients identified in this sample	Zero patients identified in this sample
Standard 5 all patients identified via standard 1 as potentially alcohol dependent will be automatically referred to ADLT (target 90% of patients meeting this standard)	Zero patients identified in this sample	4/4 100% compliant	1 of 1 = 100%
Standard 6 for all patients seen by ADLT a letter will be sent to the patient's GP summarising alcohol intake and interventions delivered (target 90% of patients meeting this standard)	Zero patients identified in this sample Quarterly ADLT figures: - see above	2/2 100% compliant	Zero patients identified in this sample

*The additional scrutiny applied in the Quarter 3 and 4 audit reveals that nurses are indeed screening for alcohol misuse in 75% and 82% of cases; this is to be commended as this is perhaps as high as anywhere in the NHS.

What have we achieved during 2011/12

- Provided bespoke educational sessions for staff on the emergency assessment unit and the wider hospital workforce, including doctors, nurses, allied health professionals, students. This ensures they are aware of expectations for Alcohol QSP standards
- Listened to feedback from nursing colleagues and reformatted the alcohol screening tool to make it more user friendly
- Established audit processes to monitor compliance and our team directly audit patient health records on a quarterly basis to monitor compliance
- Directly received referrals from wards and departments for patients who drink alcohol to excess and provided direct interventions for over a 1,000 patients – of these we have referred on to specialist community alcohol services when appropriate and have dealt 'in house' when this is sufficient

What are we aiming to achieve during 2012/13

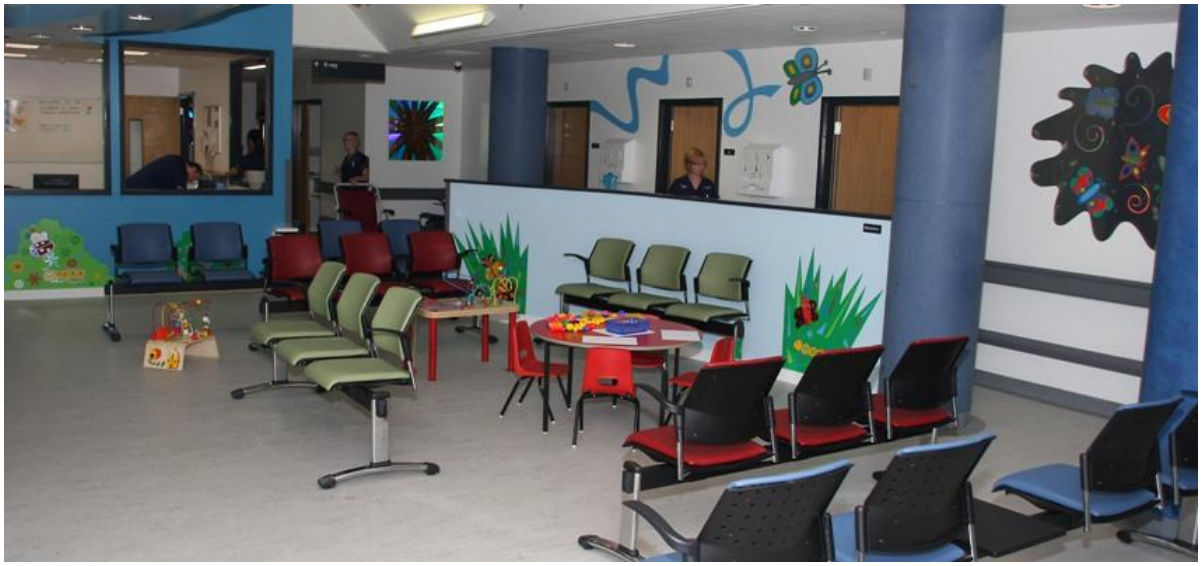
- We aim to implement a new guideline for screening that is NICE compliant
- We have designed a workbook for all clinical staff (other than doctors) that provides all the information nurses and allied health professionals need to ensure compliance with alcohol standards
- We have also commenced a programme of education for all emergency department nurses that again covers alcohol requirements and other alcohol and drug related issues (for example: responding to young people who may have alcohol or drug related problems)

Local alcohol and drug services are being significantly restructured as a 'Recovery Partnership'. This is a coming together of previously disparate substance misuse services so as to better meet the holistic needs of people with alcohol and drug problems and their families, friends and communities. The Alcohol and Drug Liaison Team is central to ensure that our organisation is recognised as a central player in our local health and social care community's response to local substance misuse problems. As such, and in the spirit of continuous quality improvement, we are building on our already established and well respected roles and functions. By way of example we plan to further utilise the Alcohol Liaison Nurse Clinic (based in the Emergency Department). We have also recently developed an Alcohol Liver Disease Clinic to seek to address local problems – Ashfield and Mansfield are in the worst ten areas of the UK for female alcohol liver disease deaths.

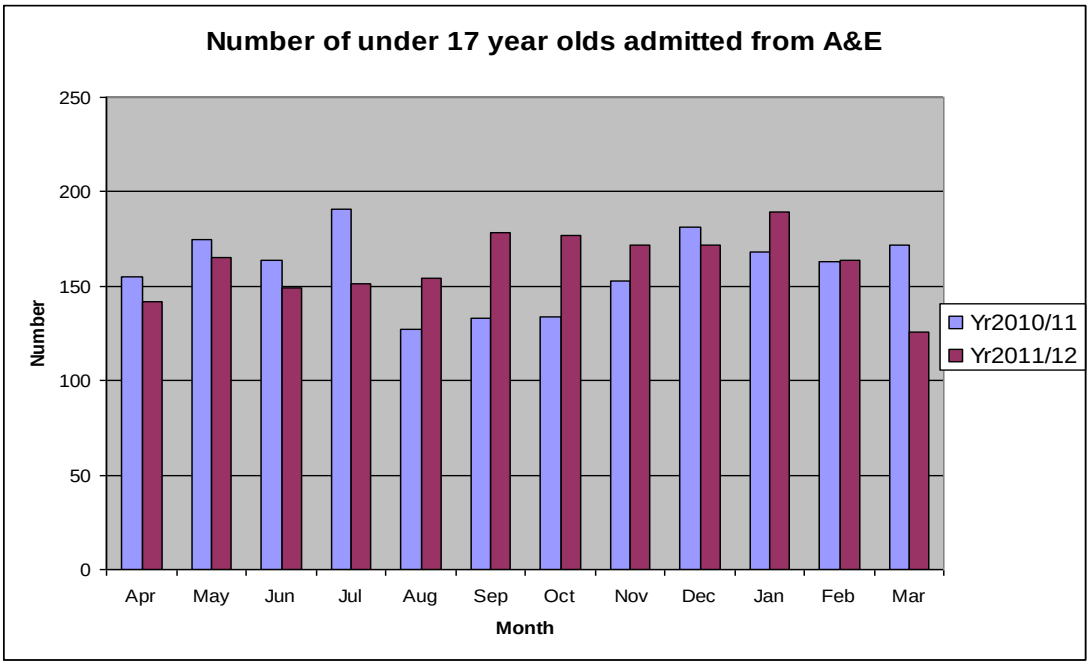
We have also developed and led on an excellent multi-agency response to High Volume Service Users (HVSU - people who attend ED either 3 times in a month or 5 times in six months - many of which have alcohol problems). It is perhaps fair to say that the Trust and the wider Recovery Partnership have developed a response to HVSU that is considered the best nationally.

How we aim to reduce the number of children who are admitted to hospital via the Emergency Department

Children's waiting room in the Emergency Department



We have identified that we are still admitting patients from the Emergency Department (ED) onto our children's ward, and whilst this is the right thing to do for many patients we believe that we may be able to prevent some of these admissions. We are looking at solutions which would enable children and young people to have a more in-depth assessment in ED. One idea being considered is to have a children's doctor based in the emergency department to assess all children and young people to establish what alternatives to admission can be arranged.



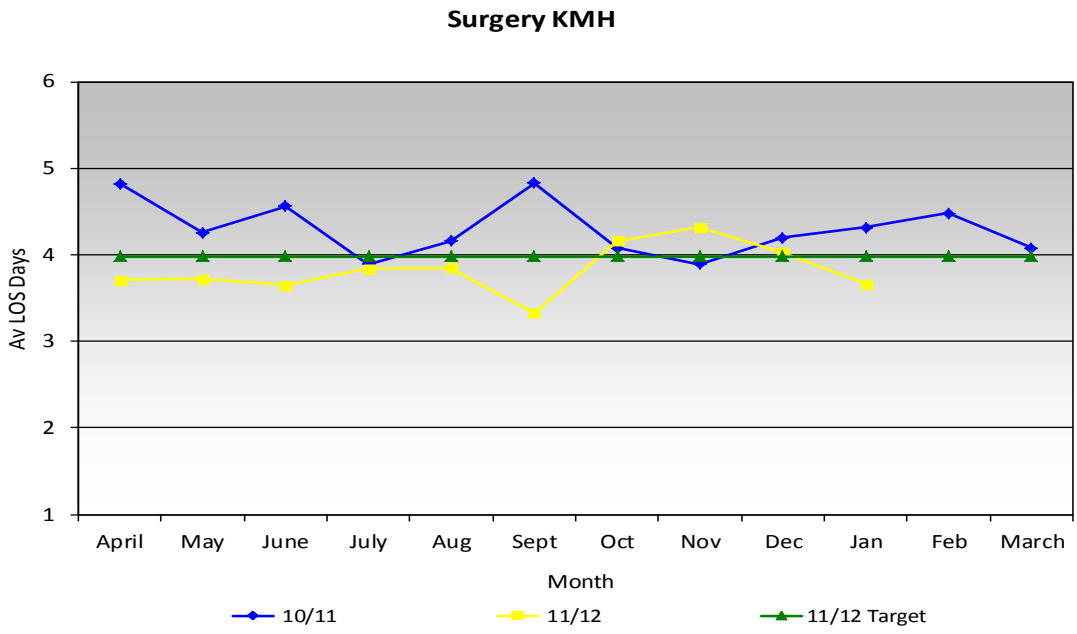
How we have reduced the time people spend in hospital

April 2011 to March 2012

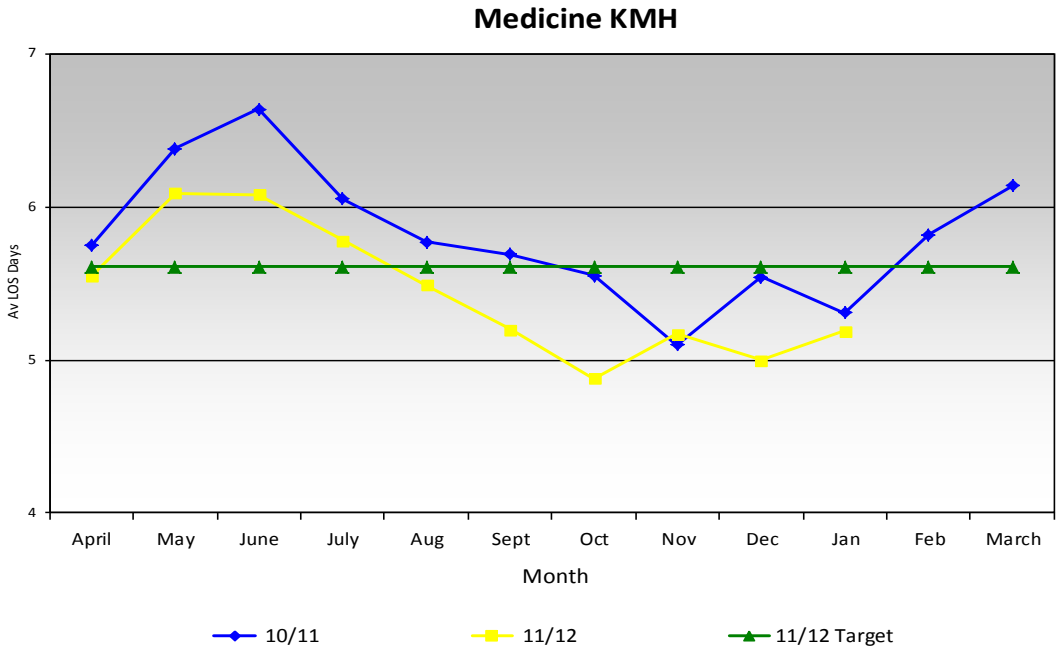
The average length of stay for patients on medical and surgical wards at King's Mill Hospital has fallen when compared with the same period in 2010/11 and we are hitting the targets set for 2011/12. The data is taken from PAS and is set locally.

