Annual Report & Accounts *2010/11*

BestCare BestPeople BestPlace

Sherwood Forest Hospitals NHS
NHS Foundation Trust

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Chairman and Chief Executive's Foreword

We are delighted to present our Annual Report for 2010/2011. As we celebrate our fourth year as a Foundation Trust, we do so with a growing reputation for the quality, safety, innovation and excellence of our services.

We are both privileged to have served our local community together over the last year, and we are immensely proud of the many significant achievements made possible by the dedication of our remarkable and talented staff.

Strong Foundations

We have spent the last year putting in place the strong foundations required to meet the challenges ahead and to continue to deliver our vision to provide the Best Care, with the Best People in the Best Place.

The vision we developed together with our staff, governors, patients and our wider community remains as important today as it has ever been. Quite simply it's about doing things the right way, by putting our patients at the heart of everything we do.

Since gaining our licence as a Foundation Trust in 2007, we have invested significantly in creating truly world class facilities, and in developing new services to meet the changing needs of our community and to support the successful achievement of our vision.

We are passionate about delivering on our pledges to our patients. Evidencing our commitment to improving the quality of our services and strengthening our accountability to our community requires transparency – being honest about how we are doing.

The production of our Annual Report provides a summary of our performance and governance arrangements over the past year and provides an important opportunity to fulfil this pledge. Our achievements during 2010/11 are summarised in this report, highlighting our successes and sharing our progress against the areas we know are your most important priorities.

Delivering For Our Community

During the year ending March 2011 we:

- Provided care for more than 77,000 patients who received treatment in our day case units or as inpatients in our hospital wards.
- Saw more than 388,000 patients in our outpatient clinics.
- Delivered 3,100 babies at our hospitals.

- Treated more than 106,000 patients in our accident and emergency departments.
- Maintained our excellent results in the national inpatients survey results, with 93% of patients rating the care they received as 'good' or 'excellent'.
- Were rated as being in the top performing Trusts for 21 categories in the independent 2010 inpatients survey.
- Achieved, for the third year in a row, a rating of *'good'* for the quality of our services and *'excellent'* for our use of resources from the Healthcare Commission.
- Continued to ensure reducing hospital and community acquired infections remained a top priority for both our Board of Directors and our Board of Governors. We were pleased to report that there were no reported cases of MRSA blood borne infections in our hospitals during the year to March 2011, making us the top performing Trust in the whole of the East Midlands.
- Succeeded in meeting our Clostridium difficile reduction targets, again making us one of the top performing Trusts across the East Midlands.
- Achieved all of our national cancer waiting times standards throughout the year.
- Delivered our financial targets, increasing our operating income to £257.8m.
- Delivered 101% of our £9.5m targeted cost improvement plans - treating more patients, more quickly and to a better standard whilst also making our services more efficient.
- Achieved a financial risk rating of 3 at the end of the year, reflecting solid financial performance in a challenging financial climate.
- Were rated 'green', the highest possible performance score for Foundation Trusts as a result of our performance against national targets at the end of the year.

Meeting the Challenge Ahead

Although our achievements have been excellent over the past year, the year ahead will see the NHS entering an increasingly challenging financial period. Nationally, the NHS needs to make savings of £20 billion over the next three years. As a result, we forecast significant reductions in our 'like-for-like' income, at the same time as the costs of our new facilities increase upon completion.

We will face unprecedented financial, strategic and operational challenges in future years. We are confident however, that the progress we have made during the last year has created a robust platform to enable us to meet the significant challenges ahead.

More than ever before, it is vitally important that we continue to deliver solid, sustainable financial performance – ensuring that we remain viable and healthy for the future. To do this, we will continue to accelerate our focus on increasing our efficiency and effectiveness and on controlling our costs.

Our Board believes that we are well prepared. We have the energy and determination necessary to manage the financial and operational risks in the coming year. We will work harder than ever before to seize the opportunities that these significant challenges will bring. Whilst we take the action necessary to address our financial challenge, we will not compromise on the quality, safety and

effectiveness of the services we provide – quality prevails at the heart of everything we do.

We remain a determined and ambitious Foundation Trust. We will continue to focus relentlessly on meeting the wider healthcare needs of our patients and on providing the Best Care, with the Best People in the Best Place for our communities.

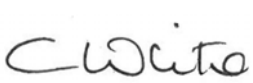
We are truly proud that the people who use our services often comment upon the excellent service they receive, and also mention the care and dedication of the staff at our hospitals. These comments are a real credit to the dedication and commitment of all of our staff and volunteers, as well as the many charities which support us. With their unwavering commitment to providing the very best standards of customer and patient care we are able to make our hospitals exceptional places to work and receive care.

In the year ahead, we will capitalise further on our strengths and focus harder on encouraging more patients to choose to receive their treatment at our hospitals. We will market our truly world class facilities, adapting quickly to a more competitive marketplace by developing new services that will diversify our income and ensure our long term health.

On behalf of the Board of Directors, we would like to extend our personal thanks and recognition to those at the heart of our Trust - our staff and volunteers - whose talents, enthusiasm and commitment to providing the very best standards of customer and patient care are greatly appreciated. Collectively, they make this Trust a very special place to work and we are both privileged to be part of that team.

Together, we will meet the challenges we face with energy and enthusiasm, continuing to build an NHS Foundation Trust which is not only more efficient and fitter today, but able to face the future with spirit and with confidence.

Tracy Doucét
Chairman



Carolyn White
Chief Executive

Our Vision and Pledges

During 2010/11, we have worked in partnership with our staff, with our members and with our Governors to develop and agree 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 - 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

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

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

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

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

We will care for you in a safe and clean environment

Pledges to Staff

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

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

We will support you to do the best in your job

We will provide a safe environment

Our pledges, which were developed with our patients and with staff across the Trust, support us to work together with pride, energy and passion to deliver our vision.

Our progress and performance during 2010/11 in delivering on our vision and in meeting our pledges to our patients and staff is highlighted throughout the remainder of this Annual Report.

Directors' Report

The Directors present their report, together with the audited financial statements and accounts for the year ended 31 March 2011 prepared under direction issued by Monitor, the Foundation Trust Regulator.

Our Principal Activities

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

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 - and we continue to provide some outpatient and community based services from Mansfield and Ashfield Community Hospitals.

We serve a diverse population and geographic area across central Nottinghamshire, including rural communities and more densely populated urban areas across both Sutton in Ashfield and Mansfield. The nature of the area's proud industrial past, strong in coal mining and textiles, is characterised by comparatively low socio-economic profiles, which in turn brings high levels of respiratory problems and other causes of 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.

As a result of our successful tender as part of the Transforming Community Services (TCS) initiative, from 1 May 2011 we also deliver a wider range of inpatient, community, sexual health and stroke services from Mansfield and Ashfield Community Hospitals and from community locations across north Nottinghamshire. This provides an ideal opportunity for us to redesign and integrate care pathways to meet the needs of our communities and to provide the very best care for our patients.

With an annual income of around £258 million, we continue to play a vital and successful role in our local economy - creating much needed employment and training opportunities, purchasing goods and services from local suppliers and creating a healthier future for all. During the year, we employed more than 3,600 WTE staff (4,660 Headcount), making us one of the largest employers in the area.

We take these responsibilities seriously and we are proud to continue to play such a key role in supporting the economic regeneration of our local community.

About Us

Sherwood Forest NHS Foundation Trust was established in February 2007. This year we celebrated four years as a Foundation Trust, delivering a wide range of acute healthcare services to the diverse communities and populations covered above.

We are immensely proud to be one of the 137 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, 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 openness, transparency and to increasing our democratic accountability. We are accountable to:

- Our local community through our 20,294 public members whose interests are represented by 20 democratically elected *public* Governors (out of 36 in total).
- Our 3,669 staff members and wider stakeholders through their election and appointment of 36 Governors on our Board of Governors.
- Our commissioners through our contract.
- Monitor, the Foundation Trust regulator and to Parliament.

Our ambition is to build upon our significant achievements so far, to continue focusing our energy and dedication on delivering excellence through the achievement of our vision. We continue in our commitment to delivering the *Best Care, with the Best People, in the Best Place* for our patients and for our wider community.

We remain committed to using our Foundation Trust freedoms to continuously improve the excellence of the care we provide. Delivering high quality services and a great patient experience remain our top priorities as we continue to invest in further developing the range and quality of healthcare services for our patients.

Over the last four years we have done this successfully by working closely with our Governors, listening to their views and understanding the changing needs of our patients through our membership. We are grateful for the important and continuing support of many local charities, as well as our 600 dedicated and committed volunteers.

The Trust is led by our Board of Directors, who along with our staff and our volunteers are our greatest source of pride and strength. Working together to deliver our objectives during the year, we have continued to transform the quality of our hospitals and improve the quality, safety, effectiveness and efficiency of our services.

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

Business Review 2010/11
Key Highlights

During the year we continued to make significant progress towards the achievement of our vision to provide the Best Care, with the Best People in the Best Place for our patients and our community and to ensure that our hospitals are a source of pride for our staff, for our patients, our stakeholders and our communities.

We have spent the last year putting in place the strong foundations required to support the delivery of our ambitious vision, including the successful delivery of quality aspirations, our financial targets and the key objectives contained within our 2010/11 Annual Plan.

- We completed the £320m investment of King's Mill Hospital in March 2011, creating truly world-class hospital facilities.
- We treated over 77,000 people in our hospital beds within spacious new wards offering 50% en-suite single rooms at King's Mill.
- We saw more than 388,000 outpatients during the year through a broad range of specialist clinics.
- We treated 30,000 day case patients in our new day case unit, without the need for an overnight stay.
- We opened the first part of our new Emergency Care Assessment Centre (ECAC) treating more than 104,000 people.
- We delivered more than 3,100 babies, and our maternity services were rated as 'excellent' by the independent Healthcare Commission in the most comprehensive national study undertaken to date.
- 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.
- We received a grant of £1m from the Doughty Foundation to build new pre-operative assessment and endoscopy units at Newark Hospital - which opened to the first patients in Autumn 2010.
- We now see more than 5,000 extra patients each year than we did three years ago as referrals continue to grow.
- During 2010/11 at Newark Hospital, we introduced more than 40 new clinic sessions per month in specialties including cardiology, stroke, ENT, orthopaedics, children's asthma. This is part of our commitment to expanding the number of services on offer at Newark, as more people choose to use local services.
- During the year NHS Nottinghamshire (the local PCT) completed the *Newark Review* which informed some of the services that will be commissioned from Newark Hospital in the future. This means that some patients, for example those with acute heart attacks and strokes, will now go to specialist centres and can return to Newark for rehabilitation locally. The *Newark Review* also brings some new opportunities. There will be more integrated services across primary and secondary care, including urgent assessment clinics for quick access to specialist opinion to prevent unnecessary admissions.
- As part of the *Newark Review* the voices of our members, Governors and the public were heard. For example, to maintain 24 hour a day

services for minor injuries, minor ailments and urgent care in the newly named Minor Injuries Unit and Urgent Care Centre.

- During 2010/11, we were successful in securing a contract to provide new community services as part of the national drive, Transforming Community Services (TCS). From May 2011, we will increase the range of our services providing:
  - Inpatient and outpatient services at Mansfield Community Hospital
  - Inpatient and outpatient services at Ashfield Health Village
  - Early Stroke Discharge services
  - CaSH and Sexions sexual health services
  - Wheelchair services

  Securing these services provides a superb opportunity to truly transform and integrate care pathways, improving the quality and effectiveness of care for our patients, whilst also welcoming more than 250 new staff to the Trust.

- We progressed a partnership with Unipart to help us to transform and improve many of our key processes and pathways. Investing in and embedding the cultural benefits of our **A**chieving **B**est **C**are (ABC) approach will help us improve our efficiency and assist us to make sure that our staff, particular those who work directly with patients have a greater impact on how our services are provided in the future.

- We showcased our **A**chieving **B**est **C**are (ABC) work at the first national NHS Innovation Expo and in the year ahead we will work to share this best practice further for the benefit of organisations across the NHS.

- We are proud of our track record for innovation in healthcare. During the year we were credited by the NHS Improvement Programme as the original developers of RAPA (Recurrent Patient Admission Alert system) - an innovation which won the Health Service Journal (HSJ) and Capgemini 'Liberating Ideas' Award for 2010.

- We successfully increased our total market share, building further on our success since becoming a Foundation Trust, outperforming the market area across most of our service portfolio. We currently secure 94.5%of the referrals from our Mansfield and Ashfield GPs cluster and 77% from Newark and Sherwood GPs.

- We continued to exceed national performance on slot availability for Choose & Book – offering choice and seeing patients quickly in order to underpin our strong performance on market share.

- We experienced zero cases of hospital acquired MRSA within the Trust, making us the best performing Trust in the East Midlands and improving our national performance to top decile within 12 months.

- We achieved amongst the lowest rates of Clostridium difficile in the region at 0.25 per 10,000 bed days.

- We received positive feedback from the Care Quality Commission (CQC) following two unannounced inspections, recognising our good progress in improving clinical governance at King's Mill Hospital and continuing high standards of care, privacy and dignity at Newark Hospital.

- We reduced our Hospital Standardised Mortality Rates (HSMRs) to below national average during the last 12 months.

- We are delighted to discover that 98% of our patients tell us that they would recommend our hospitals to family or

friends, according to audits in specific areas. This was supported by 93% of patients rating the care that they received as 'good' or 'excellent' in the national inpatient survey.

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

Improving the Quality, Safety and Effectiveness of Our Care

Quality remains our number one priority. It is at the heart of everything we do. Many of our achievements and investments have made a major contribution towards further improving the quality, safety and effectiveness of our care. Those of particular significance during the year include:

- MRSA infections – we continued to reduce hospital and community acquired infections, which remained a key priority for both our Board of Directors and our Governors. For the year ending March 2011, we were pleased to report that there were no reported cases of MRSA blood borne infection during the year, surpassing our annual reduction target of six cases and making us the top performing Trust in the East Midlands.

- Clostridium difficile - we also achieved our Clostridium difficile targets throughout the year and succeeded in reducing the number of infections, exceeding our reduction target of 63 by 14%. There were 54 cases in year.