It is not possible to compare average length of stay at Newark Hospital with 2010/11 on a like for like basis, due to the change in the types of patients seen there during the year.

The average length of stay charts for medical and surgical wards at King's Mill hospital are included below to illustrate the improvement:



Surgery	Average length of stay	**Medicine**	Average length of stay
2010/11	4.30 days	2010/11	5.81 days
2011/12 target	3.98 days	2011/12 target	5.61 days
2011/12 actual	**3.84 days**	2011/12 actual	**5.49 days**



The priority for next year will be to reduce the amount of people who are in hospital when they could be somewhere else, such as their normal place of residence or an alternative care setting.
No patient wants to spend more time in hospital than they need to and it is important that we treat patients as efficiently as possible ensuring that we communicate with them and their families about how long we need for them to stay in hospital for us to treat them.

Over the past 12 months we have consistently reduced length of stay in both medical and surgical specialties and we will continue to seek further reductions whilst at the same time monitoring quality metrics such as readmission rates and day case rates for surgery in order to triangulate patient outcomes and experience.

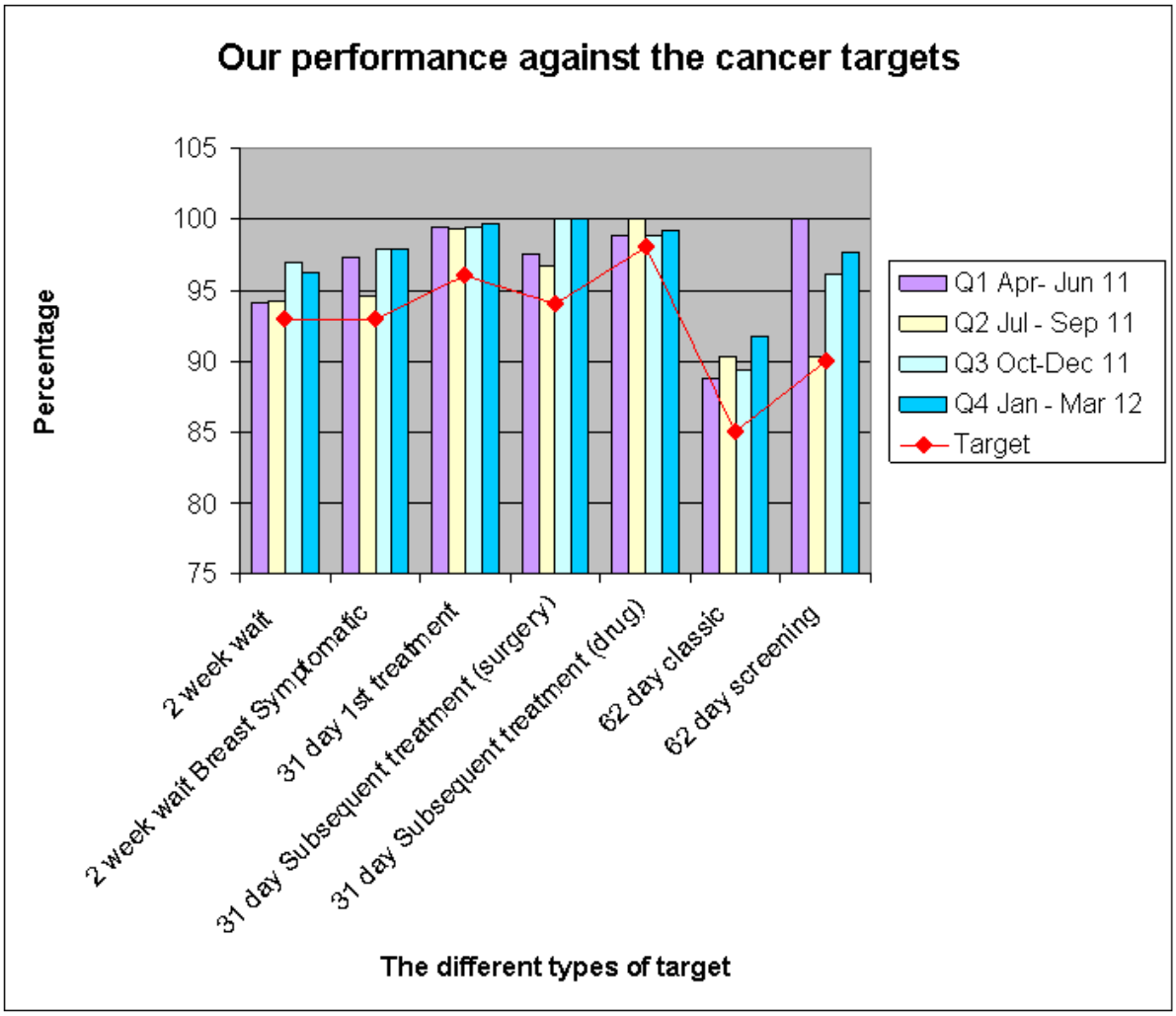
How we have achieved our cancer targets

Patients with or suspected of having cancer expect to have prioritised treatment as this will be one of the most traumatic parts of their lives. The targets that have been set for such patients reflect the importance that the public in general expect for ensuring that priority is given and that hospitals organise themselves to deliver this care.

During the past 12 months the Trust has consistently met these targets, although it has experienced some difficulty with the 62-day target as the numbers of patients treated is small, so that any delay for a patient is reported as a high percentage failure.

The Trust remains one of the best performing in the region and will continue to ensure that this area of its activity remains a key priority.

We are constantly achieving our targets and remain one of the best performing hospitals in the East Midlands. See graph below:



- The **2 week wait** refers to people who are suspected of having cancer; they need to be seen within 2 weeks
- The **2 week wait for breast symptomatic** means any patients who have breast symptoms who are not suspected of having cancer need to be seen within 2 weeks.
- **31 day to first treatment** means any patients with a diagnosis of cancer will be treated within 31 days of the decision to treat them
- **31 days subsequent-surgery** means 31 days from decision to agreement to have surgery following initial treatment to having the surgery
- **62 day classic** means 62 days from referral to receiving the 1st treatment
- **62 day screening** means 62 days from referral from the screening programme to the patient receiving their first treatment.

Our Key Achievements/Improvements

- We continue to review performance and patient pathways through the six weekly Cancer Unit Management Board group
- We continue to track all patients referred with suspected cancer against the National Cancer Waiting Time standards
- We have presented at local Primary Care Group meetings about cancer services and pathways
- All cancer teams participate in the annual National Cancer Peer Review/Accreditation programme

2.3.3 Patient Experience - other priorities

How we have improved the experience of patients with dementia and delirium

There has been a great deal of work undertaken during the last year to ensure that our patients with dementia and delirium receive the very best care. We have looked at the standards set by the National Institute of Health and Clinical Excellence to ensure that the services we provide to our patients meet those standards. We have taken part in a number of audits (including the National Audit of Dementia) and have used the results to plan and change services for this group of patients. We are developing personalised patient documentation for patients with dementia and taking steps to involve carers and family members once patients are admitted to hospital.

Over the past year a programme of dementia education for staff working across the Trust has been rolled out successfully; the aim being to ensure that all members of staff have the appropriate knowledge and skills to allow them to provide a high standard of care for patients with dementia.

The Trust's Dementia Group is a committed group of staff who care passionately about the experience of patients with dementia in our hospitals. The group has written a Dementia Strategy and Care Pathway for patients with dementia who use the services provided by the Trust and these will be launched shortly. The Dementia Group meets regularly to review what is happening across the hospitals and plan how to ensure that improvements are continually made.

Quote from a member of staff**:**

"I find the training really good, I am more confident when treating patients with dementia"

- We achieved the dementia CQUINs for last year: providing dementia training to staff and ensuring that all elderly patients admitted to the Trust had a cognitive assessment carried out (using the AMTS – Abbreviated Mental Test Score)
- Looking ahead, the ACLT (Acute Care Liaison Team) is being expanded to provide seven day working
- We invested in a significant programme of training and review with regards to MCA (Mental Capacity Act) training across the Trust to raise the awareness of mental capacity and dementia to ensure that all of our patients are treated with dignity and respect and that their basic rights were always maintained

How we have improved care for patients who are dying

Using the Commissioning for Quality and Innovation (CQUIN), the Trust's main aim was to ensure that significant improvements were made in improving choice at the End of Life.

We participated in the National Care of the Dying Audit - Hospitals (NCDAH) and have looked at the key performance indicators to try and ensure that the services we provide to our patients meet those standards.

Following on from this report, the Trust has appointed an end of life care co-ordinator, whose role is to train and support staff to maintain and sustain quality for patients and their relatives/carers who are entering the end of life phase, regardless of diagnosis.

Awareness and Educational Actions to Date

- Information has been sent to all ward leaders regarding the role of the end of life care co-ordinator
- Discussion with the training, education and development department to ensure end of life care is covered appropriately with all new and current members of staff, through the mandatory update and induction programme
- Established audit process to monitor compliance of the Liverpool Care Pathway
- Directly receive referrals from wards for patients who have been commenced on the Liverpool Care Pathway and provided direct support for patients, relatives and staff

Awareness and Educational Actions for the Coming Year

- From April 2012 End of Life Care is to be covered in our compulsory training programme, as well as continuing to be covered within the induction programme
- We have designed a workbook for all clinical staff that provides all the information nurses need to ensure compliance with providing quality end of life care
- Recommence link nurse support group
- Finalise a new policy for the Liverpool Care Pathway for the dying patient
- In response to 'The End of Life Care Strategy' (2008) re-establish the General Palliative and End of Life Care steering group, this provides a decision making forum for driving forward effective general palliative and end of life care within the organisation

How we have improved the quality of healthcare for patients with a learning disability

We have a dedicated nurse who provides training and education for staff to ensure quality care services for people with a learning disability. She has developed policies as well as practical tools to help people with a learning disability access our services.