These achievements reflect the commitment and dedication of staff across the Trust to improve our performance in those areas which matter most to our patients, in particular the tremendous work of members of the Trust's Infection Prevention and Control team.

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

During the year, 93% of patients rated the care they received as 'good' or 'excellent' and we have maintained our excellent results in achieving improvements in our national adult inpatient survey results. In the 2010 inpatient survey, undertaken by the Picker Institute on behalf of the NHS nationally, we were rated as being in the top performing Trusts for 21 areas as shown below.

National Adult Inpatient Survey 2010

We were rated in the top 20% of Trusts for the following questions:

- Were you given a choice of admission dates?

- Was your admission date changed by the hospital?

- While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

- Were you ever bothered by noise at night from other patients?

- Were you ever bothered by noise at night from hospital staff?

- In your opinion, how clean was the hospital room or ward that you were in?

- How clean were the toilets and bathrooms that you used in hospital?

- Did you have somewhere to keep your personal belongings whilst on the ward?
- Were hand-wash gels available for patients and visitors to use?
- How would you rate the hospital food?
- Were you offered a choice of food?
- Did you have confidence and Trust in the nurses treating you?
- In your opinion, were there enough nurses on duty to care for you in hospital?
- As far as you know, did nurses wash or clean their hands between touching patients?
- Were you given enough privacy when discussing your condition or treatment?
- Were you given enough privacy when being examined or treated?
- What was the main reason for delay?
- How long was the delay to discharge?
- Were you told how to take your medication in a way you could understand?
- Were you given clear written or printed information about your medicines?
- Did you want to complain about the care you received in hospital?

Treating More Patients, More Quickly Than Ever Before

This year, in spite of increased demand for our services and severe winter pressures, we have continued to reduce the time our patients wait to receive treatment in our hospitals, building further on the significant improvements made last year.

Once again, we successfully achieved the national 18 weeks waiting time target for the numbers of patients treated within the 18 week from referral to treatment. For admitted patients, 95% of patients received treatment within 18 weeks. For non-admitted performance, 97.9% of our patients received treatment within the 18 week target. During the year, the median wait from referral to treatment (for admitted patients) was 10 weeks.

Our Accident and Emergency performance has been consistently above the national target of 95% throughout the year. Despite seeing unprecedented numbers of patients our performance against the 4 hour waiting time target was 97.7% for the year ending 2010/11.

Compared to 2009/2010, we succeeded in improving our performance in delivering against the national target of 60 minutes from call to needle for those heart attack patients suitable for thrombolysis (clot busting treatment). We met the target for the year delivering 73.4%; however, our performance during quarter 4 was below the target of 68%. The treatment for heart attack patients has now changed, with suitable patients now being taken to the specialist centre to undergo a procedure to widen their narrow arteries. This is therefore not a performance target for 2011/12.

Cancer waiting time performance

Target	Standard	Q1	Q2	Q3	Q4
Cancer 31 days for second or subsequent treatment	98% Drugs	98.9%	100%	99%	99.1%
Cancer 31 days for second or subsequent treatment	94% surgery	97.6%	96.7%	97.2%	97.7%
Cancer 62 days for all referrals to treatment	85% GP	88.8%	90.3%	89%	91.1%
Cancer 62 days for all referrals to treatment	90% Screening	100%	90.3%	96.4%	n/a
Cancer 62 days for all referrals to treatment	90% consultant screening	n/a	n/a	n/a	90.2%
Cancer 2 week wait – all cancers	93%	94.1%	94.2%	93.3%	95.3%
Cancer 2 week wait – breast symptomatic	93%	97.3%	94.6%	94.2%	94.4%
Cancer 31 days from diagnosis to treatment	96%	99.4%	99.3%	100%	99.7%

The Trust has achieved all the Cancer Waiting Times standards throughout 2010/11. Whilst this has been a fantastic improvement on the previous year, the 62 day screening and 62 day classic pathways remain a challenge, including for the year ahead.

Patients choosing to delay their appointments, diagnostic tests and treatments continues to be one of the biggest challenges to our performance against mandatory national targets.

Clinical Activity	*2009/10 Actual*	*2010/11 Plan*	*2010/11 Actual*
Elective inpatients and Day Cases	38,462	42,537	40,620
Non-elective inpatients	38,265	38,571	39,279
New Outpatients	88,757	86,345	88,809
Accident and Emergency	99,380	101,167	106,788

We continue to work to improve performance further and to mitigate the risks by working closely with GPs and by hosting joint education sessions. This will ensure that patients understand they are being referred with an expectation of being seen within two weeks and treated swiftly afterwards.

Demand for Our Services

Demand for our services increased in comparison to 2009/10. We exceeded our activity for the numbers of non-elective (non-planned) inpatients, outpatient appointments and for the numbers of patients requiring treatment in our emergency departments.

Our clinical activity in year, compared to our annual plan and 2009/2010, is summarised below.

Further assessment of our quarterly performance during the year against our regulatory targets is provided on page 100. Further detailed information on our performance against our key clinical quality, patient safety, clinical effectiveness priorities and external assessment during the year is provided in our 2010/11 Quality Report starting on page 59.

Regulatory Performance - Compliance with our Terms of Authorisation

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

The Board of Directors and Monitor assess the information provided in the Trust's annual plan and in-year submissions and assign a planned risk rating for three areas – finance, governance and mandatory services.

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

For 2010/11, the governance rating was derived from a number of indicators, including service performance and third party reports and is described in a 'traffic light' rating of Green, Amber/Green, Amber/Red, Red, where Green indicates full compliance.

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

A summary of our regulatory performance comparing both our planned and actual performance during 2009/10 and 2010/11 is provided below.

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	**4**	3	3	3	4
Governance risk rating	**Amber**	Green	**Amber**	**Amber**	Red
Mandatory services	**Green**	**Green**	**Green**	**Green**	**Green**

	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**

The Board of Directors forecast an Amber/Green governance rating in the Annual Plan for 2010/11.

At the beginning of 2010/11 the Board could not self certify that plans were sufficient to provide assurance on full compliance throughout the year with the thrombolysis (clot busting) and 62 day cancer waiting time targets.

This report demonstrates that actual performance exceeded this forecast, as a result of robust action plans to mitigate risks and ensure successful delivery of these targets.

Summary Financial Performance

This financial overview summarises our performance for the financial year which ended 31March 2011. There is no relevant information which has not been brought to the auditor's attention so far as the Directors are aware.

In our fourth year as a Foundation Trust against a backdrop of improving patient services, notably through the provision of new facilities and increased access to services, while operating in an increasingly challenging financial environment it is pleasing to report that the Trust has met its financial targets in year with a surplus of £0.6m, before a technical adjustment for impairment of fixed assets totalling £141.9m, which gave an overall reported loss of £141.3.

We achieved a financial risk rating of 3 at year end (a score of 1 being 'high-risk' and 5 'low' risk).

Improved Efficiency & Value for Money

Our total operating expenses (excluding impairments and depreciation) rose during the year to £228.3m, exceeding plan by £3.6m. Of this £149.2m (65%) was spent on staffing, and 13% was spent on drugs and clinical supplies helping to ensure that our patients continue to be able to access the latest treatments.

The Trust reported a profit before impairments of £0.56m against a forecast plan of breakeven for the 2010/11.

Capital Investment

During 2010/11 the Foundation Trust invested significantly in its fixed asset infrastructure by £19.0m (£11.6m in 2009/10). This included £3.7m on upgrading or acquiring new equipment essential for the day-to-day operation of the Trust, £0.6m on improvements in information systems and technology in conjunction with the North Nottinghamshire Health Community, £12.9m on building works, and additions before impairments of £176.06m were recognised within the balance sheet to account for the new hospital funded via a Private Finance Initiative (PFI).

Looking Forward

Trading Environment and Financial Risk

Looking forward, significant risks face the Trust and whilst we have delivered financial performance for the year ending 2010/11, deficit trading positions are forecast for the next two financial years. A detailed assessment and mitigating actions to address these challenges is detailed below.

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 directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operation for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts for 2010/11.

Key Risks

This detailed forward financial planning has enabled the Trust to consider objectively the financial risks it faces going forward and to construct financial plans that, as far as possible, mitigate these risks including:

- The productivity and efficiency agenda being progressed by our main commissioners will see planned

reductions in demand for a number of services over the course of the year. Like for like clinical income from our acute contract in 2011/12 is expected to be £14.1m less than 2010/11 outturn. This 4.3% reduction is the Trust's share of our main providers 2011/12 QIPP target and commissioners' additional disinvestment in activity commissioned from our main hospitals. This has led to a significant decrease in the Trust's forecast acute income from 2011/12 onwards.

- Our Private Finance Initiative (PFI) scheme completed in April 2011. During 2011/12 the 'availability' and capital costs (i.e. debt, financing and lifecycle costs and maintenance) are forecast to increase by £6.7m and to account for 12% of turnover compared to the sector average of 5.8%, funded via the national tariff.

- The CIP/CRES target for 2010/11 of £9.5m has been delivered in full, however, the plan for 2011/12 requires the organisation to deliver a £15m cost improvement target. (6%) This is significantly in excess of any level of efficiency that has previously been delivered and represents a real challenge and risk to the Trust. A programme management office has been put in place and work is ongoing within the organisation, with the assistance of external advisors, to implement a cost reduction plan which will realise the required savings over the period. This work is not yet complete and remains a significant risk, however, the launch of a 90 day staff consultation at the start of April signalled the intent from the Board to successfully negotiate this challenging period. The PMO will be responsible for monitoring and reporting back to the Board on progress being made against the plans.

- In accordance with the NHS Operating Framework 2011/12 there is a national efficiency requirement of 4%, with pay and price inflation uplifts at 2.5%.

- The Trust is currently in a sound cash position, with a balance of £30m as at the 31 March 2011. It is not anticipating problems with its cash flow in the short term; however, it will see a significant reduction in its cash and indicates that utilisation of the working capital facility will be required in July 2012. The cash position will start to recover in 2013/14 with a positive cash balance forecast from October 2014.

- On 1st May 2011 a number of services transferred to the Trust from Nottinghamshire County PCT under the Transforming Community Services initiative. The business case considered at the April 2011 Board meeting highlighted in some detail the key risks and benefits of the transfer and the impact on the Trust's financial risk rating, as well as other governance and performance matters.

Mitigating Actions

The Board have taken steps throughout the latter part of the year to continue to prepare prudent, risk assessed financial plans for the year ahead and for the following three years to 2014/15.

In November 2010, the Board commissioned further support from external advisers to assist with the development of a robust turnaround plan; to provide independent assessment and further assurance on the robustness of our forward financial plans; to develop improved rolling cash flow forecast; to assess our principal financial risks; and to develop medium term cash and liquidity forecasts. This on-going and detailed forward financial planning has enabled the Trust Board to consider objectively

the financial risks it faces going forward and to construct financial plans that, as far as possible, mitigate risks to our liquidity and on-going compliance with the terms of our FT authorisation.

An overview of the steps we have taken to mitigate these risks include:

- Our base case, developed with the support of external advisers is assessed as being prudent, whilst maintaining a positive cash balance to 30 March 2012, providing assurance that we have sufficient cash resources to remain viable.

- Development of our detailed 2011/12 cost improvement plans commenced in February with the continuing support of external advisers. We are on track at month one and the most recent forecast full year effect of 2011/12 CIPs in 2012/13 are above plan.

- We are developing alternative plans to mitigate risks to the delivery of our £15m CIPs. Whilst the Board believe our plans for 2011/12 to be sufficiently ambitious whilst safe, we continue to discuss further mitigations and further opportunities to accelerate reductions to our cost base.

- Detailed sensitivity analysis and prudent downside scenario modelling of the key risks to non-delivery of our planned cost improvements indicate that we remain well within our working capital facility with sufficient cash headroom throughout the year ahead.

- We have undertaken considerable work to improve our use of resources (UoR) throughout 2010/11 and to benchmark our performance and develop plans to improve the future performance and contrition of our key services lines. This will continue to be enhanced in 2011/12 together with implementation of service line reporting of income and expenditure, to further focus on the areas of overspending or inefficiency. Our financial plans remain prudent and do not include any increased EBITDA contribution as a result of these actions.

The Directors have assessed these and other risks and although a challenging period has begun is confident that it can deliver a sound financial base for the Trust during the period of reorganisation and cost reduction.

Directors' Responsibilities

Going Concern

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

Audit Information

As an NHS Foundation Trust, the Board of Governors is responsible for the appointment of the Trust's external auditor. A competitive procurement process was undertaken during 2007/08, following authorisation and in November 2007 the Board of Governors appointed KPMG as the Trust's external auditors for an initial period of 3 years subject to annual evaluation. The contract with KPMG was extended in 2010/11 for a further 2 years.

We incurred £70,500 in audit service fees in relation to the statutory audit of our accounts for the twelve month period to 31 March 2011 No other audit services were required during the accounting period.

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

The Trust paid an additional £30k in respect of the 'Due diligence' assessment of Transforming community services, no other non- audit services were commissioned from KPMG during 2010/11.

Other Financial Disclosures

Accounting Policies for Pensions and Other Retirement Benefits

Our accounting policies for pensions and other retirement benefits are set out in note 3.2 (page 109) to the accounts and details of Directors remuneration can be found in the Remuneration Report on page 22 and in our 2010-11 Annual Accounts.

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 2010/11 with private patient income of 0.09%.

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 2010/11, we remained within our £362.9m prudential borrowing limit. Monitor also authorised the Trust to have a £15m working capital facility in 2010/11, however, the Trust did not exercise this option.

Remuneration Report

Role & Responsibilities of the Remuneration Committee

The primary role of the Remuneration Committee is to establish a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. It determines the remuneration and terms and conditions of the Chief Executive, Executive Directors and their direct reports.

The remuneration committee:

- Ensures levels of remuneration are sufficient to attract, retain and motivate the Chief Executive, Executive Directors and direct reports of the quality and with the skills and experience required to successfully lead the Trust
- Has delegated responsibility for setting remuneration and wider terms and conditions for the Chief Executive and Executive directors
- Considers the pension consequences and associated costs to the Trust of salary increases and other changes in pensionable remuneration
- Recommends and monitors the level and structure of remuneration for the Chief Executive, Executive Directors and direct reports to Executive Directors
- 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 authorises all severance payments across the Trust in accordance with delegated limits

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 by the committee. The committee also consider annual pay awards granted to Agenda for Change staff, medical and dental staff and very senior manager staff in setting remuneration.

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, and the Chief Executive provided reports on appraisal outcomes and performance of Executive Directors.

All Executive Directors' contracts are substantive and performance related pay arrangements were not applied during the year.

The remuneration and expenses for the Chairman and Non-Executive Directors

are determined by the Board of Governors, taking account of the external benchmarking information, salary surveys conducted by independent management consultants and by the salary levels in the wider market place.

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 33 (page 151) of the Annual Accounts. This information has been subject to audit.

Our 2011/12 Objectives - Meeting the Challenge

We will maintain a relentless and sustained focus on achieving best care, our vision and our pledges, while delivering our turnaround strategy.

Our approach to turnaround is framed by the work we have already done on our Meeting the Challenge plan since it was agreed by the Board in spring 2010:

Improving the quality, safety and reputation of our services	Developing the organisation's capacity to deliver the highest levels of performance and master operational excellence	Ensuring a sustainable financial future by protecting our cash, reducing our costs and increasing profitability	Build and develop effective partnerships with stakeholders to improve our long term sustainability
Protect and further develop the quality, safety and effectiveness of our services and enhance the quality reputation of the Trust	Develop organisational capability to deliver the highest levels of performance	Core business review to develop commercially viable sustainable high quality services	Working in effective partnership with commissioners, providers and SHA to make the most effective use of resources across the community
Build and strengthen the confidence of our patients, staff, Governors and the wider community in the services we provide	Develop and continually improve operational excellence	Excellent financial and business management	Protect our core business and assets in support of our long term sustainability by working closely with community colleagues
	Maximise the flexibility, productivity and skills of our people to deliver our strategy, vision and pledges	Minimise the costs of our PFI and improve our asset utilisation	Diversify our NHS and non-NHS revenue streams to improve our viability

We will continue to work across these four domains over the next three years but our analysis in 2010/11 has demonstrated the need to secure the Trust's future through a Turnaround Strategy (April 2010).

The Turnaround Strategy establishes the following order of focus and intensity of approach over the next three years to secure our long term financial viability:

1. **Stabilisation** - Cost and asset reduction, protecting our cash and working capital to improve short term liquidity forecasts, strengthening cash flow forecasting, delivering our cost reduction plans and enhancing capability in 10/11 (year 0), developing robust cost reduction plans for 11/12 and developing our overarching turnaround strategy.

2. **Integration** – Ensuring integration of service line strategies with strategic repositioning. Securing core business profit improvement and driving efficiency (clear strategies for service line investment, repositioning and pragmatic disinvestment). Improving asset utilisation and securing sustainability.

3. **Maximisation** - Revenue enhancement through diversification, competing to win and securing increased market share in profitable market segments. Improved asset utilisation (mitigating risks of sunk estate and high fixed PFI costs).

The Board of Directors

The Board of Directors directs the business of our Trust and, with participation from the Board 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 skills, their experience and their strong links with the local communities. Our executive directors were appointed because of their business focus and management experience of health services.

The Board of Governors appoints all non-executive directors. During the year they re-appointed Tracy Doucét as Chairman, and David Heathcote and Bonnie Jones as non-executive directors.

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

*At the meeting held on 25 November 2010, Denise Weremczuk acted as Executive Director of Nursing and Quality and Andy Molyneux acted as Executive Medical Director.

*Mike Mowbray was the Executive Medical Director until July 2010.

Profiles of the Board of Directors

Tracy Doucét, Chairman (14/14)

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 Board of Governors, Tracy also chairs the Board of Directors' Remuneration, Nomination and Investments committees and the Board of Governors Nomination Committee.

Tracy joined the Board as a non-executive director when 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, improving communication, governance, customer focus, leadership and performance.

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

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

Carolyn White, Chief Executive (13/14)

Carolyn was appointed interim Chief Executive in February 2010, having previously been appointed Executive Nurse Director in February 2007, and subsequently acting Chief Executive from December 2009.
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.

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

Jane Warder, Chief Operating Officer (13/14)

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

Her responsibilities as Chief Operating Officer include directing and managing the Trust's day-to-day operations, leading the Trust's strategy and improvement, communications, customer experience and business development directorates. Jane also deputises for the Chief Executive.

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. She has Masters degrees in both Organisational Consulting and Counselling Practice and she is passionate about leading organisational strategy and embedding transformation to drive growth and secure improved customer experience.

Lee Bond, Executive Director of Finance (11/14)

Lee joined the Board of Directors in August 2007, and also leads 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 acts as the Trust's principal advisor on all financial matters.

Nabeel Ali, Executive Medical Director (7/10)

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

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 Sherwood Forest Hospitals 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 (9/14)

Susan was appointed interim Executive Director of Nursing & Quality in May 2010

on secondment from Nottingham University Hospitals NHS Trust.

Susan has worked within the NHS for 28 years in a variety of senior nursing, service improvement and patient experience roles. Susan has worked within the NHS for 28 years and has a Professional Practice Degree and a Masters in Business Administration.

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 was 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.

Karen Fisher, Executive Director of Human Resources (13/14)

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

Karen 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.

Bonnie Jones, Non-Executive Director (14/14)

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 Investments Committee and chairs the Organ Donation Committee. She is the non executive director representative on the Trust's Infection Control Committee, and the lead safeguarding non executive director.

Bonnie was formerly an investigator with HM Customs & Excise, specialising in common agricultural policy fraud.

She represented the National Childbirth Trust at North Nottinghamshire Health Authority's Maternity Services Liaison Committee, and went on to be the lay member of Newark and Sherwood Primary Care Group.

Bonnie was subsequently appointed chair of Newark and Sherwood Primary Care Trust in 2000. During Bonnie's six years there the Trust developed as a lead commissioning organisation in Trent, working closely with the Hospitals Trust.

David Heathcote, Non-Executive Director (11/14)

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 Investments Committee, the Nominations Committee, and the Remuneration Committee. He is also the lead non executive director for the Trust's whistle blowing, and also 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 (11/14)

David joined the Trust in November 2005 and was appointed to the Foundation Trust 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.

Iain Younger, Non-Executive Director (12/14)

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

From an initial background in Human Resources, Iain has been a board member of a number of FTSE companies and charitable organisations, and has

wide experience in the development of strategic and business plans, including mergers and acquisitions, for a number of large private and public sector concerns.

Iain also brings considerable experience as a Non-Executive Director, having held appointments within the business, education, and voluntary sectors.

Stuart Grasar, Non Executive Director (11/14)

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 the Public Services Department at North Nottinghamshire College in Worksop.

He has also held boardroom appointments since 1984 with the Ilkeston Consumer Co-operative Society, becoming chairman of the whole group from 2003 until 2006.

His achievements include the development and motivation of people to move onto successful careers and his commercial experience has contributed to successful business trading.

Responsibilities of the Board of Directors

During the year ended 31 March 2011, the Board of Directors comprised 12 directors, equal numbers of non-executives and executives including the Chairman and Chief Executive. 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 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 members.

The Chief Executive:

- Leads the executive and provides visible day-to-day leadership of the Trust.
- Leads the executive in 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:

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

The Board of Directors met 14 times during the year. The Board of Directors meets monthly in confidence and holds a public Board meeting each quarter. Extra-ordinary meetings were held in June 2010, February 2011 and in March 2011. Attendance for each Director is shown alongside their respective profiles above.

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 the Terms of its Authorisation and to develop proposals on priorities, risk mitigation, values, standards and strategy.

Committees of the Board

The Board of Directors previously established four sub-committees:

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

The membership and role of each of these committees at 31 March 2011 is summarised below.

Audit Committee

The audit committee met regularly throughout the year. Chaired by David Leah, membership of the committee comprises four non-executive directors (including the committee chair) 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 Executive Director of Finance, Chief Executive and Company Secretary. Other Executive Directors attend by invitation. The committee met on five 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 2010/11 was as follows:

David Leah - Chairman	5 of 5
David Heathcote	5 of 5
Bonnie Jones	4 of 5
Iain Younger	4 of 5

Nominations Committee

During 2010/11 the role of the Nominations Committee was reviewed and two separate Committees were established – a Nominations Committee – Executive Directors and a Nominations Committee – Board of Governors.

The Nominations Committee for Executive Directors 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 Executive Director of Human Resources are present for any discussion relating to their own role.

The Board will establish an appointments committee as required to appoint executive directors to the Board, the committee will include the Chairman or her nominee, a minimum of one Non-Executive Director, the Chief Executive and where considered appropriate an external advisor.

The Nominations Committee met four times during 2010/11, attendance was as follows:

Tracy Doucét - Chairman	4 of 4
David Heathcote	3 of 4
Bonnie Jones	3 of 4
Carolyn White	2 of 4

Investments Committee

The Investments 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 Investments Committee meetings during 2010/11 was as follows

Tracy Doucét - Chairman	6 of 8	Lee Bond	8 of 8
David Heathcote	8 of 8	Susan Bowler	3 of 7
Bonnie Jones	6 of 8	Karen Fisher	4 of 8
Iain Younger	5 of 8	Jane Warder	7 of 8
Carolyn White	8 of 8		

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's 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 2010/11. 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 2011, the Members of the Remuneration Committee were:

Tracy Doucet - Chairman	5 of 5
David Heathcote	3 of 4
Bonnie Jones	4 of 5
Stuart Grasar	4 of 5

Corporate Governance

Compliance with the Code of Governance during 2010/11

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 it to assist NHS Foundation Trusts boards to ensure good governance, 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. 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; the second part confirms whether we comply with the provisions of the Code.

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 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 2010/11. The Chief Executive is the Accounting Officer for the Foundation Trust.

The Board of Directors is confident that its composition, skills and experience was appropriate during 2010/11 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 Board 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 Board of Governors.

A register of Directors' interests is maintained by the Company Secretary, and can be obtained by writing to the Trust's Headquarters. Currently all Directors 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 Board of Governors in accordance with the 2006 Act. The Board of Governors met on six occasions during 2010/11 (including the Annual Members 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 Board of Governors has also established a number of committees in order to meet its responsibilities and ensure that it focuses on issues of importance to members of the Trust.

The outcome of this process was reported to the Board of Governors. The Chairman subsequently conducted individual appraisals of the Chief Executive and Non-Executive Directors.

Regular development sessions are arranged for Governors, and during 2010/11 further amendments to Board of Governors' governance arrangements were made with reference to Monitor's – 'Guide for Governor's - Your statutory Duties'. A Lead Governor was appointed in October 2009 and has remained in post throughout 2010/11.

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 Director. 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 2010/11, both the Board of Directors and the Board 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 2010/11, with the Chairman's performance being assessed through 360^0 appraisal led by the Senior Independent Director who was supported by the Lead Governor.
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 2010/11. The assessment process will be used again in 2011/12 and consideration will be given to further developing self-assessment and external assessment mechanisms.

Directors and Governors joining the two Boards also receive induction and on-going training.

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

Director Remuneration

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

The Remuneration Committee reviewed levels of Executive Directors' pay in 2010/11 and the Board 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 Board 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 regularly attend Board of Governor meetings and meetings of its committees to ensure that they understand Governors' views. The Lead Governor and a second Public Governor 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, together with an explanation for this assessment.

Principle A3.2 – The Board of Directors has carried a Non-Executive Director vacancy during 2010/11 and as a result we did not have the majority of independent Non-Executive Directors required under our constitution during the period 1 April 2010 to 31March 2011. The Chairman has a casting vote and as such the Non-Executives retain majority control.

Board of Governors

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

As a Foundation Trust the Trust Chairman chairs both the Board of Governors and Board of Directors. The Board of Governors 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 and Newark Hospital 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 auditor.
- Receiving the Annual Report and Accounts.
- Providing views on the Trust's forwards plans and Annual Plans.
- Development of membership.
- Representing the interests of members.

All meetings of the Board of Governors are public meetings and in 2010/11, six meetings were held, including our Annual Members Meeting in September 2011.

Four meetings were held in the Mansfield constituency, one in the Newark and Sherwood constituency and one in the Derbyshire constituency. Two of the meetings - in April and November 2010 - were informal meetings, as the number of Governors in attendance was not sufficient to constitute a quorum.

The Board 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 three additional working committees;

Performance & Strategy Committee – involved in:

- Monitoring in-year performance
- 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

Quality & Patient Experience Committee – involved in:

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

Membership & Governance Committee – involved in:

- Gathering views of patients, carers and staff on 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 Board of Governors, reporting performance and delivery against plans and regulatory targets throughout the year.

During the year, the Board of Governors and its sub-committees continued to engage in the development of the Trust's plans for the period 2011/12. The Governors continued to represent the interests of their members in the development of the Foundation Trust and the local health community.

During 2010/11, 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 Board of Governor meetings
- Board Directors attend Governors' induction meetings and developmental sessions
- Two Public Governors, including the Lead Governor have been invited by the Chairman to attend confidential Board of Directors meetings during the year
- Non-Executive Directors and Executive Directors attend Board 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 joint working between the Board of Directors and Governors throughout the year.

During the year, Governors contributed to the consultations on Newark urgent care and mental health services undertaken by the Trust's commissioners NHS Nottinghamshire County, by Monitor the NHS Regulator, by the Foundation Trust Network and by the Department of Health. During the year, Governors sought members' views as part of the National consultation on aspects of the NHS White Paper –Equity &Excellence: Liberating the NHS.

The Board of Governors organised a large number of activities and events during 2010/11, 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. We have arranged events on diabetes, prostate cancer, infection prevention and control, incontinence, bowel cancer and the new hospital build.