- The Learning Disability (LD) Policy was ratified in October 2011. This explains to people that pathways across inpatients, emergency and outpatients may need to be adjusted to meet the needs of people with a learning disability
- We have implemented a 'Hospital Traffic Light Assessment' which is a patient held document to share information with staff about the needs of the person with a learning disability
- The Risk, Dependency and Support Assessment has been implemented across the hospitals to highlight if any additional support is required for a hospital stay
- A Learning Disability Steering Group takes place quarterly with representation of people with a learning disability, family, carers and hospital staff
- People with learning disabilities have helped to produce an 'easier read' questionnaire to capture patient experience – this will be implemented during 2012
- During the following year the steering group is looking at producing accessible information and an alert card to raise awareness of learning disability to be launched in 2012

Highly Commended by the National Nursing Times

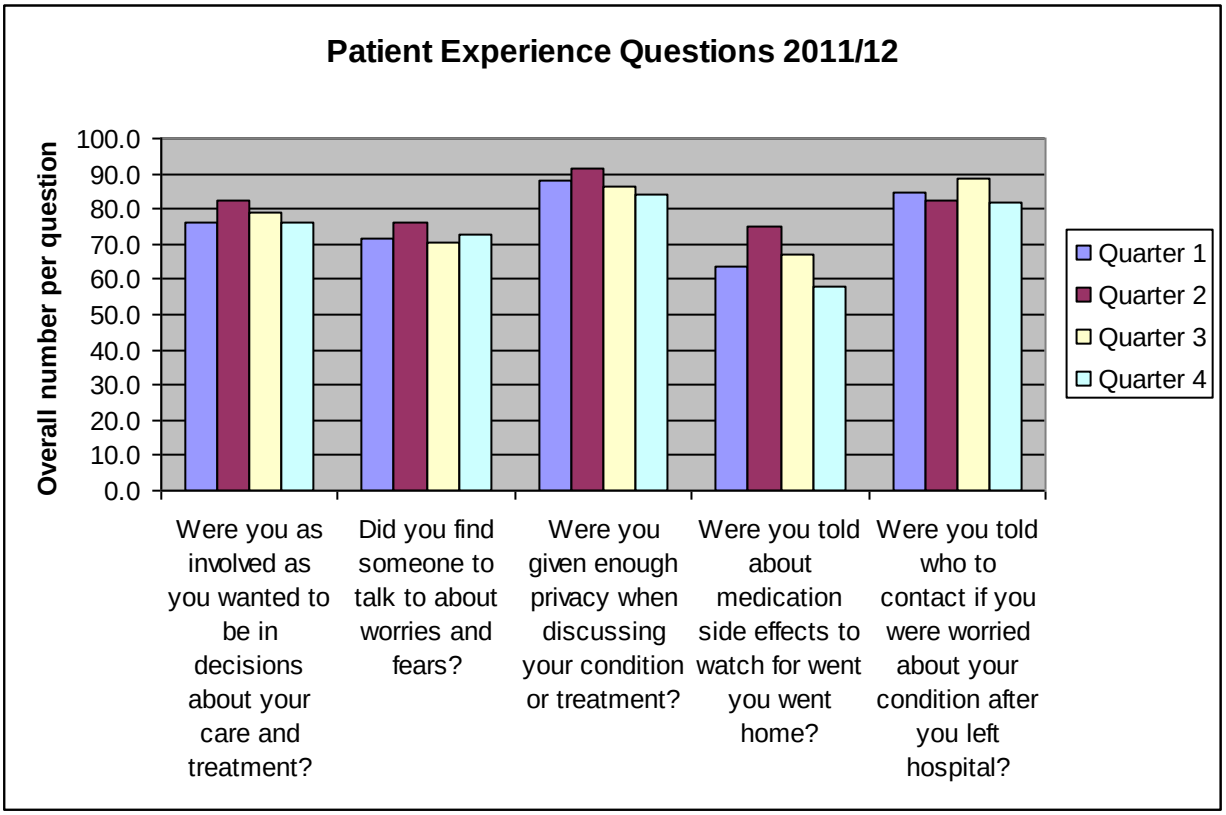
The Learning Disabilities Nursing Project was entered in the National Nursing Times Awards and was highly commended. The project was developed to improve end of life care for people with learning disabilities.

The project, jointly led by us and Nottinghamshire Healthcare Trust, also shortlisted for the Medipex NHS Innovation Awards, has a local focus across Nottinghamshire. The project team has produced a number of resources to support end of life care, including a DVD about receiving bad news, which raises awareness of how to support someone with a learning disability.

The project also aims to improve support for GPs, consultants and nurses, as well as staff in residential units. These changes ensure current support and care are identified and planned at an early stage, thereby reducing inappropriate use of health services and decreasing emergency admissions to hospital.

How we have listened to our patients

Over the past year we have asked a set of questions each month to 200 people who have recently been discharged from hospital. These patients have been home for a few weeks and so are better placed to reflect on their experiences. The graph below shows the scores over the past year. Quarter 4 results will be available in July 2012. The data is gathered by the use of postal questionnaires and is governed by national standard definitions.

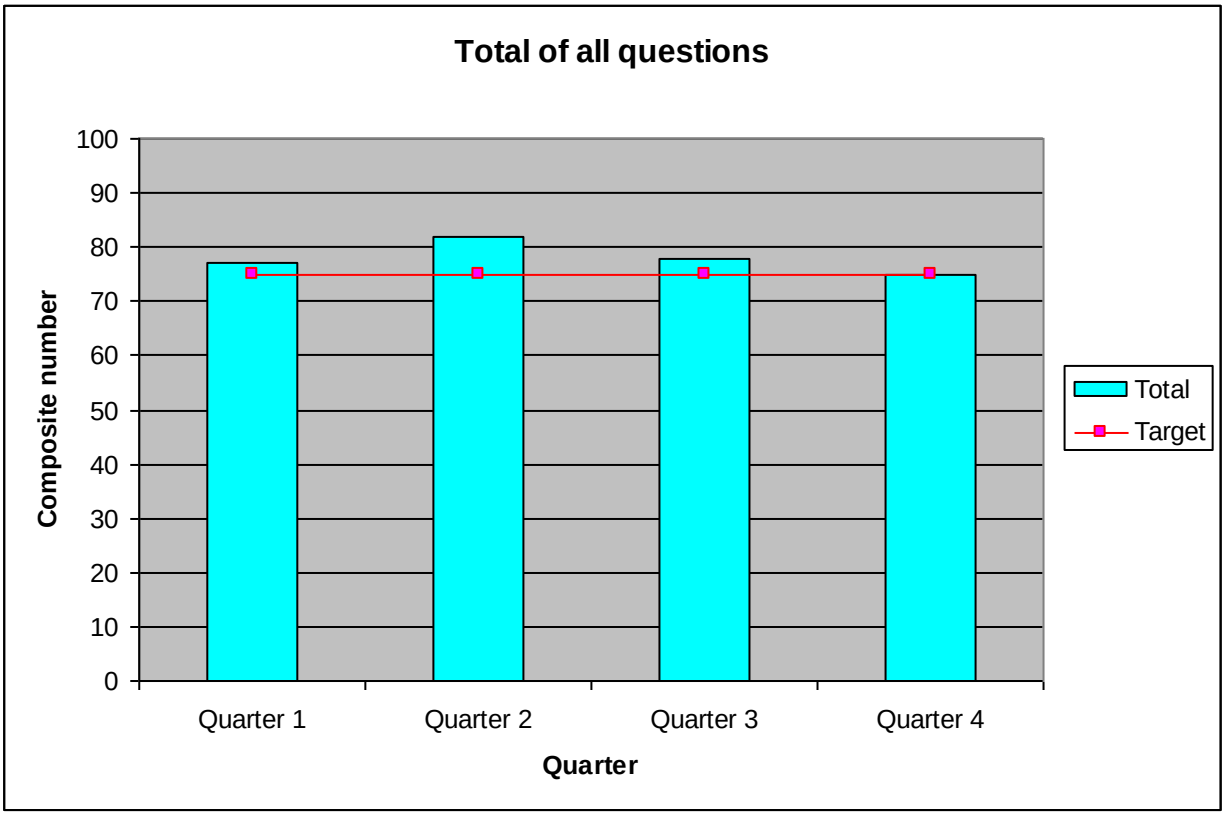


The results show there is room for improvement. Over the past year we have been working with the senior nurses in the organisation and developed a programme for them to ask 10 patients per month a set of questions. This enables them to gain the patient experience at first hand. The senior nurses then discuss their findings with the ward leaders to ensure improvements are made where needed.

Pharmacy is piloting small cards to give to patients to encourage them to ask questions about their medication if they are unsure at any stage.

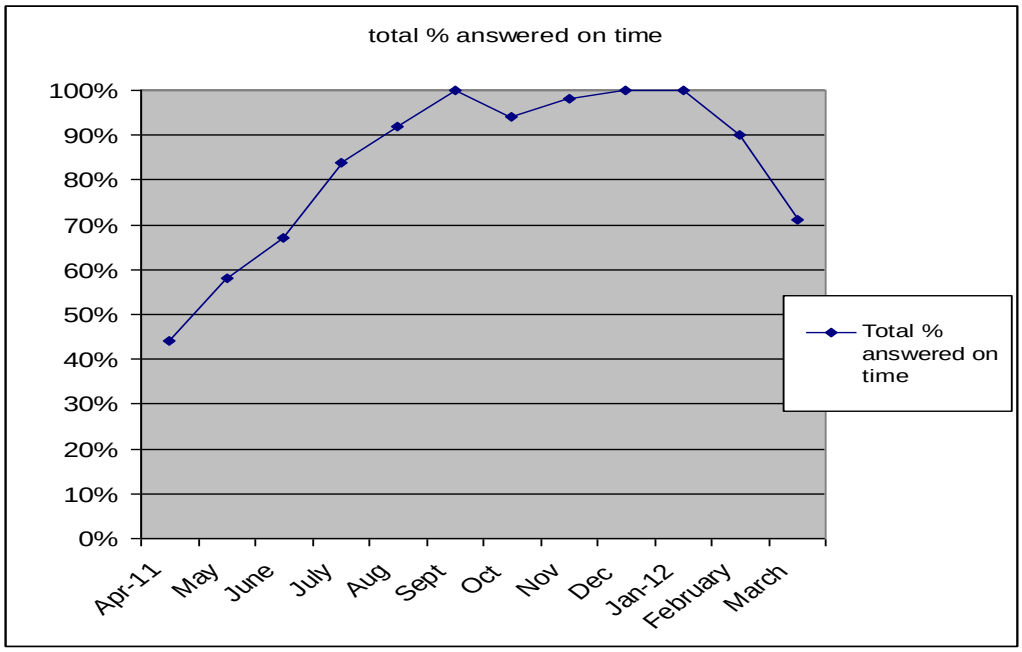
An area for concern is not being able to influence the patient's experience as the questions are asked after discharge. For the coming year the questions will be asked before the patient leaves the ward. This will ensure that if they give a negative answer or if they do have worries these can be addressed before the patient leaves the ward.

The table below shows the cumulative results for the five questions above and the target set for the year. The results are positive but we are striving to do even better for the following year. The overall target for next year has increased to 80%.