Our Governors receive no remuneration, although they are able to claim expenses. The expense rates paid to Governors in 2010/11 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 2010

Governor	Constituency	Elected or Appointed	Attendance 6 Maximum
Eve Booker	Ashfield	E	5
Mary Wilde	Ashfield	E	3
Beryl Perrin	Ashfield	E	6
Craig Gunton-Day	Ashfield	E	3
Richard Webster	Ashfield	E	2
Loris Lester (from May 2010)	Ashfield	E	2 of 4
Yvette Price-Mear	Mansfield	E	3
Christine Smith	Mansfield	E	3
Davina Fordom	Mansfield	E	6
Geoff Stafford	Mansfield	E	6
John Marsh – Lead Governor	Mansfield	E	5
Frank Shields	Mansfield	E	6
Hilda Tagg	Newark & Sherwood	E	2
Margaret Ralls	Newark & Sherwood	E	6
Patricia Richards	Newark & Sherwood	E	5
Jim Barrie	Newark & Sherwood	E	5
Elaine Ellison	Newark & Sherwood	E	2
Tim Wright (from May 2010)	Newark & Sherwood	E	3 of 4
Dorothy Platts	Derbyshire	E	2
Walter Satterthwaite	Derbyshire	E	4
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	4
Alison Whitham	Staff – King's Mill Hospital	E	5
Sharon McAlister (to Oct2010)	Staff - King's Mill Hospital	E	2 of 3
Angie Emmott	Staff – Newark Hospital	E	6
Alison Luke	Staff – Newark Hospital	E	6
Ron Tansley)	Staff – Volunteers KMH	E	6
Nicola Juden	Staff – Volunteers NH	E	4
Barry Answer	Mansfield District Council	A	5
Mark Avis	Nottingham University	A	3
Mick Parker	Ashfield District Council	A	3
David Payne	Newark & Sherwood District Council	A	5
Amanda Sullivan	NHS Nottinghamshire County	A	4
Patricia Harman	West Notts. College	A	4
Vickie Minion (to May 2010)	Nottinghamshire County Council	A	1 of 2

Board Director attendance at Board of Governor meetings during 2010/11

Director	Position	Attendance Maximum 6
Tracy Doucét	Chairman (Board of Directors & Board of Governors)	5
Bonnie Jones	Vice-Chairman	5
Stuart Grasar	Non-Executive Director	6
David Heathcote	Non-Executive Director & SID	6
David Leah	Non-Executive Director	6
Iain Younger	Non-Executive Director	5
Carolyn White	Chief Executive	4
Nabeel Ali (from July 2010)	Executive Medical Director	1 of 4
Lee Bond	Executive Director, Finance	3
Susan Bowler	Executive Director of Nursing and Quality	0 of 5
Karen Fisher	Executive Director, Human Resources	6
Mike Mowbray (to July 2010)	Executive Medical Director	0 of 2
Jane Warder	Chief Operating Officer	5

Our Membership

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

Public Constituencies:

- **Ashfield Constituency** - including the geographic boundaries of Ashfield District Council and the Wards of Ravenshead and Newstead, from Gedling District Council
- **Derbyshire Constituency** - including Wards from Bolsover District Council and North East Derbyshire District Council
- **Mansfield Constituency** - including the geographic boundaries of Mansfield District Council and the Ward of Welbeck from Bassetlaw District Council
- **Newark & Sherwood Constituency** - including the geographic boundaries of Newark & Sherwood District Council plus Wards from Bassetlaw District Council, South Kesteven District Council and Rushcliffe District Council.

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

Our public membership continued to grow during 2010/11 and increased by 6.7% from 19,016 at the end of March 2010 to 20,294 at the end of March 2011. In addition to over 20,000 public members, 5,200 staff and volunteer members we also had 1,077 affiliate members at the end of March 2011.

In order to ensure that our public membership is representative of those eligible to become members, we analysed the membership and compared it to our catchment population including age, gender, ethnic group and social-economic group.

	Number of members	Membership profile %	Population Profile %	Representation
Age (years)				
0-16	24	0.1%	1.3%	1.2 % under
17-21	813	4.0%	5.4%	1.4% under
22+	17,996	88.7%	93.3%	4.6% under
Unknown	1,461	7%		
Ethnicity				
White	18,823	92.8%	98.7%	5.9% under
Mixed	29	0.14%	0.46%	0.32% under
Asian	100	0.49%	0.41%	0.08% over
Black	46	0.22%	0.19%	0.03% over
Other	14	0.07%	0.22%	0.15% under
Unknown	1,247	6.1%		
Socio-economic groupings				
ABC1	7,389	36.4%	42.6%	6.2% under
C2	9,430	46.4%	18.1%	28.3% over
D	1,108	5.5%	21.3%	15.8% under
E	2,269	11.2%	17.8%	6.6% under
Unclassifiable	98			
Gender				
Male	7,769	38.3%	48.9%	10.6% under
Female	12,488	61.5%	51.1%	10.4% over
Unknown	37	0.18%		
Constituency				
Ashfield	6,080	29.9%	28.2%	1.7% over
Mansfield	6,575	32.4%	23.8%	8.6% over
Derbyshire	2,255	11.1%	16.3%	5.2% under
Newark & Sherwood	5,383	26.5%	31.7%	5.2% under

Staff Constituencies

The staff constituency is divided into four classes:

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

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

Membership Recruitment

The Trust's Communications and Membership Manager has played a significant part in driving forward membership by recruiting more members and enhancing our engagement programme.

The profile of the membership has increased across the Trust and the community with the Board of Governors being heavily involved in the recruitment and engagement of the members in 2010/11.

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

The membership and engagement committee has reviewed the membership recruitment target for 2011/12 based on the number of public members recruited during 2010/11 (2,747 new members), the number of members lost and the focus on engagement with the existing members. They have recommended to the Board of Directors that a target of recruiting an additional 2,000 public members in 2011/12 should be set to bring the total to 21,000public members by the end of March 2012.

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

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 M&E committee and new innovative methods of engagement are discussed.

In summary:

- The Trust magazine 'Best Care, Best People, Best Place' is distributed three times a year to all members. This has proved to be very popular and over 3,450 members have requested to receive it via email which has helped to reduce our printing costs.

- Monthly member events take place to engage members with their 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 contacted with information, surveys and invitations to events based on their areas of interest; this is extremely useful and valuable to our membership.

- 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 regular articles in the magazine regarding membership and Governors. Regular staff Governor drop-in sessions have taken place. This has raised the profile of the staff Governors and has enabled their constituents to contact them when necessary

- The Membership Manager and Governors have attended various community groups and events to inform the public about the membership scheme and also to engage with the members. Events include Falls Awareness event (Ashfield), Health Awareness event (Newark), NHS Community in Unity events (Worksop and Nottingham), Health and Wellbeing market place (Mansfield) and the LINKS Annual Conference.

Future Membership Recruitment and Engagement

While the Trust was satisfied that its membership was broadly representative of its local population at the end of 2010/11, actions will be taken during 2011/12 to increase membership numbers and ensure that it is representative of the local population. We will also improve and increase the level of engagement with our members – both public and staff.
In 2011/12 we will focus on the recruitment of:

- 16-21 year olds
- Males
- Derbyshire and Newark & Sherwood constituencies
- Socio-economic group D.

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

- Improving new member welcome packs
- Continuing and improving the Trust magazine and the quality and range of stories
- Continuing the rolling programme of member events and meet your Governor sessions
- Using social media to engage with members
- Working closely with the Achieving Best Care (ABC) team to set up focus groups for members to involve them with any service improvements to the patient pathway.

The recruitment and engagement of members increased at a slower rate in 2010/11 compared to previous years and therefore the recruitment targets have been lowered to reflect this natural plateau that the Trust has reached. The Trust will focus its efforts on high quality engagement with members, and less on the recruitment of new members.

To Contact Local Governors

All Governors can be contacted by emailing Governors@sfh-tr.nhs.uk or by telephoning 01623 622515, extension 3509.

Find out more about our Board of Governors and look up individual Governors on our website at www.sfh-tr.nhs.uk , and you can follow us on Twitter www.twitter.com/SFHFT to find out more about us and to keep up to date with our latest members' events.

Valuing Our Staff

The Board of Directors is committed to working with our staff and unions to deliver continuous improvements to the standards and quality of care we provide to our community. During the year, we worked together to improve staff engagement, to promote health and safety, to deliver training and management development and to develop policies and best practice.

Our staff are our greatest asset. The Trust has developed and published pledges for both staff and patients. These pledges set the standards which form the basis of our relationships with staff and patients. We have reaffirmed our commitment to our pledges - to listen and to communicate openly with our staff.

Staff Engagement

During the latter part of the year we worked closely with Staff Side/Trade Union colleagues to consult on and to agree our approach to meet the challenges ahead, working together in partnership to support our staff, whilst we take the difficult actions necessary to mitigate our financial risks ahead.

The Trust holds many forums to brief staff on our plans and on the priorities and objectives contained within our Annual Plan which sets out our vision and strategy for the coming years. Our Meeting the Challenge staff engagement sessions assist us to work with staff to identify potential service improvement solutions for the future.

During the year ending March 2011, we agreed a set of joint Board and Union partnership principles. We received more than 400 suggestions from staff supporting our plans by highlighting opportunities for improvement across our services. The suggestions made are being reviewed and responses will be uploaded to the Meeting the Challenge area of the Trust's intranet.

The Trust has a number of other regular formal and informal mechanisms in place to support the pledge to our staff - "We will listen to you". The Joint Staff Partnership Forum is the forum for consultation and negotiation, the forum meets on a monthly basis to discuss and explore the key strategic issues of the Trust. The Workforce Change Group is a forum which supports and oversees consistency of approach to changes affecting our staff. This forum works effectively and is a key forum to support the implementation of the Workforce Transformation programme.

The Trust uses a number of mechanisms to engage with, and obtain comments from staff, including; the national NHS Staff Survey, in-year survey methods regarding specific topics, engagement sessions with our staff Governors and the Chief Executive has a 'blog'.

The Trust is implementing a challenging workforce transformation programme during 2011/12 which will affect many of our staff. To do this in a way that is perceived to be fair and transparent will require a continued focus on engagement and communication processes, ensuring that staff are aware of the Trusts priorities and work with us to seek continued improvement in the way we deliver best care to our patients.

Countering Fraud & Corruption

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

2010 Staff Survey

The Trust participates in the National Staff Survey on an annual basis in which it surveys 850 randomly sampled staff. There are two types of key findings – percentage scores, or 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 survey is shown below:

	2009		2010		Trust Improvement/Deterioration
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	50%	50%	52%	52%	Increase in % points 2010 Trust = Average

	2009		2010		Trust Improvement/Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff receiving job-relevant training, learning or development in last 12 months					
	78%	78%	83%	78%	Increase in % points (positive) Not changed significantly. 2010 Trust highest (best) 20%
Percentage of staff suffering work-related stress in last 12 months					
	26%	28%	24%	28%	Reduction in % points (positive). Not changed significantly. 2010 Trust lowest (best) 20%
Percentage of staff experiencing discrimination at work in last 12 months					
	---	---	9%	13%	Comparisons with 2009 not possible due to changes to the format of survey questions 2010 Trust lowest (best) 20%
Trust commitment to work-life balance					
	3.47	3.40	3.54	3.38	Increase in scores (positive). Statistically significant increase 2010 Trust highest (best) 20%

	2009		2010		Trust Improvement/Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Perceptions of effective action from employer towards violence and harassment					
	3.58	3.55	3.49	3.56	Reduction in points Statistically significant decrease 2010 Trust lowest (worst) 20%
Percentage of staff receiving equality and diversity training in last 12 months					
	26%	35%	33%	41%	Increase in % points (positive). Statistically significant increase. 2010 Trust below (worse than) average
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months					
	---	---	10%	8%	Comparisons with 2009 not possible due to changes to the format of survey questions 2010 Trust above (worse than) average
Percentage of staff experiencing physical violence from staff in last 12 months					
	---	---	2%	1%	Comparisons with 2009 not possible due to changes to the format of survey questions 2010 Trust above (worse than) av

Note: National Average figures given represent those for Acute Trusts

The 2009 staff survey outcomes suggested the need to improve our approach to staff appraisal, incident reporting processes regarding errors, near misses or indents, 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 2010 staff survey outcomes identify many positive responses, with the Trust performing average or above in 31 out of the 38 key finding areas – see below.

The survey responses show an improvement in 4 key finding areas, no change in 21, 6 areas which have worsened and 7 new key finding areas which were previously unreported and therefore have no comparable data.

40 key findings

	2009	2010
Best 20%	18 Areas	9 Areas
Better than Average	12 Areas	9 Areas
Average	7 Areas	13 Areas
Worse than Average	3 Areas	6 Areas
Worse 20%	0	1 Area

Whilst the Trust is pleased with the survey outcomes there remain a number of areas which require improvement. Therefore the Trust's Action Plan for 2011/12 will focus on:

- Providing innovative ways of delivering Equality and Diversity Training
- Improving the perceptions of staff regarding the actions the Trust takes regarding physical violence
- Maintaining engagement and valuing staff during a significant period of workforce transformation
- Supporting staff to contribute to improvements at work
- Developing a better understanding of staff group specific issues.

Detailed action plans are being developed for these priority areas and will be led by identified managers within the Trust. Delivery of the action plans will be overseen by the Workforce Committee.

Equality, Diversity and Inclusivity

Approach to Diversity and Inclusivity

Diversity and inclusivity is fundamental to all the Trust does, both in the way we provide services to our community and the way in which we manage our staff. The Trust is committed to treating all its service users and staff with dignity and respect.

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

Diversity and Inclusivity Leads

The Director of Human Resources is the Diversity and Inclusivity Executive Lead. There is also a nominated Non-Executive Lead for diversity and inclusivity. To support our partnership approach to all aspects of the diversity and inclusivity agenda, there is also a nominated staff side lead.

How Performance is Monitored

The organisation assesses the delivery of our diversity and inclusivity priorities on an on going basis via a Diversity and Inclusivity Committee. This Committee is led at executive level, meets bi-monthly and reports to the Executive Management Board. The purpose of the Diversity and Inclusivity Committee is to support activities within the Trust to ensure that the statutory board responsibilities and obligations under law relating to equality and diversity are met.

The Committee has two work steams: Workforce and Mental Capacity Act/Vulnerable Adults that provide regular feedback. These work streams support the development of work in the Trust in ensuring that it operates as an equal opportunities employer, which recognises and utilises the diversity of its workforce, embracing and developing those skills to provide services for the current and future needs of the community it serves. They also work to ensure that service users are treated with dignity and respect to make sure equal access to services provided.

The Committee provides an annual report to the Board of Directors which agrees the Trust's priorities and actions to be delivered.