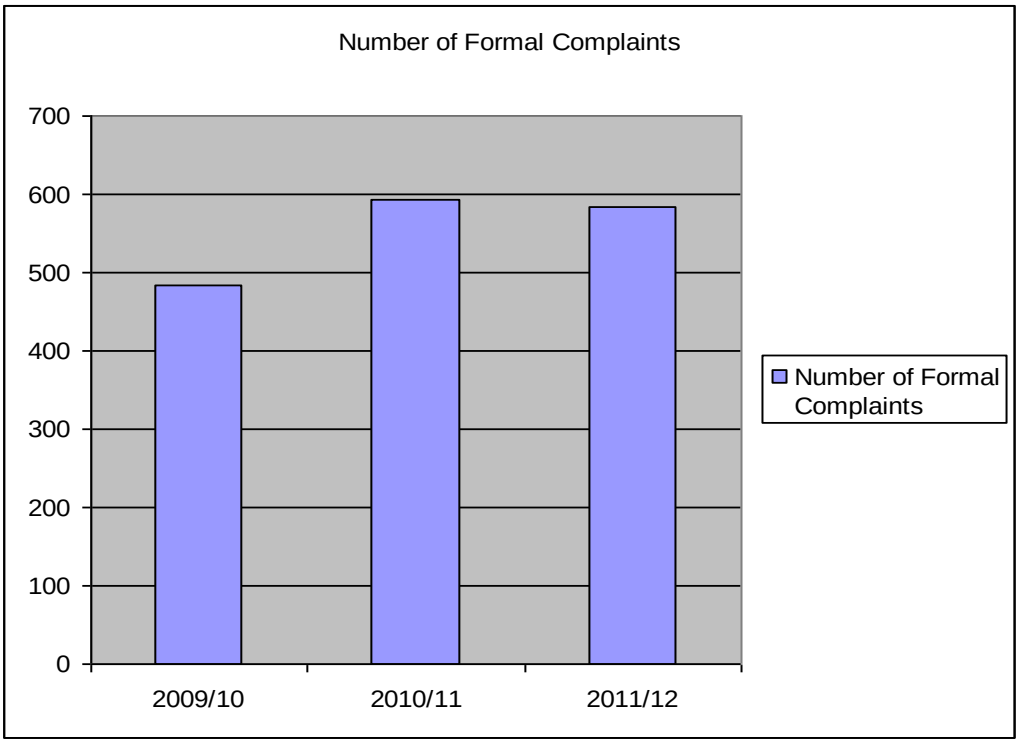


How we have improved the time we respond to people who make a formal complaint

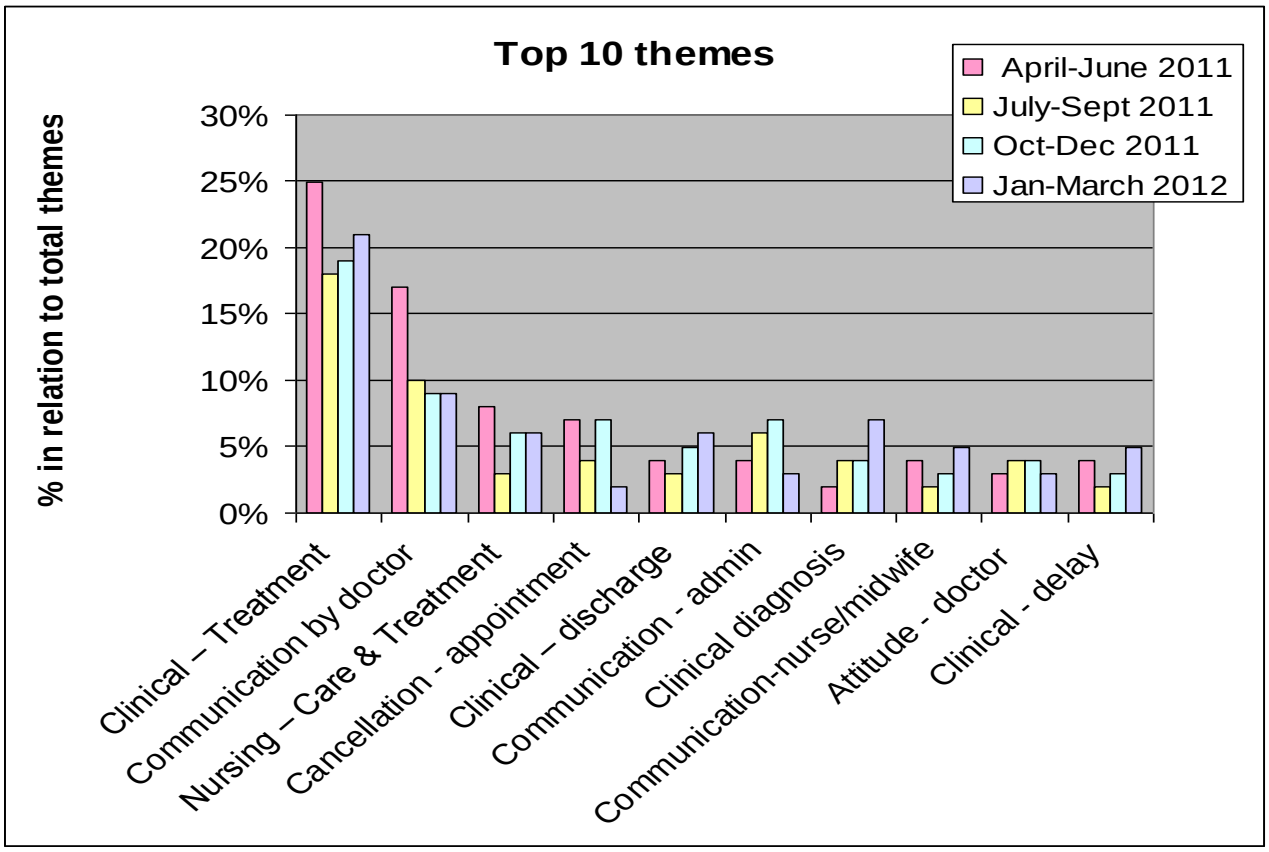
The graph below shows the percentage of people who received a response to their complaint letter within the agreed time frame. Performance was poor at the beginning of the year. An increase in staffing levels and service redesign saw a dramatic increase in the performance. The drop in performance experienced in February and March was in relation to sickness and other competing priorities within the organisation. We have seen more patients admitted and the need for more people to prioritise immediate patient care. We monitor the performance monthly and anticipate an improvement over the coming months.



The graph below shows the number of formal complaints logged for each financial year.



During next year we are working on capturing the lessons learnt from complaints to ensure we learn from what our patients are telling us and are able to make service improvements.



The graph above shows the themes from the letters of complaint for the last year. The percentage is the amount of times each theme was mentioned as a percent of the total subjects mentioned.

2.3.4 An overview of measures

Quality measures that are reported monthly to the Trust Board.

Integrated Performance Measure		Reportable to	Threshold	2011/12	2010/11	2009/10	2008/9	2007/08
Referral to Treatment: Admitted Patient Care *patients treated within 23 weeks*		Monitor	23 weeks	N/A	94.86%	94%	95%	86%
Referral to Treatment: Non Admitted Patient Care *patients treated within 18.3 weeks*		Monitor	18.3 weeks	N/A	98.12%	98.70%	99%	90%
Referral to Treatment: Admitted Patient Care *(95th percentile - patients treated within 23 weeks)*		Monitor	23 weeks	18.14 weeks	N/A 95th percentile reportable from 11/12			
Referral to Treatment: Non Admitted Patient Care *(95th percentile - patients treated within 18.3 weeks)*		Monitor	18.3 weeks	16.14 weeks	N/A 95th percentile reportable from 11/12			
A&E Clinical Quality: Total Time in A&E Dept *(% <4 hour wait)*	SFHFT	Monitor	4 hours > 95%	96.21%	97.70%	98.70%	98%	98%
Re-admissions (within 30 days) Emergency		Internal	-	7.92%	-	-	-	-
A&E Clinical Quality: Unplanned re-attendance rate within 7 days of original attendance		Internal	=<5%	6.17%	-	-	-	-
A&E Clinical Quality: Left without being seen rate		Internal	=<5%	2.09%	-	-	-	-
A&E Clinical Quality: Time to Initial Assessment for patients arriving by emergency ambulance (95th percentile - <15 Minutes)		Internal	=<15	49	-	-	-	-
A&E Clinical Quality: Time to Initial Assessment for patients arriving by emergency ambulance (Median Minutes)		Internal	=<16	7	-	-	-	-
A&E Clinical Quality: Time to Treatment (Median minutes wait from arrival to treatment)		Internal	=<60	55	-	-	-	-
Cancer 2 week wait: All Cancers		Monitor	93%	95.32%	94.20%	94.40%	99.80%	99.70%
Cancer 2 week wait: Breast Symptomatic		Monitor	93%	96.39%	95.10%	92.80%	-	-
Cancer 31 day wait: from diagnosis to first treatment		Monitor	96%	99.60%	99.60%	98.80%	99.30%	99.80%

Cancer 31 day wait: for subsequent treatment - surgery	Monitor	94%	98.98%	97.30%	94.30%	-	-
Cancer 31 day wait: for subsequent treatment - drugs	Monitor	98%	99.70%	99.20%	99.70%	-	-
Cancer 62 day wait: urgent referral to treatment	Monitor	85%	89.54%	89.70%	84.50%	-	-
Cancer 62 day wait: for first treatment - screening	Monitor	90%	96.35%	93.10%	90.50%	-	-
Infection Prevention Control: MRSA Bacteraemia *(No. of cases attributed to Trust)*	Monitor	0	0	0	14	31	26
Infection Prevention Control: Clostridium Difficile Infections *(No. of cases attributed to Trust)*	Monitor	43	45	54	96	177	324
Access to Healthcare for people with learning disabilities	Monitor	Compliant					

2.3.5 What do other people say about this Quality Report?

Comments from the Overview and Scrutiny Committee

The committee notified us that they did not intend to review our report this year and therefore we are not expecting any feedback.

Comments from the Primary Care Trust

"NHS Nottinghamshire County Primary Care Trust (PCT) monitors quality and performance at the Trust throughout the year. There are monthly quality and performance review meetings and frequent ongoing dialogue as issues arose. A number of visits to wards and other patient areas have taken place in response to in-year issues. The PCT also has an appointed Governor at the Trust therefore enabling us to better understand the views and concerns of public and staff Governors. The information brought together from these different sources has been used to support assessing our level of assurance.

"Towards the end of the year the Trust successfully implemented improvements which have led to the removal of concerns raised by the Care Quality Commission relating to patient records and consent (especially assessments associated with the Mental Capacity Act).

"The Trust continues to demonstrate a high level of commitment to patient safety and experience. This report describes the areas of good practice reported to us and areas of concern we have monitored the Trust against. Including the failure to achieve the required reduction in Clostridium Difficile (an infection acquired whilst in hospital) and the two Never Events. We are assured that the Trust has reviewed its processes and implemented change in response to both issues.

"The Trust has considerable financial challenges in the year ahead and we will seek further assurances of service quality as changes take effect."

Comments from the Local Involvement Network

"Overall Nottinghamshire County LINk is impressed with the in-roads that Sherwood Forest Hospitals NHS Foundation Trust has made into infection control, with particular reference to MRSA. However, we are disappointed to find that some of the data is incomplete and inconsistent throughout the document which means we are unable to fully comment on the report. The LINk would like to commend your achievements in the reduction of pressure ulcers, the use of same sex accommodation and your focus on safeguarding".

Explanatory note: This Quality Report was shared with stakeholders on 10 April for a requested 4 week response, as detailed in the Monitor guidelines. The draft document at that time did not include all year-end figures as they were not available. The LINk have been given the opportunity to comment on a more recent draft, but declined as they did not have a Board meeting scheduled in the required timeframe.

2.3.6 Statement of Directors' Responsibility in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (quality Accounts) Regulations 2010 as amended to prepare Quality accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12
- Papers relating to the quality reported to the board over the period April 2011 to June 2012
- Feedback from the commissioners dated 21 May 2012
- Feedback from the governors dated 24 May 2012
- Feedback from LINks dated 3 May 2012
- The Trust's complaints report published under regulation 18 of the local authority social services and NHS complaints regulations 2009, dated June 2011
- The latest national patient survey dated April 2011
- The latest staff survey dated March 2011
- The Head of Internal Audit's opinion over the Trust's control environment dated April 2012
- CQC quality and risk profiles dated 2011/12
- The quality report presents a balanced picture of the NHS Foundations Trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the Board.

Tracy Doucét
Chairman
29 May 2012

Martin Wakeley
Chief Executive
29 May 2012

3. ANNUAL ACCOUNTS

3.1 Financial Statements

3.1.1 Statement of the Chief Executive Officer's Responsibilities as the Accounting Officer of Sherwood Forest Hospitals NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive Officer 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 National Health Service 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 recognized gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

• Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

• Make judgments and estimates on a reasonable basis;

• State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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*.

Martin Wakeley
Chief Executive
29 May 2012

3.1.2 FTC Summarisation Schedules

Summarisation schedules numbers FTC01 to FTC40 and the WGA schedules for 2011/12 are attached.

Chief Financial Officer 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* 2011/12 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.

Fran Steele
Chief Financial Officer
29 May 2012

Chief Executive Officer Certificate

1. I acknowledge the attached FTC schedules, which have been prepared and certified by the Chief Financial Officer, 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 Chief Financial Officer above.

Martin Wakeley
Chief Executive
29 May 2012

3.1.3 External Audit Opinion and Certificate

INDEPENDENT AUDITOR'S 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 2012 on pages 160 to 202. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 155, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Sherwood Forest Hospitals NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Sherwood Forest Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

29 May 2012

INDEPENDENT AUDITOR'S REPORT TO MONITOR ON THE SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the NHS Foundation Trust Consolidation Schedules numbered FTC01 to FTC 40 of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2012, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to Monitor in accordance with paragraph 5.6 of the Audit Code for NHS Foundation Trusts (March 2011) and for no other purpose.

In our opinion the Consolidation Schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion and certificate.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

29 May 2012

3.2 Annual Accounts 2011/12

3.2.1 Foreword by the Chief Executive

FOREWORD TO THE ACCOUNTS FOR THE YEAR ENDED

31 MARCH 2012

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

These financial statements for the year ended 31 March 2012 have been prepared by the Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraph 24 and 25 of Schedule 7 to the National Health Service Act 2006. They are presented in the form which Monitor has, with the approval of the Treasury, directed.

The 4 key financial statements are supported in Section A by an outline of the basis of preparation and the Trust specific context. Section B details the overarching accounting policies. More detailed notes to the statements are provided in Section C and cross referenced where appropriate

The previous accounts were for the year ended 31 March 2011.

Martin Wakeley
Chief Executive
29 May 2012

3.2.2 Financial statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Operating income	*C1-C4, C.6.4,C8*	252,823[1]	252,443[2]
Operating expenses	*C5,C6.1*	(240,530)[1]	(236,865)[2]
Operating surplus/(deficit)		**12,293**	**15,578[2]**
Finance costs			
Finance income	*C12.1*	306	329
Finance costs – financial liabilities	*C12.2*	(18,796)	(14,645)
Net finance costs		**(18,490)**	**(14,316)**
Retained surplus / (deficit) for the year (excluding impairments)		**(6,197)**	**1,262**
Reversal of Impairment	*C15*	13,258	6051
Impairment	*C15*	(2,878)	(147,944)
Retained surplus / (deficit) for the year		**4,183**	**(140,631)**
Other comprehensive income			
Impairments	*C15*	(103)	(13,824)
Revaluation gains on property	*C15*	0	2,851
Other reserve movements	*SOCITE*	0	(212)
Total comprehensive income / (expense for the year		**4,080**	**(151,816)**

The notes in C. under section 3.2.5 form part of these accounts and are cross referenced as appropriate.

[1] In 2011/12 the Trust undertook additional services as part of 'Transforming Community Services'. The impact of this change, (c. £14.5m) and the effect on income and expenditure is reflected in the notes to the accounts.

[2] IAS 20 Government grant funded and donated assets came into effect in year (Accounting Note B.6.4). As a result a prior period adjustment has been made to the 2010/11 Operating income. The change in treatment improved the previously reported position by £0.71m from (£141.337m) to (£140.631m).

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	Note	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Non-current assets			
Intangible assets	C14	1,229	1,963
Property, plant and equipment	C13	232,006	224,942
Trade and other receivables	C18	1,065	1,032
Total non-current assets		**234,300**	**227,937**
Current assets			
Inventories	C17	2,885	2,816
Trade and other receivables	C18	9,875	12,375
Cash and cash equivalents	C21	22,766	29,685
Total current assets		**35,526**	**44,876**
Current liabilities			
Trade and other payables	C19	(26,236)	(28,458)
Borrowings	C20,C24	(4,880)	(4,639)
Provisions	C22, C23	(1,224)	(6,779)
Other liabilities		(8,780)	(3,273)
Total current liabilities		**(41,120)**	**(43,149)**
Non-current liabilities			
Trade and other payables	C19	(5,905)	(6,039)
Borrowings	C20,C24	(349,790)	(354,670)
Provisions	C22	(504)	(528)
Total non-current liabilities		**(356,199)**	**(361,237)**
Total assets employed		**(127,493)**	**(131,573)**
Financed by taxpayers' equity			
Public dividend capital		84,303	84,303
Revaluation reserve		14,909	16,962
Income and expenditure reserve		(226,705)	(232,838)
Total taxpayers' equity		**(127,493)**	**(131,573)**

The Trust, under the National 'Transforming Community Services', entered a three year contract on the 1st May 2011. No assets have been transferred and therefore the 2009/10 Statement of Financial Position is not disclosed above.

The financial statements over sections 3.2.2 to 3.2.5 were approved by the Board and signed on its behalf by:

Martin Wakeley, **Chief Executive,** 29 May 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public dividend capital (PDC)	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 31 March 2011					
As previously stated	84,303	16,962		(232,838)	(131,573)
Retained surplus / (deficit) for the year				4,183	4,183
Net gain / (loss) on revaluation of property, plant and equipment		(103)			(103)
Transfer of excess current cost depreciation over historical cost depreciation		(247)		247	0
Other transfers between reserves		(1,703)		1,703	0
Taxpayers' equity at 31 March 2012	**84,303**	**14,909**	**0**	**(226,705)**	**(127,493)**
Taxpayers' equity at 31 March 2010					
As previously stated	84,303	27,963	1,965	(93,988)	20,243
Prior period adjustment			(1,965)	1,965	0
Retained surplus / (deficit) for the year				(140,631)	(140,631)
Net gain / (loss) on revaluation of intangible assets					
Net gain / (loss) on revaluation of property, plant and equipment		(10,973)			(10,973)
Transfer of excess current cost depreciation over historical cost depreciation		(28)		28	
Other recognised gains and losses				(212)	(212)
Taxpayers' equity at 31 March 2011	**84,303**	**16,962**	**0**	**(232,838)**	**(131,573)**

Note B.6.4 relates to the change in the treatment of charitable expenditure. As a result of the change capital purchases donated to the Trust are now recognised within income on receipt and associated reserves have been transferred to the Income and expenditure reserve. This does not impact on the separate Governance or Management and reporting arrangements relating to Sherwood Forest Hospitals General Charitable Fund (Charity Registration Number 1054086)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Note	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Net cash generated from operating activities			
Operating surplus / (deficit) from operations		22,673	(126,315)[3]
Depreciation and amortisation		8,463	8,609
Impairments and reversals		(10,380)	141,893[3]
(Increase) / decrease in trade and other receivables		2,467	(1,511)
(Increase) / decrease in inventories		(69)	28
(Decrease) / increase in trade and other payables		(4)	7,613
(Decrease) / increase in provisions		(5,579)[4]	5,774
(Decrease) / increase in other liabilities		5,507	(2,820)
Other movements in operating cash flows		(360)	(795)
Net cash inflow from operating activities		**22,718**	**32,476**
Cash flows from investing activities			
Interest received		306	329
Payments to acquire intangible assets		(11)	(218)
Purchase of property, plant and equipment		(6,501)	(18,821)
Net cash (outflow) from investing activities		**(6,206)**	**(18,710)**
Cash flows from financing activities			
Capital element of finance lease rental payments		0	(2)
Capital element of private finance initiatives		(4,639)	(3,657)
Interest element of private finance initiative		(18,796)	(14,645)
Public dividend capital paid		0	(48)
Other financing activities		4	1,018
Net cash used in financing activities		**(23,431)**	**(17,334)**
(Decrease) in cash and cash equivalents		**(6,919)**	**(3,568)**
Cash and cash equivalents at 1 April		**29,685**	**33,253**
Cash and cash equivalents at 31 March		**22,766**	**29,685**

[3] The significant movement in the prior year includes impairment on completion of PFI redevelopment.

[4] Movement relates to contract disputes which were finalised in year.

3.2.3 A. Basis of preparation and Trust specific context

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Annual Reporting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. 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.

A.1 Basis of preparation

In accordance with IAS 1 these accounts have been prepared on a going concern basis and for the period to twelve months from the proposed date of the audit opinion the Directors have sufficient assurance that the Trust will continue as a going concern.

Whilst the Trust has recorded a deficit before impairment for 2011/12 of £6.18m this is a significant favourable variance to the original plan which forecast a deficit of £9.44m. This improvement combined with a renegotiation of the working capital facility in year has significantly improved the actual and forecast cash position of the Trust.

The Trust continues to have a significant cost reduction target for 2012/13. There is also a much wider programme of actions to mitigate the risk to cash on an ongoing basis. This drive for continued improvements in efficiency is undertaken in an environment where quality and safety are paramount.

Regulators and the Trust's External Auditors have been, and will continue to be, kept informed throughout the development and implementation of those actions.

A.2 Trust Specific Context

A.2.1 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.

A.2.2 Third Party Assets

The Trust held £nil (£nil in 2010/11) as cash in hand or at bank at 31 March 2012 on behalf of patients or other third parties.

A.2.3 Related party transactions

Sherwood Forest Hospitals NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Sherwood Forest Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent entity. A detailed schedule of income and expenditure is shown in note C.28.

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 Trust Board of Directors. Sherwood Forest Hospitals Charitable Funds purchased goods and services for the Trust during the financial year, and also provided purchases for patients and staff at Sherwood Forest Hospitals. The administration of the Charity is carried out by the Trust, and during the financial year the Trust charged the Charity for this service.

The audited accounts / Summary Financial Statements of the Funds Held on Trust are available separately.

3.2.4 B. Accounting Policies

B.1. Key judgements and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

In year a revaluation was undertaken by the 'Valuation Agency Office' of the land and building assets of the Trust under the modern equivalent cost valuation method. The movements in market value have been reflected in the financial position and are separately identified in notes C.1.3. and C.5.

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.

B.2. Changes to Accounting Standards

The Trust is aware of proposed changes to accounting standards which are relevant to this Trust such as IAS 16, Property Plant and Equipment, IAS 32 Financial Instruments: Presentation. Based on the current proposals, any changes implemented would have no impact on the financial statements as presented.

B.3. 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.

B.4. Expenditure on employee benefits

B.4.1 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.

B.4.2 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 the 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.

B.5. 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.

B.6. Property, plant and equipment

B.6.1 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.

B.6.2 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.