Publication Duties

The Trust has developed and published its Equality Scheme 2011 - 2015 on the internet site to show how it intends to meet the diversity and inclusivity agenda and how this is been implemented in practice across the Trust.

The Trust is currently reviewing the data it publishes as a result of the Equality Act 2010 and the New Public Sector Duty. A consultation is currently being carried out in line with the specific duties reviewing the information public organisations are required to publish. Nevertheless there will be a requirement for the Trust to publish sufficient information to demonstrate its compliance with the general duties as outlined by the New Public Sector Duty by 31 July 2011.

Until the new publication duties are implemented the Trust will continue to monitor its workforce and to publish the results of this monitoring. As a result the Trust produces an Employment Process Data Report via ESR and NHS Jobs relating to all gender, race, sexual orientation, disability, age and religion or belief and publishes results on the Trust's internet site on an annual basis. The report outlines the statistics for the following categories:

- Applications received
- Short listed applications
- Appointed applicants

- Case work (ethnicity and gender only)
- Staff promotions
- Leavers

The Trust publishes information, including the following:

- Annual Diversity and Inclusivity Report
- Annual report on training activity (ethnic origin and gender)
- A report is produced on a annual basis on Equality Impact Assessment
- Equality Scheme 2011 - 2015
- Religion and Belief – A practical guide for the NHS
- The Secretary of State report on disability equality
- Sexual Orientation – A practical guide for the NHS
- The Gender and Access to Health Services Study
- Trans – A practical guide for the NHS
- Transgender Experiences – Information and Support

Action Plan

An Action Plan has been developed by the Diversity and Inclusivity Committee and agreed by the Board of Directors, this Action Plan is monitored by the Committee and work is carried out by the work streams as described previously.

The following objectives have been agreed:

Action	Progress	Timeframe
Implement an Equality Scheme 2011 – 2015 in line with the Equality Act 2010 and the New Public Sector Duty.	The Scheme has been developed and approved by the Trust Board of Directors. An action plan has been developed to support the Trust's Equality Objective and to meet the New Public Sector Duty. The action plan will be implemented and monitored by the Diversity and Inclusivity Committee.	April 2011
Ensure commitment to Equality Impact Assessment roll-out across the Trust and to monitor the mapping and priority assessments for the next 12 month, this work will direct the work of the committee, identifying areas of concern and necessary actions.	A three year roll out plan has been agreed by the Trust Board of Directors. Equality Impact Assessment Leads within the Divisions have been identified to implement the roll our plan.	October 2011
Undertake further analysis of data for service users, workforce and training data, to establish underlying trends and issues and take action where necessary.	Analysis is ongoing and updates have been given to the Diversity and Inclusivity Committee. Further continued analysis is required to establish underlying trends and actions.	October 2011
Develop the work of the Committee to ensure Human Rights issues are considered across the Trust both in service delivery and workforce.	A number of Human Rights training programmes have been developed, for example Deprivation of Liberty Training and Mental Capacity Act Training. Further work is required to ensure Human Rights issues are considered across the Trust.	December 2011
Develop and implement an action plan to incorporate Mindful Employer principles into recruitment, selection and retention to ensure the best care is delivered by the best people in the best place.	An action plan has been developed and is currently being implemented to ensure the Trust meet the requirements outlined by being a Mindful Employer, and also supporting staff that experience mental health issues.	October 2011
Develop a Diversity and Inclusivity package within the Trust.	A Diversity and Inclusivity Training package has been developed and is being rolled out and delivered within the organisation. The course is run every six weeks and all staff is encouraged to attend.	Ongoing

Staff Membership Information

Further details about staff membership can be found on page 41.

Sickness Absence

Our target for sickness absence was set at 3.5% for 2010/11 which represents a 25% reduction from the 2009/10 outturn. The Trust took a number of positive steps during the year in order to drive down sickness absence, thus ensuring the supply of appropriate numbers of staff to support the delivery of best care in the most cost effective way.

The Trust launched a new absence management policy which introduced measures and effective reporting/notification to managers to support with the management of sickness absence. As a result absence rates have decreased every month during 2010/11 with the exception of February 2011. The Trust succeeded in reducing absence to 4.18% in 2010/11, a reduction of 0.59% compared with 09/10, where absence was 4.77% for the year.

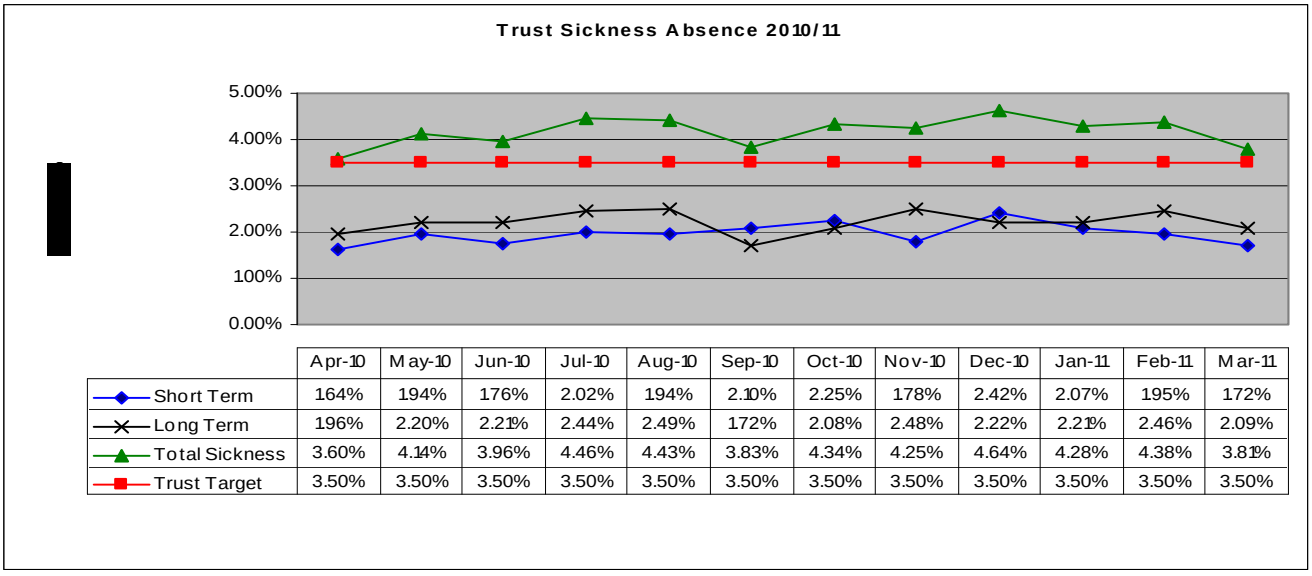
The Trust achieved reductions in both short term absence (0.51%) and long term absence (0.08%) – this is positive as short term absence has the highest impact on day to day running of the hospital and lessens the need for agency usage and maintains patient care quality to an optimum.

Through the policy, absence has been managed by measuring staff against triggers, over the past 12 months 15% of staff have hit the short term measure of three separate episodes within a six month period. Also in 2010/11, 14% of staff hit the long term trigger of being absent for four consecutive weeks or longer.

Whilst not achieving delivery of the full sickness absence target of 3.5% the Trust made significant progress in reducing sickness absence rates and achieved a reduction of 0.59% from 2009/10 rates. The target of 3.5% will be delivered during 2010/11 with continued support and focus of both managers and employees.

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

The table below shows our sickness absence rates for 2010/11:



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Short Term	164%	194%	176%	2.02%	194%	2.10%	2.25%	178%	2.42%	2.07%	195%	172%
Long Term	196%	2.20%	2.21%	2.44%	2.49%	172%	2.08%	2.48%	2.22%	2.21%	2.46%	2.09%
Total Sickness	3.60%	4.14%	3.96%	4.46%	4.43%	3.83%	4.34%	4.25%	4.64%	4.28%	4.38%	3.81%
Trust 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%

Health and Safety

An appropriately qualified and experienced Health & Safety Manager leads the Health & Safety function within the Trust. The Board of Directors receive a detailed health and safety report on an annual basis, together with monthly updates on specific issues.

Below are a number of key Health & Safety indicators captured and reported within the Trust.
Staff Health and Safety Incidents by Type 2010/11:

Health & Safety Staff Incidents							
		2009/10 Total	*Quarters, 2010/11*				2010/11 Total
			Qtr 1	*Qtr 2*	*Qtr 3*	***Qtr 4***	
1.	Abuse of staff by patients	138	*57*	*38*	*43*	*38*	176
2.	Accident of some other type or cause	72	*15*	*18*	*12*	*10*	55
3.	Collapse of a structure or fitting	14	*2*	*2*	*3*		7
4.	Collision with an object	37	*7*	*7*	*13*	*20*	47
5.	Contact with a very hot or very cold surface	17	*1*	*1*	*3*	*3*	8
6.	Environmental Matters			*3*			3
7.	Exposure to a biological hazard	11	*4*	*7*	*9*	*5*	25
8.	Hazardous and avoidable exposure to infection	1	*1*				1
9.	Hazardous exposure to electricity or electric shock	1				*1*	1
10.	Injured whilst restraining a patient	1					
11.	Injury from clean sharps	16	*1*		*7*	*3*	11
12.	Injury from dirty sharps	83	*24*	*18*	*12*	*14*	68
13.	Lifting in the course of moving a load	8	*2*	*3*	*1*		6
14.	Lifting or moving a patient or other person	27	*2*	*18*	*3*	*2*	25
15.	Lifting or moving an object other than a load	4				*1*	1
16.	Person struck by a projectile	5					
17.	Road traffic accident	3				*1*	1
18.	Sharps or needles found	7	*4*	*2*	*6*	*3*	15
19.	Slips, trips and falls	81	*10*	*21*	*30*	*9*	70
20.	Stress related illness	1	*1*				1
21.	Stretching or bending injury other than lifting	13	*5*	*6*	*2*	*4*	17
22.	Trapped in lift, locked in a room, other traps	13	*2*	*7*	*5*	*7*	21
23.	Unintended exposure to radiation	1	*1*		*1*		2
24.	Work related upper limb disorder syndrome	2		*1*		*1*	2
	Total	**556**	**139**	**152**	**150**	**122**	**563**

The Datix Clinical Coding Scheme (CCS) was introduced from December 2008. The switch to Datix CCS codes also means that fewer incidents are being recorded as 'staff accidents' and are instead being correctly coded to the type of incident they relate to, e.g. injury from dirty sharps. However, the use of the new codes means that direct comparisons with previous years figures for types of health and safety staff incidents are not possible.

The overall level of reported staff health and safety incidents has increased slightly from 556 in 2009/10 to 563 in 2010/11. One of the main categories to see a rise in reporting is of the abuse of staff by patients (176 as against 138). Most of this increase resulted from incidents in the first quarter of the year. During this time one patient generated 9 separate incident reports relating to the abuse of staff during their stay. Ward 33 also generated 13 incident reports due to the activities of a few difficult patients.

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 29 to 23. The decrease was due in part to fewer slip accidents resulting from the bad weather in December and January. This resulted in only 2 specific RIDDOR reports being made when last year the Trust made 6 reports of staff injuries due to slips in snow and ice. The Trust also saw a decrease in the number of staff RIDDOR reports made in relation to moving and handling of patients.

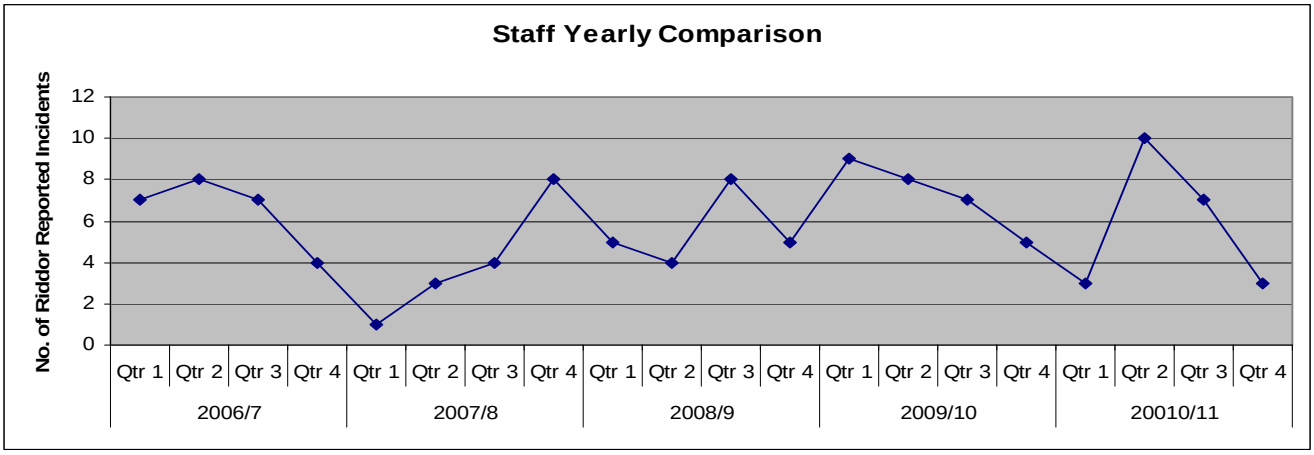
RIDDOR Reports by Year

RIDDOR Reports by Year			
Year	**Number of Employee RIDDOR Reports**	**Number of RIDDOR Reports re Members of the public**	**Total**
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