• Intangibles	5	years
• Plant and machinery	5 - 15	years
• Transport	7	years
• Information Technology	5	years
• Furniture and furnishings	5 - 10	years
• Buildings	50 - 70	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 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

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

B.6.3 De-recognition

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

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

B.6.4 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

*B.6.5 Private finance initiative (PFI) transa*ctions

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. A PFI liability is recognised at the same time as the PFI asset is recognised. It is measured initially at the same amount as the fair value for the PFI assets and is subsequently measures as a finance lease liability 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 applied to the opening lease liability for the period and is recognised in finance costs.
The service charge is recognised in operating expenses and the finance cost is charged to 'finance costs' in the Statement of Comprehensive Income.

B.7. Intangible assets

B.7.1 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.

B.7.2 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.
Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

B.7.3 Amortisation

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

B.8. 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.

B.9. 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.

B.10. Financial instruments and financial liabilities

B.10.1Recognition

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.

B.10.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

B.10.3 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'.

B.10.4 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. 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.

B.10.5 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.

B.10.6 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.

B.10.7 Determination of fair value

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

B.10.8 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate.

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

B.11. Leases

B.11.1 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.

B.11.2 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.

B.11.3 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.

B.12. 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, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

B.12.1 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 £30.287m (2010/11 £19.696m).

B.12.2 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.

B.13. Contingencies

Contingent assets, that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note C.23. unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

B.14. Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor 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. The Trust does not currently pay any PDC as it has negative net relevant assets, due to the impairment of the main PFI.

B.15. 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.

B.16. Corporation Tax

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

B.17. Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

B.18. Third party assets

Assets belonging to third parties such as money held on behalf of patients are not recognised in the accounts since the 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 Reporting Manual.

B.19. 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.

B.20. Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.
Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks.

3.2.5 C. Detailed Notes to the Financial Statements

C.1. Operating Income	Year ended 31 March 2012	Year ended 31 March 2011
C.1.1 **Income from activities**	**£000**	£000
NHS Trusts	1,608	1,724
Primary Care Trusts	205,295[5]	190,197
Non NHS:		
- Private patients	162	182
- NHS injury scheme [6]	1,181	1,221
	208,246	**193,324**

[6] NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection. (9.6% 2010/11)

C.1.2 **Analysis of income from activities**		
	£000	£000
Inpatient - elective income	38,926	41,613
Inpatient - non elective income	65,519	65,949
Outpatient income	40,840	40,757
A & E income	10,553	9,496
Other NHS clinical income	49,457[6]	32,382
Private patient income	162	182
Other non protected clinical income	2,789	2,945
Total income from activities	**208,246**	**193,324**

C.1.3 **Other operating income**		
	£000	£000
Research and development	543	359
Education and training	12,050	11,880
Charitable and other contributions to expenditure	645	1,544
Non patient care services to other bodies	11,571	17,583
Other income	19,768[7]	27,753
Total other operating income (excluding impairments)	**44,577**	**59,119**
Reversal of impairments	13,258	6,051
Income from continuing operations	**266,081**	**258,494**

[5] Change in year reflects the additional income received due to the transfer of community services to the Trust under a three year contract as part of the National 'Transforming Community Services' programme.

[7] The reduction is due to the cessation of funding from the NHS Bank to support additional running costs during the PFI re-development (£7.2m 2010/11).

C.1.4 Income from mandatory services

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Income from activities	208,246	193,324
Less: NHS injury cost recovery scheme	(1,181)	(1,221)
Private patient income	(162)	(182)
	206,903	**191,921**

C.2. Private patient income

	Year ended 31 March 2012	Year ended 31 March 2011	Base Period
	£000	£000	£000
Private patient income	162	182	198
Total patient related income	208,246	193,324	101,221
Proportion (as a percentage) [8]	0.08%	0.09%	0.20%

[8] 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 2002/03 (the base year). The Trust received 0.08% of its patient related income from private patients during the year ended 31 March 2012, which is within the limit which Monitor has set at 0.20%.

C.3. Segmental analysis

Sherwood Forest Hospitals NHS Foundation Trust acts as a lead body for the Nottinghamshire Health Informatics Service. Income and expenditure for this function is not material to the overall accounts and has not therefore been separately disclosed. Expenditure is broadly in line with income for this body. 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.

C.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. These are not material transactions in terms of the overall income of the Trust.

C.5. Operating expenses

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Services from Foundation Trusts	159	239
Services from other NHS Trusts	155	1,785
Services from other NHS bodies	894	1,285
Purchase of healthcare from non NHS bodies	296	438
Employee expenses – executive directors	1,119	730
Employee expenses – non executive directors	146	137
Employee expenses – staff	152,113	148,341
Drugs	14,101	13,101
Supplies and services – clinical	17,863	17,094
Supplies and services – general	1,083	1,230
Establishment	2,334	2,593
Transport	257	168
Premises	15,481[9]	12,196
Provision for impairments of receivables	346	27
Depreciation of property, plant and equipment	7,722	7,680
Amortisation of intangible assets	741	929
Auditor's services – statutory audit	56	70
Other auditors' remuneration	44	14
Clinical negligence	4,408	3,519
Loss on disposal of property, plant and equipment [10]	0	304
Legal fees	189	672
Consultancy services	1,351	1,847
Decommissioning / workforce transformation[11] / [12]	1,619	1,995
Training, courses and conferences	556	624
Early retirements	56	55
Redundancy [12]	2,335	0
Hospitality	153	195
Losses, ex gratia and special payments	6	12
Other[13]	14,947	19,585
Operating expenses of continuing operations (excluding impairments)	**240,530**	**236,865**
Impairments of property, plant and equipment	2,878	147,944
Operating expenses of continuing operations	**243,408**	**384,809**

[9] Additional costs 2011/12 relate to premises rental costs associated with TCS.
[10] The 2010/2011 losses noted above all relate to plant, property and I.T. equipment which are all non protected assets.
[11] 2010/11 includes the decommissioning of resources, an East Midlands procurement collaborative which was discontinued on 31st March 2011 at a cost of £711k. 2011/12 relates to additional costs incurred in delivering the cost reduction and pay/non-pay review.
[12] Costs incurred as part of the Trust's cost improvement and service delivery review programme.
[13] This includes service charge payments made to the Trust's PFI partner. Details of our PFI schemes are detailed in note C.20.

C.6. Operating leases (excluding off balance sheet PFI)	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
***C.6.1* As lessee**		
Minimum lease payments	206	456
Total	**206**	**456**
***C.6.2* Future minimum lease payments due**	**£000**	£000
Payable		
Not later than one year	173	295
Between one and not later than five years	328	316
Later than five years	157	214
Total	**658**	**825**
***C.6.3* As lessor**	**£000**	£000
Rents recognised in period	1,917[14]	461
Total	**1,917**	**461**
***C.6.4* Total future minimum lease payments**	**£000**	£000
Receivable		
Not later than one year	302	58
Between one and not later than five years	2,487[14]	219
Later than five years	417	488
Total	**3,206**	**765**

[14]Movement relates to new Oncology suite. Lease income was not recognised in 2010/11 as the contractual arrangements were not finalised.

C.7. Limitation on auditors' liability	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Limitations on auditors' liability	500	500

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.

C.8. Employee costs and numbers

C.8.1 Employee costs

	Year ended 31 March 2012 £000	Permanently employed £000	Other £000	Year ended 31 March 2011 £000
Salaries and wages	122,790	122,790	0	119,272
Social security costs	8,885	8,885	0	8,698
Employer contributions to NHS pension scheme	14,424	14,424	0	14,189
Termination benefits	2,655	2,655	0	92
Agency costs	6,884	0	6,884	6,821
	155,638	**148,754**	**6,884**	**149,072**

8.2 Average number of persons employed

	Year ended 31 March 2012 Number	Permanently employed Number	Other Number	Year ended 31 March 2011 Number
Medical and dental	446	389	57	449
Administration and estates	841	837	4	904
Healthcare assistants and other support staff	647	647	0	594
Nursing, midwifery and health visiting staff	1,151	1,099	52	1,092
Scientific, therapeutic and technical staff	462	460	2	448
	3,547[15]	**3,432**	**115**	**3,487**

[15] Current year figures include an additional 200 staff who transferred to the Trust under TCS.

C.9. Retirements due to ill-health

During 2011/12 there were 4 (2010/11 5) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £308k (2010/11 £141k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

C.10. Better Payment Practice Code

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2012		Year ended 31 March 2011	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	53,422	116,695	51,891	113,359
Total non-NHS trade invoices paid within target	51,212	114,284	50,279	111,896
Percentage of non-NHS trade invoices paid within target	96%	99%	97%	99%
Total NHS trade invoices paid in the year	1,763	15,662	1,547	14,130
Total NHS trade invoices paid within target	1,611	14,040	1,405	13,371
Percentage of NHS trade invoices paid within target	91%	90%	91%	95%

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.

C.11. The Late Payment of Commercial Debts (Interest) Act 1998

No amounts have been included in finance costs (2010/11 nil) and no compensation has been paid to cover debt recovery costs under this legislation.

C.12. Finance income

C.12.1 Interest receivable

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Bank accounts	306	329
Total	**306**	**329**

C.12.2 Finance costs

	£000	£000
Interest on long term obligations under PFI finance leases	192	0
Interest on obligations under PFI finance leases	18,604	14,645
Total	**18,796**	**14,645**

C.13. Property, plant and equipment

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: at 1 April 2011	**17,977**	**483,829**	**1,014**	**788**	**27,953**	**4,731**	**362**	**536,654**
Additions purchased	(3)	2,915	140		889	194	12	4,147
Additions donated		39			307		14	360
Impairments	(953)							(953)
Reclassifications		(11,686)	(249)	(788)	(275)	16		(12,982)
Revaluation surpluses		850						850
Other in year revaluation								
Reclassified as held for sale								
Disposals		(164)			(549)	(1,048)	(82)	(1,843)
At 31 March 2012	**17,021**	**475,783**	**905**	**0**	**28,325**	**3,893**	**306**	**526,233**
Depreciation at 1 April 2011	0	293,687	249	0	14,714	2,916	146	311,712
Provided during the year		4,550			2,461	674	37	7,722
Impairments	75	2,803						2,878
Reversal of impairments		(13,258)						(13,258)
Reclassifications		(12,476)	(249)		(270)	9		(12,986)
Revaluation surpluses								
Other in year revaluation								
Reclassified as held for sale								
Disposals		(166)			(545)	(1,048)	(82)	(1,841)
Depreciation at 31 March 2012	**75**	**275,140**	**0**	**0**	**16,360**	**2,551**	**101**	**294,227**
Net book value at 31 March 2012								
Purchased	16,946	12,170	905		10,855	1,336	173	42,385
Donated		1,425			1,110	6	32	2,573
PFI		187,048						187,048
Finance lease								
Total at 31 March 2012	**16,946**	**200,643**	**905**	**0**	**11,965**	**1,342**	**205**	**232,006**
Protected	**13,746**	**200,093**						**213,839**
Non protected assets	**3,200**	**550**	**905**		**11,965**	**1,342**	**205**	**18,167**

Prior year:

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation: at 1 April 2010	**16,010**	**308,161**	**884**	**79,257**	**27,154**	**4,539**	**240**	**436,245**
Additions purchased	1,143	117,833	130	143	2,245	782	101	122,377
Additions donated		1,018			55		21	1,094
Impairments		(13,824)						(13,824)
Reclassifications		78,612		(78,612)				0
Revaluation surpluses	824	2,028						2,852
Other in year revaluation								0
Reclassified as held for sale								0
Disposals		(9,999)			(1,501)	(590)		(12,090)
At 31 March 2011	**17,977**	**483,829**	**1,014**	**788**	**27,953**	**4,731**	**362**	**536,654**
Depreciation at 1 April 2010		157,560	249		12,988	2,808	106	173,711
Provided during the year		4,029			2,914	697	40	7,680
Impairments		141,893						141,893
Reversal of impairments								
Reclassifications								
Revaluation surpluses								
Other in year revaluation								
Reclassified as held for sale								
Disposals		(9,795)			(1,188)	(589)		(11,572)
Depreciation at 31 March 2011	**0**	**293,687**	**249**	**0**	**14,714**	**2,916**	**146**	**311,712**
Net book value at 31 March 2011								
Purchased	17,977	24,999	765	788	11,903	1,802	196	58,430
Donated	0	1,077	0	0	1,336	13	20	2,446
PFI	0	164,066	0	0	0	0	0	164,066
Finance lease	0	0	0	0	0	0	0	0
Total at 31 March 2011	**17,977**	**190,142**	**765**	**788**	**13,239**	**1,815**	**216**	**224,942**
Protected	**14,462**	**189,542**	**0**	**0**	**0**	**0**	**0**	**204,004**
Non protected assets	**3,515**	**600**	**765**	**788**	**13,239**	**1,815**	**216**	**20,938**

C.14. Intangible assets

	Software licenses and trademarks 2011/12 £000		Software licenses and trademarks 2010/11 £000
Cost or valuation at 1 April 2011	**5,314**	**Cost or valuation at 1 April 2010**	**5,138**
Revaluation		Revaluation	
Impairments		Impairments	
Reclassifications	(11)	Reclassifications	
Revaluation surpluses		Revaluation surpluses	
Additions purchased	11	Additions purchased	218
Additions internally generated		Additions internally generated	
Additions donated		Additions donated	
Reclassified as held for sale		Reclassified as held for sale	
Disposals		Disposals	(42)
Gross cost at 31 March 2012	**5,314**	**Gross cost at 31 March 2011**	**5,314**
Amortisation at 1 April 2011	**3,351**	Amortisation at 1 April 2010	**2,464**
Provided during the year	741	Provided during the year	929
Indexation		Indexation	
Impairments		Impairments	
Reversal of impairments		Reversal of impairments	
Reclassifications	(7)	Reclassifications	
Other revaluation		Other revaluation	
Reclassified as held for sale		Reclassified as held for sale	
Disposals		Disposals	(42)
Amortisation at 31 March 2012	**4,085**	**Amortisation at 31 March 2011**	**3,351**
Net book value: at 31 March 2012	**1,229**	**Net book value: at 31 March 2011**	**1,963**
Purchased	1,224	Purchased	1,953
Donated	5	Donated	10
Total at 31 March 2012	**1,229**	**Total at 31 March 2011**	**1,963**

C.15. Impairments

Impairments in the period arose from:	Tangible	
	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Impairments charged to operating expenditure	2,878	147,944
Reversal of impairments	(13,258)	(6,051)
Impact on retained surplus / (deficit) for the year	**(10,380)**	**141,893**
Reduction in revaluation reserve due to impairments	953	13,824
Revaluation gains recognised in the revaluation reserve	(850)	(2,851)
Movement on revaluation reserve	**103**	**10,971**
Total impact on Statement of Comprehensive Income	**(10,277)**	**152,864**

All impairments in year reflect the general economic conditions relating to the fall in property prices. No impairments were recognised relating to intangible assets.

C.16. Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were:

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Property, plant and equipment	360	28
Intangible assets	0	21
Total	**360**	**49**

C.17. Inventories

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Drugs	1,026	1,257
Materials	1,670	1,546
Energy	189	13
Total	**2,885**	**2,816**

C.17.1 Inventories recognised in expenses

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Inventories recognised as an expense in the period	23,109	21,337
Total	**23,109**	**21,377**

C.18. Trade and other receivables

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Current (falling due within one year)		
NHS receivables	5,386	5,370
Other trade receivables	1,286	1,163
Provision for the impairment of receivables	(414)	(107)
Prepayments	133	327
Accrued income	119	3,995
Other receivables	3,365[16]	1,627
Total current trade and other receivables	**9,875**	**12,375**
Non-current (falling due after more than one year)		
NHS receivables	1,147	1,048
Other trade receivables		
Provision for the impairment of receivables	(161)	(126)
Prepayments	79	83
Other receivables	0	27
Total non-current trade and other receivables	**1,065**	**1,032**
Total trade and other receivables	**10,940**	**13,407**

The great majority of income, and therefore debtors, 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 £4.65m however the Trust is aware of no reason why these are not recoverable. The Trust does not hold any collateral over the balances.

[16] Movement relates to HMRC VAT debtor as two months receipt were outstanding at year end.

***C.18.1* Movement in the provision for the impairment of receivables**	**Year ended 31 March 2012 £000**	Year ended 31 March 2011 £000
Balance at 1 April	233	235
Increase in provision	349	72
Amounts utilised / reversed	(7)	(74)
Balance at 31 March	**575**	**233**

All debts are reviewed and provisions made based on the probability of payment for non NHS debtors following referral to external debt recovery agencies, and based on national guidance for debts relating to the compensation recovery unit (10.5%). No provisions are made for NHS debtors.

C.19. Trade and other payables

Current (falling due within one year)	**Year ended 31 March 2012 £000**	Year ended 31 March 2011 £000
Receipts in advance	1,200	2,445
NHS payables	4,046	2,681
Non-NHS trade payables – capital	1,055	3,407
Tax and social security costs	3,027	2,989
Accruals	11,468	11,483
Other payables	5,440	5,453
Total current trade and other payables	**26,236**	**28,458**
Non current (falling due after one year)		
Receipts in advance	2,275	2,600
Non-NHS trade payables – capital	3,630	3,439
Total non-current trade and other payables	**5,905**	**6,039**

C.20. Borrowings

Capital Current	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Private finance initiative (PFI) contract	4,880	4,639
Total current	**4,880**	**4,639**
Capital Non-current		
Private finance initiative (PFI) contract	349,790	354,670
Total non-current	**349,790**	**354,670**
Total borrowings	**354,670**	**359,309**

C.20.1 Amounts payable under PFI

MAS

PFI Service Charge obligations	Minimum lease payments: Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Gross PFI liability	**1,400,243**	**1,391,937**
Of which liability is due:		
Within one year	19,324	17,351
Between one and five years	89,897	82,556
After five years	1,291,022	1,292,030
Net PFI liability	**599,054**	**555,232**
Of which liability is due:		
Within one year	19,324	17,351
Between one and five years	77,297	69,404
After five years	502,433	468,477

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.

There is no service charge applicable to the LHA PFI schemes.

PFI Interest Charge obligations	MAS Year ended 31 March 2012 £000	MAS Year ended 31 March 2011 £000	LHA Year ended 31 March 2012 £000	LHA Year ended 31 March 2011 £000
Gross PFI liability	364,231	382,787	649	719
Of which liability is due:				
Within one year	18,318	18,556	69	71
Between one and five years	70,631	71,714	246	257
After five years	275,282	292,517	334	391
Gross PFI liability	**364,231**	**382,787**	**649**	**719**
PFI Capital Charge obligations				
Gross PFI liability	356,623	358,225	1,046	1,084
Of which liability is due:				
Within one year	4,839	4,601	41	38
Between one and five years	21,995	20,912	193	181
After five years	326,789	332,712	812	865
Gross PFI liability	**353,623**	**358,225**	**1,046**	**1,084**

C.20.2 Finance lease receivables

The Trust has no finance leases where it is the lessor in operation.

C.*20.3* Private Finance Initiative schemes deemed to be off-balance sheet

Leicester Housing Association

The Trust is currently committed to one off-balance sheet PFI scheme relating to residential accommodation for the Kings Mill site, as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, but where the Trust does not have control, and therefore the Trust is required to account for the PFI scheme 'of statement of financial position' ('off-balance sheet'). This means that the Trust does not recognise the scheme as an asset of the Trust.

The arrangement is with Leicester Housing Association, including the construction of new residential accommodation and the upgrade of existing accommodation combined with a 35 year contract to manage and operate the accommodation. The Trust has guaranteed to utilise a minimum level of the overall accommodation but the majority of risks associated with operating and letting the properties have been transferred to Leicester Housing Association. The estimated capital value of the scheme is £5.7m

The Trust has recognised the following items within its accounts for the year ended 31 March 2012:

	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet – gross	281
Amortisation of PFI deferred asset[17]	(140)
Net charge to operating expenses	**141**

A credit was 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 HM Treasury guidance this has been excluded in the above net charge calculation.

The Trust is committed to make the following payments in 2012/13 relating to the unitary charge to Leicester Housing Association.

	£000
PFI scheme which expires in 2035	281

In addition to the commitments in 2012/13 the Trust has the following unitary charge commitments in respect of the PFI to the end of the scheme:

	£000
• Not later than one year;	130
• Later than one year and not later than five years; and	520
• Later than five years.	2,340

The 35 year contract started in September 2000 and will end in September 2035.

C.20.4 Private Finance Initiative schemes deemed to be on-balance sheet

The Trust is currently committed to two on-balance sheet PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, therefore the Trust is required to account for the PFI scheme 'on-balance sheet' and this means that the Trust treats the asset as if it were an asset of the Trust.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the Kings Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were in use on 31 March 2011, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA), to construct a day nursery and out of hours facility, on the Kings Mill hospital site, and the assets were all brought into use by 2002, with an estimated capital value of £1.3m.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional termination consideration.

	MAS £000	LHA £000
Amounts included within operating expenses in respect of PFI transactions deemed to be on-balance sheet	15,993	0
Amounts included within depreciation in respect of PFI transactions deemed to be on-balance sheet	4,020	14
Amounts included within interest payable in respect of PFI transactions deemed to be on-balance sheet	18,556	48
Total charge to operating statement	**38,569**	**62**

The Trust is committed to make the following payments in 2012/13 relating to the capital funding repayment, the associated interest and the unitary charge. The MAS scheme unitary charge can vary year on year, depending on whether there have been any contract variations, under/over performance against the contract and is subject to an annual inflationary uplift based on RPI. In addition the soft facilities management services part of the service charge is subject to market testing on a 5 yearly basis.

	MAS £000	LHA £000
PFI scheme which expires;		
Day nursery (contract end April 2025)		43
MAS PFI (contract end March 2043)	42,480	
Out of Hours (contract end January 2027)		66

In addition to the commitments in 2012/13 the Trust has the following commitments in respect of the Capital element of the PFI to the end of the respective schemes.

	£000	£000
• Not later than one year;	4,839	41
• Later than one year and not later than five years; and	21,995	193
• Later than five years.	326,789	813
Contract start date:	Oct 2005	Apr 2000 / Jan 2002
Contract end date:	Mar 2043	Apr 2025 / Jan 2027
Years to the end of the contract	31	15

C.21. Cash and cash equivalents	**31 March 2012 £000**	**31 March 2011 £000**
Balance at 1 April	29,685	33,253
Net change in year	(6,919)	(3,568)
Balance at 31 March	**22,766**	**29,685**
Made up of		
Cash with the Government banking service (RBSG / Citibank) / Office of Paymaster General	22,760	29,680
Cash in hand	6	5
Cash and cash equivalents	**22,766**	**29,685**

C.22. Provisions for liabilities and charges

	Pensions relating to other staff £000	Legal claims £000	Other £000	31 March 2012 Total £000
At 1 April 2011	468	4,429	2,410	7,307
Arising during the period	55	121	281	457
Utilised during the period	(56)	(2,705)	(890)	(3,651)
Reversed during the period	(22)	(1,355)	(1,008)	(2,385)
At 31 March 2012	**445**	**490**	**793**	**1,728**
Expected timing of cashflows				
Within one year	49	490	685	1,224
Between one and five years	196	0	32	228
After five years	200	0	76	276
	445	**490**	**793**	**1,728**

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Pensions relating to former staff (excluding directors)	49	50	395	418
Other legal claims	490	4,429	0	0
Other	685	2,300	109	110
Total	**1,224**	**6,779**	**504**	**528**

£30.287m is included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the Trust (31/03/11 £19.696m)

C.23. Contingent liabilities

	31 March 2012 £000	31 March 2011 £000
Gross value	59	39
Amounts recoverable	0	0
Net contingent liability	**59**	**39**

This relates to third party claims where there is insufficient certainty on the possible future liabilities to recognise in the current year expenditure position.