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

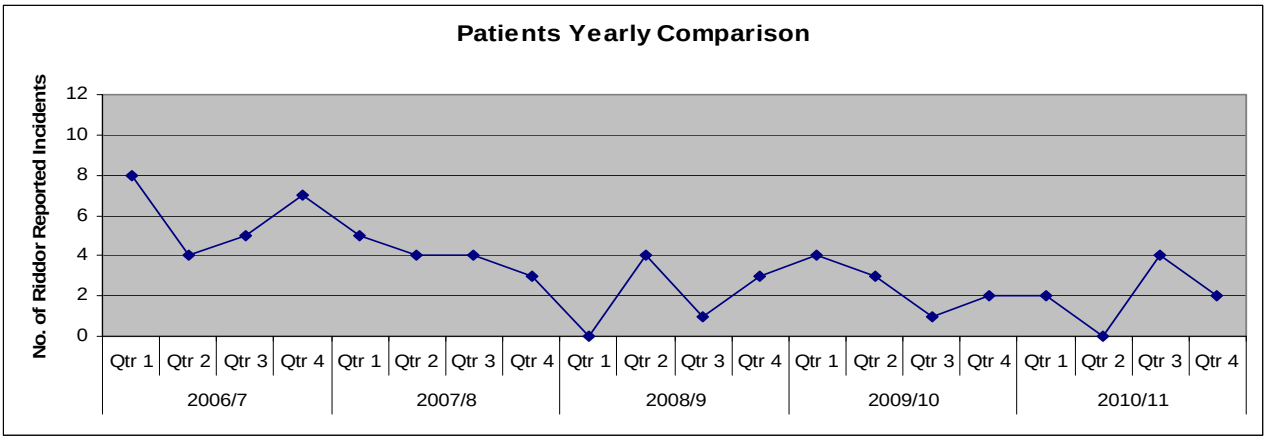
Staff RIDDOR reports by Type and Year

Staff RIDDOR reports by Type and Year						
Type	**2010/11**	**2009/10**	**2008/9**	**2007/8**	**2006/7**	**2005/6**
Moving and handling patient	7	11	5	6	6	7
Manual handling object	4	5	3	2	3	2
Violence and aggression from a patient	-	2	1	1	4	3
Burn from hot food or beverage	-	1	2	1	1	1
Slip	6	7	1	4	5	2
Trip	-	1	5	2	0	2
Hit by moving or falling object	2	0	4	1	3	1
Hit a stationary object	-	1	0	0	0	1
Contact with a hazardous substance	1	0	0	2	2	
Other	3	1	1	1		1
TOTAL	**23**	**29**	**22**	**20**	**24**	**20**



Patient RIDDOR reports by Type and Year

Type	2010/11	2009/10	2008/9	2007/8	2006/7	2005/6
Unobserved fall	2	5	2	8	8	7
Fell from chair/toilet commode	1	0	1	4	4	1
Fell from bed/trolley	1	2	0	2	4	1
Walking to toilet unassisted		1	0	6	5	1
Mobilising without assistance	2	2	2	2	4	1
Slip		0	1	1	0	1
Trip		0	2		1	
Patient transfer	2	0	0	1	0	1
Other		0	0	1	1	
TOTAL	**8**	**10**	**8**	**25**	**27**	**13**



Annual Staff Survey – Key Findings	2010	2009	2008	2007
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	81% (N. Av.80%)	75% (N. Av. 78%)	76% (N. Av. 76%)	75% (N. Av. 73%)
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; needlestick and sharps injuries; slips, trips or falls; or exposure to dangerous substances.	16% (N. Av. 16%)	13% (N. Av. 17%) Lowest (best) 20%	13% (N. Av. 17%)	17% (N. Av. 19%)
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.	24% (N. Av. 28%) Lowest (best) 20%	26% (N. Av. 28%)	27% (N. Av. 27%)	34% (N. Av. 32%)
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.	33% (N. Av. 37%) Lowest (best) 20%	33% (N. Av. 39%) Lowest (best) 20%	36% N. Av. 38%)	35% (N. Av. 35%)
Key Finding 22: 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. 95%)	94% (N. Av 95%)	90% (N. Av. 95%)	96% (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	3.44 (N. Av. 3.45)	3.45 (N. Av 3.42) Statistically significant increase since 2008	3.42 (N. Av. 3.42) Statistically significant increase since 2007	3.34 (N. Av. 3.37)

Annual Staff Survey – Key Findings	2010	2009	2008	2007
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.				
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 2009 score are not possible.***	10% (N. Av. 8%)	11% (N. Av 11%)	14% (N. Av. 12%)	13% (N. Av. 12%)
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 2009 score are not possible.***	2% (N. Av. 1%)	1% (N. Av 2%)	2% (N. Av. 2%)	2% (N. Av. 1%)
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 2009 score are not possible.***	14% (N. Av. 15%)	16% (N. Av. 21%) Lowest (best) 20%	21% (N. Av. 22%) Statistically significant decrease since 2007	27% (N. Av. 25%)
Key Finding 27: 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.	13% (N. Av.15%)	14% (N.Av.18%) Lowest (best) 20%	18% (N. Av. 19%)	20% (N. Av. 19%)
Key Finding 28: 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).	3.49 (N. Av.3.56) Lowest (worst) 20% Statistically significant fall since last survey	3.58 (N. Av. 3.55) Statistically significant increase since 2008	3.55 (N. Av. 3.54)	3.53 (N. Av. 3.50)

The annual NHS staff survey provides the Trust with valuable feedback on staff's perception of the Trust's performance on a range of measures relating to health, well-being and safety. Of the 11 measures provided the Trust is in the best 20% of Trusts in 2 areas, better than average in 4 and in the worst 20% of Trusts in 2 areas (both of these relate to violence and aggression).

It was pleasing to see that following last year's below average return for health and safety training the action plan designed to promote health and safety courses to staff has apparently produced results.

Trust scores compared to other Trusts on issues relating to violence, bullying and harassment are mixed. Overall, Trust scores compared to last year on violence, bullying and harassment have remained about the same. The Action Plans developed for 2011/12 will focus on improving staff's perception of the effectiveness of action by the Trust in relation to violence and aggression.

Areas for action on the staff survey results

- Improve awareness of the need to report violence experienced by staff
- Improve awareness of the need to report bullying and harassment in a confidential fashion
- Consider publicising, in an anonymous way, the action taken by the Trust against those perpetrating violence, bullying, harassment or abuse

Occupational Health

The Trust has an in-house occupational health service that provides services to Trust staff and staff from other organisations, both NHS and private sector, totalling approximately 10,500 staff throughout the health community in the Mansfield, Ashfield and Newark areas.

The occupational health service currently operates from King's Mill Hospital, Mansfield Community Hospital and a weekly satellite clinic within Eastwood Centre at Newark Hospital.

- Contacts to the occupational health service continues to rise with musculoskeletal and stress/anxiety/psychological issues being the predominant reasons for referral. Innovative initiatives have been introduced to drive improvements in these areas

- The Trust has a proactive stress awareness education programme for managers to assist in addressing stress issues in staff. It is also of note that the 2010 Staff Survey outcomes identified a reduction in the amount of Trust staff who considers that they are suffering from work related stress by 4%

- There is a musculoskeletal pain service for staff who experience any type of musculoskeletal problems. Staff are able to access dedicated assessment and treatment appointments with a specialist nurse in pain management and an extended scope practitioner physiotherapist

- The Trust vaccinated 50.3% of staff who have patient contact against influenza during 10/11 – this is the **second highest** rate when compared to 22 other NHS Trusts within the East Midlands (range of percentage of staff vaccinated 11.8% -52.1%:non finalised data received from Strategic Health Authority March 2011)

- The occupational health service has registered with the SEQOHS Occupational Health Service accreditation scheme which was launched in March 2011. This is a national voluntary accreditation scheme which will provide occupational health services with a framework for quality assurance. The service is currently working towards the standards and anticipates to be assessed during 2012.

Sustainability, Environment and Climate Change

Greenhouse Gas Emissions

The Trust, through both the physical construction of the new build PFI hospital and the development and installation of energy efficient schemes, has continued its commitment to reducing the impact to the environment and to improve our sustainability.

This commitment to sustainability improvement is ongoing and the Trust continues to explore further developments to enhance our efficiency

Items include:

- During the phased completion of the new build PFI hospital, the new boilers are powered by gas, with the original coal fed boilers now decommissioned.
- The Trust has installed a closed loop heat pump into the adjoining lake which provides 40% of the site heating load and 100% of the site cooling load. 2011/12 will see the first year of full commission of the geo-thermal lake heat pump with the completion of the hospital construction. Comparative data will therefore be available 2012/13.
- The new build contains a number of in-built design solutions to minimise emissions and to provide an energy efficient building. These include ventilation ducts designed to minimise fan power, fluorescent lighting, timers, motion detectors, daylight sensors and sedum grass roofing. The building is designed to consume less than 55Gj of energy per annum, and data on the effectiveness of the new build and comparative data will be available 2012/13 following completion of the construction late 2010.
- Other options to reduce CO2 emissions being investigated include heat recovery from the electricity being generated by the coal mine methane and the installation of Photovoltaic panels on the roof.
- The Trust achieved CRC registration in October 2010. The carbon footprint will be determined by July 2011.

- The Trust has registered for the EU ETS scheme which the PFI Hard FM contractor manages on the Trust behalf. Trading has not yet commenced.

Area	Source Data	Applicable Metric	Non - Financial Data			Financial Data £000		
			2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Greenhouse Gas Emissions	Direct GHG Emissions	tons CO2	n/a	n/a	15,502	n/a	n/a	n/a

Waste Minimisation and Management

During the construction phase of the PFI the waste management service provided as part of the PFI contractual arrangements, was delivered on an interim basis and based on the in-house service in 2004. Now the PFI contract has moved to Steady State the contractual requirements are extensive in respect of waste minimisation, management, recycling and reporting.

***Please note** the tonnes reported and waste cost for 2010/11 include Newark Hospital.*

Area	Source Data	Applicable Metric	Non – Financial Data			Financial Data £000 – Cost relates to all waste streams		
			2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Waste Minimisation and Management	Domestic Waste	Tonnes	388	429	510	254,000	309,000	527,240
	Clinical Waste	Tonnes	428	569	599	n/a	n/a	n/a

Finite Resources

For the past five years the Trust has experienced a phased construction of the new PFI hospital on the King's Mill site, therefore there have been a number of instances of double running, and a changing proportion of new and retained estate. On that basis energy usage has not been consistent and comparative data is not accurately like for like.

There were omissions from meter readings provided during 2009/10 which have led to the sharp increase in the KWH reported in 2010/11.

Area	Source Data	Applicable Metric	Non – Financial Data			Financial Data £000		
Kings Mill Hospital Site			2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Finite Resources	Water	Cubic Metres	154,084	181,927	175,185	293,000	302,000	326,103
	Electricity	KWH	14,005,756	24,322,745	27,426,900	1,765,000	1,812,000	1,861,930
	Gas	Cubic Metres	853,291	978,938	2,949,840	205,000	237,000	1,133,507
	Coal	Tonnes	2,797	1,789	454	355,000	246,000	67,073
Newark Hospital Site								
Finite Resources	Water	Cubic Metres	n/a	9,279	9,494	n/a	16,099	16,262
	Electricity	KWH	n/a	1,444,590	1,469,730	n/a	150,266	162,594
	Gas	Cubic Metres	n/a	355,143	405,609	n/a	94,154	149,246
	Coal	Tonnes	n/a	n/a	n/a	n/a	n/a	n/a

During 2010/11 the Trust completed the Good Corporate Citizen Toolkit and the results have been used to develop the Sustainability Action Plan to be submitted for Board Approval.

Baseline monitoring was undertaken throughout 2010/11, with AMR meters installed where necessary to meet CRC requirements. This data collection along with the energy management, provided within the PFI will continue to underpin the work of the Sustainability Committee and inform the sustainability and energy usage reports issued to the Board.

Data Confidentiality

The Trust reported one serious untoward incident relating to a breach in confidentiality in 2010/11. Full details are included in the statement on internal control (SIC).

QUALITY REPORT 2010/11

QUALITY REPORT 2010/11 PAGE

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Quality Report 2010/11

Part One

Foreword

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

During the last year we have continued to develop our vision of Best Care, Best People, Best Place. This has been supported by our service improvement programme Achieving Best Care (ABC). We are extremely proud of the significant achievements that have been made this year and of the recognition some of our services have received nationally.

We know that hospital cleanliness and hospital acquired infections are issues which our patients are passionate about and so I am delighted to report that **no** patients have experienced a hospital acquired MRSA blood infection this year and that we have seen significant reductions in Clostridium difficile infections.

Safeguarding children and vulnerable adults, development of our dementia service and care of those patients with learning disabilities have remained a high priority for us, but we have given equal importance to other services and patients within our hospitals.

National stroke indicators show that our patients are receiving timely services and assessments to enhance their recovery and we continue to be fully accredited for all elements of our laboratory services, stroke care and management of acute coronary syndrome.

Our low Caesarean section rates demonstrate that mothers who choose to have their babies at our hospital are more likely to have a normal birth.

We know that our staff are our greatest asset and we are proud of all their achievements. They continue to be key to influencing the quality of care we offer our patients and they helped us in conjunction with patients and carers, governors and members to produce a set of pledges to assist in achieving our shared vision. I was delighted once again to receive our excellent staff survey results which reflect the enthusiasm and commitment our staff have to helping us to achieve our ambitions and recognise the efforts we have made to be a good employer.

During 2011/12 we will again focus on three key priority areas; patient safety, clinical effectiveness and patient experience, ensuring that we have a balanced set of objectives which influence those things which make the most difference to our patients. We have strengthened our governance arrangements so that we can continue to provide positive assurances regarding the quality and safety of the health provision for our local population.

This report, while looking back over our achievements in 2010/11, also looks forward to the coming year which we know will be very challenging for us. With this in mind, it is even more important that we continue to drive up our quality standards, protect our patients from harm and ensure that we continue to improve. Our commitment to this is absolute.

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

Carolyn White
Chief Executive
26 May 2011

Statement of Directors' Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are satisfied that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board from April 2010 to June 2011
  - Feedback from the commissioners dated 31 May 2011
  - Feedback from Governors dated 19 May 2011
  - Feedback from LINks dated 12 May 2011
  - The 2010 National Patient Survey
  - The 2010 National Staff Survey
  - CQC Quality and Risk Profiles dated Sept 2010 – May 2011
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Tracy Doucét, Chairman, 26 May 2011

Carolyn White, Chief Executive 26 May 2011

Part Two

Priorities for Improvement in 2011/12

The Trust has made a number of significant quality and safety improvement initiatives, which we will continue to progress in 2011/12. This report gives an overview of these and also focuses on our three key priorities as we move forward.

Our key priorities for 2011/12 are based on the domains of quality and reflect the potential to improve patient safety, clinical effectiveness and patient experience. We feel these priorities will stretch the organisation further in its vision of providing Best Care, Best People, Best Place.