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.

C.24. Prudential borrowing limit

The Trust has a maximum cumulative long term borrowing limit of £359.4m.
Monitor has also authorised the Trust to have a £19m working capital facility in place. The Trust did not exercise this option in year.

	Year ended 31 March 2012 Actual	Approved	Year ended 31 March 2011 Actual	Approved
Minimum dividend cover – times	N/A[17]	>1.0 times	N/A[17]	>1.0 times
Minimum interest cover – times	1.1[18]	>2.0 times	1.5[18]	>2.0 times
Minimum debt service cover – times	0.9[17]	>1.5 times	1.2[17]	>1.5 times
Maximum debt service to revenue %	9.2	<10.0%	7.3	<10.0%

[17] No dividends payable due to negative net relevant assets following the impairment of PFI assets.
[18] Due to its PFI schemes the Trust has its Prudential Borrowing limit set to allow for the PFI debt being on balance sheet, which is currently £359.4m. This limit is adjusted annually as it currently exceeds the normal 'tier 2' calculated limit.

C.25. Management Costs

	£000	£000
Management costs	7,811	7,267
Income (net of NMET[19] income)	241,169	240,223
Percentage	3.24%	3.03%

[19] This relates to income received for continuous professional development and training relating to Doctors and Nursing staff.

C.26. Financial instruments and related disclosures

	Carrying value 31 March 2012 £000	Carrying value 31 March 2011 £000
Current financial assets		
Cash and cash equivalents	22,766	29,685
Trade and other receivables	9,875	12,375
Non-current financial assets		
Trade and receivables	986	949
Total financial assets	**33,627**	**43,009**
Current financial liabilities		
Financial liabilities measured at amortised cost:		
PFI Finance leases	4,880	4,639
Trade and other payables	35,016	31,731
Provisions under contract	1,728	7,307
Non-current financial liabilities		
Financial liabilities measured at amortised cost:		
PFI Finance leases	349,790	354,670
Total financial liabilities	**391,414**	**398,347**

The fair value on all these financial assets and financial liabilities approximate to the carrying value recognised in the Statement of Financial Position.

C.27. Exit packages

	2011/12			2010/11		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	1	43	44	8	0	8
£10,000 - £25,000	5	46	51	14	0	14
£25001 - £50,000	0	16	16	3	0	3
£50,001 – £100,000	2	6	8	1	0	1
£100,000 - £150,000	1	1	2	1	0	1
£150,001 - £200,000	0	0	0	0	0	0
£200,001 - £250,000	0	0	0	1	0	1
£250,001 - £300,000	0	1	1	0	0	0
Total number of exit packages by type	**9**	**113**	**122**	**28**	**0**	**28**
Total cost (£000)	**312**	**2,343**	**2,655**	**605**	**0**	**605**

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury / Monitor approval was required.

The cost of ill-health retirements fall on the relevant pension scheme and are not included in this disclosure. Details can be found in note C.9.

C.28. Related party transactions

	2011/12 Income £000	2011/12 Expenditure £000	2010/11 Income £000	2010/11 Expenditure £000
Bassetlaw PCT	1,438	0	1,279	58
Department of Health	82	0	69	0
Derby City PCT	144	0	362	14
Derby County PCT	20,228	0	20,756	271
Derby Hospitals NHS Foundation Trust	129	44	367	19
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	10	69	12	68
East Midlands Ambulance Services NHS Trust	99	40	3	5
East Midlands Strategic Health Authority	11,895	84	11,846	48
Kettering Foundation Trust	0	0	80	0
Leicester County and Rutland PCT	7,610	0	8,904	7
Leicester City PCT	31	0	142	0
Leicester Partnership Trust	31	109	72	127
University Hospitals Leicester Trust	303	14	401	59
Lincolnshire PCT	3,964	0	4,650	0
Moorfield Eye Hospital NHS Foundation Trust	0	25	0	0
NHS Blood and Transplant	0	840	0	982
NHS Business Services Authority	0	1,247	0	1,049
NHS Litigation Authority	0	4,408	0	3,519
Northampton Teaching PCT	30	0	281	0
Northampton Trust	0	0	138	0
Nottingham University Hospitals NHS Trust	3,884	1,818	3,706	1,943
Nottingham City PCT	3,942	0	4,198	464
Nottinghamshire County PCT	184,827	4,413	176,122	2,364
Nottinghamshire Healthcare NHS Trust	3,884	1,272	1,711	393
NHS Purchasing and Supply Agency	0	6,089	0	5,979
Oxfordshire And Buckinghamshire Mental Health NHS Foundation Trust	0	51	0	46
Sheffield Children's NHS Foundation Trust	41	62	40	104
Sheffield Teaching Hospitals NHS Foundation Trust	0	83	1	56
United Lincolnshire Hospitals NHS Trust	6	2	231	1

C. 29. Senior managers' disclosure

29.1	2011/12				2010/11			
Name and title	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1,000)**	**Salary (bands of £5000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1,000)**
Executive Directors								
Mr M. Wakeley (Chief Executive Officer. Appointed 1 October 2011)	95-100	0	1,600	14	N/A	N/A	N/A	N/A
Mrs C. White (Interim Chief Executive / Deputy Chief Executive effective 1 October 2011)	155-160	0	3,900	22	155-160	0	5,900	22
Mrs S. Bowler (Executive Director of Nursing and Quality) .	95-100	0-5	200	10	95-100	0	0	0
Ms J. Warder[1] (Chief Operating Officer. Left 29 February 2012)	100-105	280-285	2,300	15	115-120	0	4,300	17
Ms F. Steele[2] (Chief Financial Officer) Appointed 1 January 2012	40-45	5-10	0	6	N/A	N/A	N/A	N/A
Mr A. Marshall[3] (Interim Executive Director of Finance 20 June to 30 November 2011)	55-60	0	0	0	N/A	N/A	N/A	N/A
Mrs E. Konieczny (Acting Director of Finance 1 December to 31 December 2011)	5-10	0	0	1	N/A	N/A	N/A	N/A

Name and title	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (nearest £100)	Employer pension contributions (nearest £1,000)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (nearest £100)	Employer pension contributions (nearest £1,000)
Mr L. Bond (Executive Director of Finance. Left 19 June 2011)	25-30	0	1,000	4	115-120	0	4,000	16
Ms K. Fisher (Executive Director of Human Resources)	90-95	0	4,000	13	95-100	0	500	13
Ms L. Dadge[4] (Non - Voting Commercial Director. In post from 5 January 2012)	20-25	5-10	800	3	N/A	N/A	N/A	N/A
Dr N. Ali (Executive Medical Director In post from 26 July 2010)	25-30	160-165	1,200	18	15-20	105-110	0	12
Dr M. Mowbray (Executive Medical Director. In post to 11 July 2010)	N/A	N/A	N/A	N/A	5-10	35-40	7,000	5

Non-Executive Directors								
Ms T. Doucet[5]	60-65	N/A	N/A	N/A	40-45	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	10-15	N/A	N/A	N/A
Mr I. M. Younger	10-15	N/A	N/A	N/A	10-15	N/A	N/A	N/A

Benefit in kind relates to lease car P11D taxable charge

[1] Other remuneration relates to a contractual redundancy and notice period payment.
[2] Other remuneration relates to a contractual recruitment incentive.
[3] Services provided under contract by PWC.
[4] Other remuneration relates to a contractual performance related payment.
[5] Additional fee in 2011/12 is due to an increase in hours worked.

Hutton Disclosure

	2011/12	**2010/11**
Band of highest paid directors' remuneration (£000's)	195-200	155-60
Median total remuneration	24,554	24,554
Ratio of median to highest paid Director	8.04	6.41
No of employees paid more than highest paid director	0	2

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

The ratio to highest paid director has been calculated based on the mid-point of the salary banding of the highest paid director.

C.29.2

Name and Title	2011/12 Real increase during the year in pension and lump sum at age 60 (bands of £2,500)	2011/12 Total accrued pension (incl. lump sum) at age 60 at 31 March 2012 (bands of £5,000)	2011/12 Value of cash equivalent transfer value as at 1 April 2011 (nearest £1,000)	2011/12 Real increase in cash equivalent transfer value during the year ended 31 March 2012 (bands of £1,000)	2011/12 Value of cash equivalent transfer value at the end of the reporting period - 31 March 2012 (bands of £1,000)	2010/11 Real increase during the year in pension and lump sum at age 60 (bands of £2,500)	2010/11 Total accrued pension (incl. lump sum) at age 60 at 31 March 2011 (bands of £5,000)	2010/11 Value of cash equivalent transfer value as at 1 April 2010 (nearest £1,000)	2010/11 Real increase in cash equivalent transfer value during the year ended 31 March 2011 (bands of £1,000)	2010/11 Value of cash equivalent transfer value at the end of the reporting period - 31 March 2011 (bands of £1,000)
Executive Directors										
Mr M. Wakeley	62.5-65	125-130	0	236	470	N/A	N/A	N/A	N/A	N/A
Mrs C. White	0-2.5	220-225	912	92	1,027	82.5-85	215-220	608	289	912
Mrs S. Bowler	(2.5)-(5)	155-160	576	64	654	45-47.5	150-155	442	122	576
Ms J. Warder	(5)-(7.5)	150-155	509	58	586	37.5-40	150-155	428	71	509
Ms F. Steele	0-2.5	5-10	0	7	27	N/A	N/A	N/A	N/A	N/A
Mr L. Bond	2.5-5	110-115	283	25	403	2.5-5	100-105	321	(46)	283
Ms K. Fisher	0-2.5	140-145	514	71	598	5-7.5	135-140	539	(38)	514
Ms L. Dadge	0-2.5	40-42.5	133	9	174	N/A	N/A	N/A	N/A	N/A
Mr A. Marshall	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mrs E. Konieczny	10-12.5	125-130	0	47	556	N/A	N/A	N/A	N/A	N/A
Dr N. Ali	0-2.5	200-205	939	68	1,031	2.5-5	195-200	970	(37)	939
Dr M. Mowbray	N/A	N/A	N/A	N/A	N/A	(5)-(7.5)	215-220	1,192	(54)	1,030

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 is contractually committed to three performance related in year bonuses, and payments made are disclosed above.

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

The Trust has purchased from a related party a total of £11,200 during 2011/12 (2010/11: £22,600) for room hire for Podiatry clinics with The Nottingham Road Clinic. Dr. N. Ali is a Director and Shareholder of The Nottingham Road Clinic and the relationship has been identified in the register of interests. For 2011/12, £9,600 had been paid and £1,600 remaining to be paid as at 31/03/2012.

Martin Wakeley
Chief Executive Officer
29 May 2012