We have made our choices based upon our patient feedback, information taken from our patient survey responses both nationally and locally, and our quality schedule and contract, where our commissioners have chosen their priorities based upon their experiences within our local community

We will report our progress through our monthly and quarterly quality reports which are presented to:

- Board of Directors
- PCT Monthly Quality Scrutiny Panel
- Clinical Governance Committee
- Patient Quality and Experience sub-committee of the Board of Governors

Priority One - Patient Safety

Our aim is to reduce our Hospital Standardised Mortality Ratio (HSMR).

The 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.

We will address this priority through our newly created Mortality group chaired by the Executive Medical Director.

We aim to reduce mortality levels to achieve top 25% nationally.

This will be undertaken by agreeing and understanding where mortality occurs and identifying areas for improvement.

Monitored: It will be monitored via the Mortality group.

Measured: It will be measured using the Dr Foster intelligence data.

Reporting: The monitoring will be reported to the monthly Clinical Governance Committee with exception reporting to the board.

Priority Two - Clinical Effectiveness

Our aim is to reduce ambulance turnaround time within the Emergency Department.

Delays in handover times impact on the outcome of our patient's treatment and reduce the quality of our patient's experience. They also reduce the availability of emergency ambulances for other users.

We will address this priority through organisational redesign and refining the patient pathway.

Monitored: It will be monitored by our service line reporting.

Measured: It will be measured by our performance against targets.

Reported: Performance will be reported to the board monthly by monitoring information.

Priority Three – Patient Experience

Our aim is to embed in practice the use of the Malnutrition Universal Screening Tool (MUST). Malnutrition is both a cause and a consequence of ill-health. Even people who are well-nourished, eat and drink less if they are ill or injured and although this may only be short-lived as part of an acute problem, if it persists the person can become undernourished to an extent that may impair recovery or precipitate other medical conditions.

We will address this through rigorous training programmes and performance management.

Monitored: It will be monitored by the Nutrition Board, the nursing care metrics and Essence of Care Nutrition benchmark.

Measured: It will be measured by monthly audits.

Reported: Performance will be reported to the Board of Directors by the quarterly quality report.

Further Quality Priorities that we are Recommending for 2011/12

Patient Safety

To ensure our patients are free from accidental injury due to the healthcare we provide.

We aim to:

- Maintain and improve outcomes for healthcare associated infections MRSA, MSSA, C Diff E coli and urinary infections following catheterisation.
- Implement High Impact Actions to reduce patient falls, pressure ulcers and urinary catheters.
- Maintain a zero tolerance on avoidable hospital acquired pressure ulcers and reduce the number of hospital acquired ulcers based upon 2010/11 outturn.
- Maintain a philosophy that normalises birth including monitoring Caesarean section rates, vaginal births and home births. Sustain or improve performance to ensure we remain within the national top quartile benchmarks.
- Prevent of avoidable acute kidney infection.

Clinical Effectiveness

Clinical effectiveness is the extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve the health of patients securing the greatest possible health gain from the available resources.

We aim to:

- Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE).
- Continue to improve monitoring of acutely ill patients.
- Further reduced incidents of slips, trips and falls.
- Maintain compliance with Same Sex Accommodation.
- Reduce inappropriate readmissions by improving discharge communication.
- Implement a system within the Trust which identifies people who smoke, providing brief advice and where appropriate, refers to local specialist stop smoking services.
- Improve patient outcomes in acute stoke patients.
- Improve patient pathways through the Emergency Department.
- Improve access to contraceptive services in termination and maternity services.
- Improve the number of patients asked about their alcohol intake.
- Reduce the number of under 17 year old accident and emergency attendees who are admitted into hospital.

Patient Experience

This is how our patients feel about the care they receive whilst in our hospitals.

We aim to:

- Improve patients experience for patients suffering dementia
- Improve outcomes for end of life care
- Improve the quality of health care for patients with learning disabilities
- Improvement against the five national indicator measures

  - o Were you involved as much as you wanted to be in decisions about your care and treatment?
  - o Did you find someone on the hospital staff to talk to about your worries and fears?
  - o Were you given enough privacy when discussing your condition or treatment?
  - o Did a member of staff tell you about medication side effects to watch out for when you went home?
  - o Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Part Three

How have we delivered our priorities in 2010/2011?

This part of the quality account details our achievements in 2010/11, commencing with an update report on our key priorities.

In 2009/10 we identified our key priorities for 2010/11 as:

Priority 1 To further reduce incidents of slips, trips and falls

Priority 2 To reduce avoidable death, disability and chronic ill health from VTE (venous thromboembolism)

Priority 3 To improve privacy and dignity of patients including Same Sex Accommodation

Priority 1

Patient Safety

To further reduce incidents of slips trips and falls

Description of the Issues and Rationale for Prioritising

Falls are the commonest presentation of an older person to Accident and Emergency. 30% of the population over the age of 65 will fall each year and this rises to 45% in the over 85's (1). Half of those who do fall will fall again within the year. The National Patient Safety Agency reports that falls are the commonest reported adverse event for patients (2). Our local population appears to be at an intrinsic higher risk of falling. This work is a high priority for our commissioners.

At the Trust we recognise the importance of good assessment and risk prevention and have identified that we can improve our practices to reduce falls.

Some of the actions that we have put into place are:

- We conduct Trust-wide observational audits of risk assessment tools and care plans.
- We identify trends and high risk areas ongoing analysis of the Trust's falls per occupied bed days and comparison with National Patient Safety Agency figures.
- We analyse our information systems (DATIX) to identify trends and hotspots and from this, develop action plans using calculated falls per occupied bed days as per National Patient Safety Agency, Royal College of Physicians and National Service Framework guide lines.
- We review the falls rate data in more detail and categorise falls into 'no harm', 'low harm', 'moderate harm', 'serious harm' and 'catastrophic harm'.
- We review serious incidents relating to inpatient falls using root cause analysis.
- We have a training programme for both to raise awareness and ensure consistent management has been implemented.
- We have developed a new ideas culture to introduce high impact, low cost changes.

Our Key Improvements / Achievements

- Our monthly audits demonstrate we have dramatically improved the number of patients who are risk assessed for falls on admission and that those at risk of falling have appropriate plans of care in place

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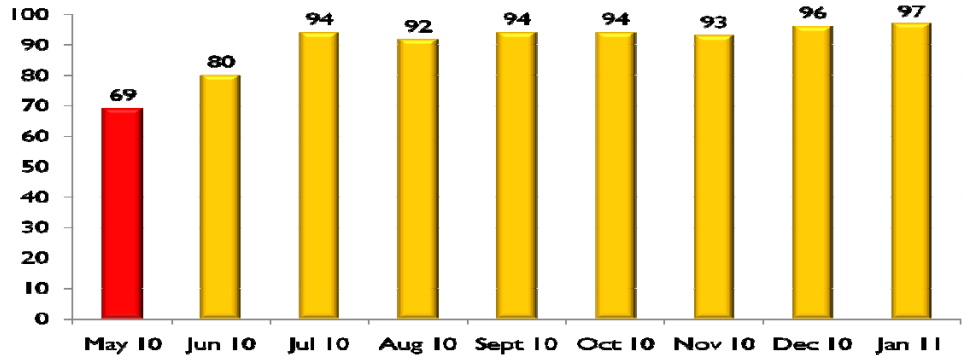


Falls Risk Assessment Audits

- The average Trust falls rate is 9.21 per 1000 occupied bed days (in line with national figures), most of which result in no harm.
- Our Trust has a lower rate of moderate harm outcomes at 1% compared to the national average of 3.3%

Further Planned Improvements for 2011/12

- We are planning a triangulation audit of 'Falls Risk Assessment/Care Plan'.
- We have improved care for our patients who suffer with dementia/delirium. We are looking at alternative methods to improve patient orientation on the wards.
- The work undertaken by the Elderly Care Assessment Team at the point of admission has meant that our patients who attend hospital following a fall receive an appropriate falls review, a follow up telephone call and appropriate referrals to the Falls Community Team, Intermediate Care and the Falls Clinic at King's Mill Hospital.
- Our orthopaedic service has been developed to ensure appropriate patients are referred to the Falls Community Team, Falls Clinic and the Osteoporosis Nurse Service.

References

1. Campbell, A., Reinken, J., Allan, B., Martinez, G. (1981), "Falls in old age: a study of frequency and related clinical factors", Age and Ageing, Vol. 10 No.4, pp.265-70.

2. National Patient Safety Agency Report - Slips, trips and Falls in Hospital (2007).

Priority 2

Clinical Effectiveness

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

Description of the Issues and Rationale for Prioritising

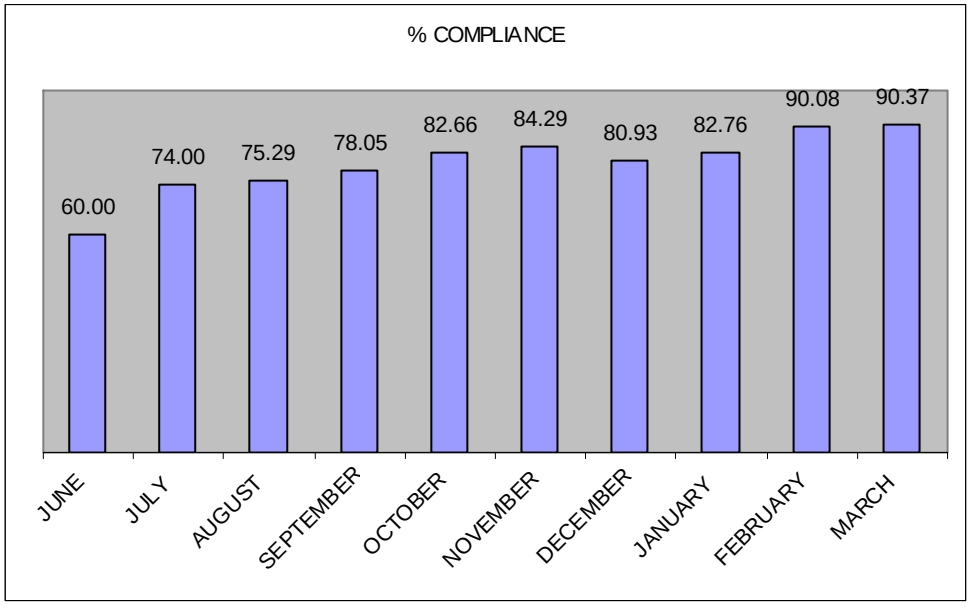
Venous thromboembolism (VTE) is the formation of a blood clot (thrombus) in a vein. It was thought that each year there are 25,000 preventable deaths from VTE in hospitals in England. The Department of Health published a thromboembolism risk assessment strategy, recommended for use with all patients on admission to hospital. The aim is that all adults admitted to hospital are risk-assessed for VTE, this is documented on the risk assessment form and where appropriate, the patient receives the right prevention measures. This priority formed part of our Commissioning for Quality and Innovations (CQUIN).

Aim

- Our aim was that at least 90% of our adult inpatients would receive a VTE risk assessment on admission.
- Where VTE / deep vein thrombosis / pulmonary embolus (PE) are diagnosed, we would instigate a root cause analysis (RCA) process, to review whether care had been appropriate, learn lessons and implement changes.

Our Key Improvements / Achievements

- Our audits demonstrate continuous improvement achieving 90% for the months of February and March 2011 for adult inpatients receiving a VTE risk assessment on admission.



- We have been reported as delivering the 'best regional performance' for four out of the five published months.
- Others have visited us to learn about our data collection as we have been identified as having exemplary processes.
- We are pleased to say there have been no care issues identified in any patients who had VTE noted on the death certificate.
- 96% of patients who had received a VTE risk assessment on admission receiving appropriate prophylaxis.

Priority 3

Patient Experience

To improve privacy and dignity of patients including Same Sex Accommodation (SSA)

Description of the Issues and Rationale for Prioritising

In January 2009 the Department of Health announced as a priority a package of measures designed to 'all but eliminate mixed-sex accommodation' by 2010. The Trust publicised a declaration of compliance with SSA on 1 April 2010. National monitoring and reporting was introduced with effect from December 2010 with details of all breaches of sleeping accommodation available to the public from January 2011, with contractual financial sanctions. This priority was part of our quality schedule and quality contract with the commissioners.

Aim

- To be compliant with the requirements of a national document - PL/CNO/2010/2, sustaining the principles of same sex accommodation for all our patients.

Our Key Improvements / Achievements

- We have reported no breaches of SSA for 51 weeks of the year.
- We are able to publicise a declaration of compliance with the new policy statement thereby confirming that we have eliminated mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice.
- Due to the breaches within our Emergency Admissions areas in December 2010, we have allocated two single occupancy side room as 'short stay' areas. This means that our patients will not be mixed together, even when the unit is busy.

Part Four

Other Quality Improvements in 2010/2011

Patient Safety

To reduce cases of healthcare acquired infections (specifically urinary tract infections and Methicillin Sensitive Staphylococcus Aureus [MSSA Bacteraemia])

Description of the Issues and Rationale for Prioritising

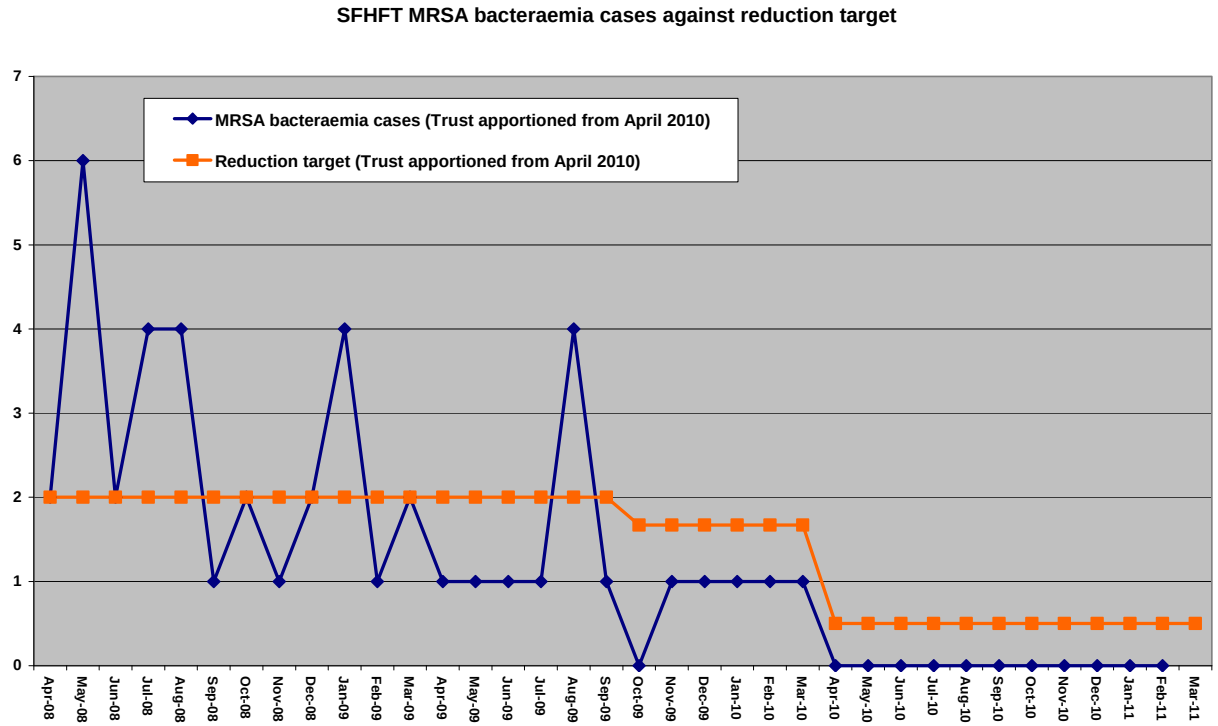
We are extremely proud of our successes in relation to infection, prevention and control and set ambitious targets of no Trust acquired cases of MRSA Bacteraemia and a reduction in cases of Clostridium Difficile (C Difficile). We also wanted to develop work in relation to other hospital acquired infections to ensure we achieve the same successes as those demonstrated with MRSA and C Difficile.

Our Key Improvements / Achievements

- At the beginning of the year we successfully implemented a MRSA screening programme for all our elective admissions. Over 2010/11, we extended this programme to ensure all emergency admissions were screened within 24 hours of admissions.
- To ensure we treat our patients with the correct antibiotics we have undertaken antibiotic audits. These demonstrate excellent results.
- We have scored very highly for our Patient Environment Action Team (PEAT) and mini PEAT inspections.

2010/11 has been a year of many successes:

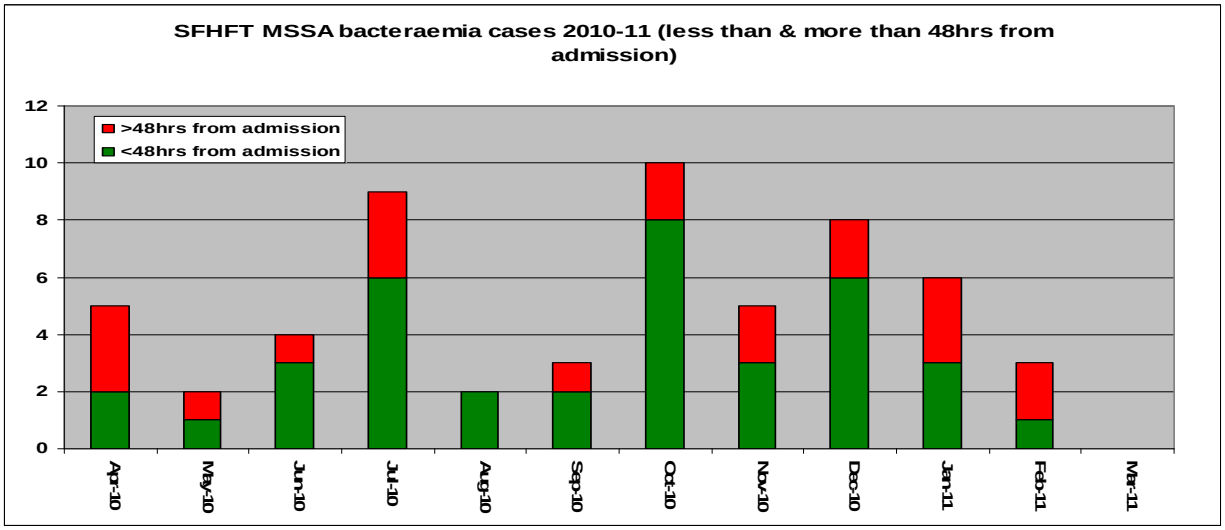
- We are the only Trust in the East Midlands that reached and surpassed a full year with no Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia which is demonstrated in the following graph.



- We were set a target of no more than 63 hospital acquired C Difficile cases. We successfully managed to meet this target. We reported 54 hospital acquired cases of C Difficile. We are one of the best performing hospitals within the East Midlands.
- We screen all our inpatient admissions for MRSA.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

- Reporting of MSSA bacteraemia prior to January 2011 was voluntary, however, from January 2011 this reporting is mandatory. We are currently setting ourselves improvement targets.



Urinary tract infections

This is a newer target which we are working towards achieving. In the absence of any national guidance/definition of a urinary tract infection associated with a urinary catheter, we are working to reduce the

number of unnecessary catheterisations, which will reduce the number of urinary tract infections. We are ensuring we achieve over 75% compliance with High Impact Intervention audits for insertion of urinary catheter.

Patient Safety

To maintain a zero tolerance on hospital acquired pressure ulcers

Description of the Issues and Rationale for Prioritising

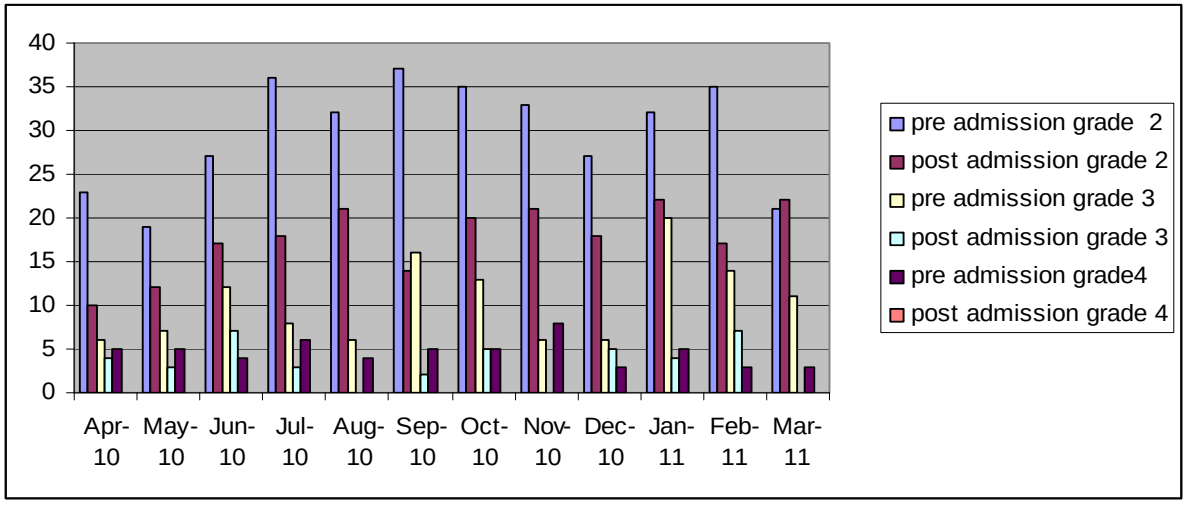
Pressure ulcers occur in 4-10% of patients admitted to hospital. Pressure ulcers can occur in any patient but are more likely in high risk groups, such as the elderly, people who are obese, malnourished, or have continence problems, people with certain skin types and those with particular underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection.

Pressure Ulcers are reported as grade 1 being least serious and grade 4 the most serious.

Our Key Improvements / Achievements

- During 2010/11 a total of 40 hospital acquired Grade 3 pressure ulcers were reported.
- We are proud to announce that no patients whilst in our hospitals developed a Grade 4 pressure ulcer during 2010/11.

Total number of Pressure Ulcers for 2010/11– Pre and post admission



Patient Safety

To implement National Best Practice standards within the Patient Safety First campaign to include specific focus on reducing slips, trips and falls.

The National Patient Safety First campaign was designed to encourage, inform and motivate clinicians to change practice, and to inspire leaders to embrace the safety culture. It was designed to reduce harm in four key areas by the implementation of evidence based interventions in clinical practice.

Safety Express is the name of the new Safe Care Work Stream and so named, in order to drive improvements forward at a rapid pace, in partnership with existing programmes, in particular 'Energising for Excellence, High Impact Actions, Patient Safety First, the Productive Series' and the National VTE Implementation group, within each SHA region.

The Safety Express programme aims to work in collaboration with other participating Trusts within the Strategic Health Authority region to reduce harm from:

- Pressure ulcers
- Falls
- Catheter acquired urinary tract infections
- Venous thrombo-embolism, (VTE)

All of these domains have been reported within this quality report.

Patient Safety

To implement the World Health Organisation (WHO) theatre checklist.

Description of the Issues and Rationale for Prioritising

The safe surgery checklist, which was launched by WHO as a recommended guideline for safe practice, has since gained global recognition by operating theatre staff, including surgeons and anaesthetists. In January 2009, the National Patient Safety Agency (NPSA) issued a patient safety alert, requiring NHS organisations to implement the WHO Surgical Safety Checklist (SSC) for every patient undergoing a surgical procedure. The checklist has been crucial in introducing safer surgery practices to reduce patient harm and the level of surgical complications.

Our Key Improvements / Achievements

- We implemented the SSC on 1 June 2009 in all our main theatres, across both of hospitals. The implementation followed the guidance contained within the 'WHO starter kit'.
- The layout of the checklist initially followed that recommended by the WHO, and has undergone several modifications and redesigns, to reflect our local practice and ensure we continue to engage and support staff.
- We have audited compliance with the checklist every six months and have

implemented changes following the results.

- Specific questions added to the checklist have allowed the Trust to comply with two NPSA Safety Practice Notices, related to throat packs (Safer Practice Notice NPSA/2009/SPN001), and finger tourniquets (Rapid Response Report NPSA/2009/RRR007).

Patient Safety

To maintain improvement in Caesarean section rates to be within the top quartile of peer comparator Trusts

Description of the Issues and Rationale for Prioritising

2010/11 was again a very successful year for maternity services at Sherwood Forest Hospitals, of which we are very proud. On 9 November 2010 the new state of the art maternity unit at King's Mill officially opened the door to expectant mums. This new unit complements national accolades for Sherwood Forest Hospitals NHS Foundation Trust (SFH) maternity services in 201/11 when:

- SFH was one of only two Trusts in the East Midlands whose maternity services were rated as 'Best Performing' by the Care Quality Commission.
- NHS Information Centre figures released in 2010 revealed impressively low Caesarean section rates and higher home birth rates.

Our Key Improvements / Achievements

- Our Lower Segment Caesarean Section Rate for 2010/11 is 16.94%, suggesting that ladies who have their babies at SFHFT are more likely to have a normal birth. This continues to be the best in the East Midlands region (nationally around 25%).
- We have successfully maintained our Lower Segment Caesarean Section Rate for 2010/11 alongside an increasing birth rate, which has increased by 6% since 2009/10.
- As part of the NHS East Midlands Normalising Birth work-stream we are sharing our best practice to influence other birthing units across the East Midlands region. Our work is being incorporated into the 'Towards Excellence' website.
- We have introduced the WHO Checklist in maternity Theatres.

Clinical Effectiveness

To achieve the 62 day Cancer Targets

Description of the Issues and Rationale for Prioritising

It is important that patients with suspected and diagnosed cancer have appointments, tests and treatments in a timely fashion, both to improve their outcomes and their experience in the NHS. This is a national target.

Our Key Improvements / Achievements

62 day Classic patients referred from their GP or upgraded by consultant

- We are pleased to report that our actual performance was above the national standard (85%) for the whole year.

62 day Screening patients referred from National Screening programmes

- We are able to report that our actual performance was above the national standard (90%).
- To achieve this we have:
  - Continued monthly meetings with the Cancer Centre to discuss referrals from other hospitals.
  - Appointed an additional Colonoscopist who is accredited for the screening programme.
  - Continually reviewed performance through the 6 weekly Cancer Unit Management Board group.
  - With our Primary Care Trust colleagues, we are leading a project on the education of 2 week wait pathways in GP setting and are re-launching the use of a 2 week wait patient information leaflet prior to referral.

Patient Safety

To continue to improve monitoring of acutely ill patients

Description of the Issues and Rationale for Prioritising

Monitoring patients (checking them and their health) regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems. The NICE clinical guideline describes how patients in acute hospitals should be monitored to help identify those whose health becomes worse and how they should be cared for if this happens.

Our Key Improvements / Achievements

- Our overall Trust compliance with six NICE mandatory vital signs is 88% (this has improved significantly from 46% in 2008).
- Our compliance with respiratory rate, heart rate, blood pressure, oxygen saturation and temperature monitoring is excellent (99-100%).
- All patients (100%) in our hospitals have observations recorded every 12 hours as a minimum.

Patient Safety / Experience

To improve the care of patients with Dementia

Description of the Issues and Rationale for Prioritising

Dementia is one of the most important issues we face, as the population ages. ‘Living well with Dementia - a National Dementia Strategy’ was published in February 2009. It set out a vision for transforming dementia services with the aim of achieving better awareness of dementia, early diagnosis and high quality treatment at whatever stage of the illness and in whatever setting. Raising the quality of care for people with

dementia and their carers is a major priority for our Trust.

Our Key Improvements / Achievements

Strategy

- The Nottinghamshire Dementia strategy is in its first draft and has utilised the expertise of neighbouring hospitals and community services to formulate the foundations for the SFHFT document.
- The Dementia Strategy Steering Group has membership from all disciplines and is led by senior decision makers from nursing and medicine, as well as the involvement of a carer.
- The first draft of our strategy has encapsulated the importance of the individuality of dementia from a patient perspective, reflecting a whole system pathway approach

In Practice

- The lead consultant is leading the development of clinical pathways where early assessment and diagnosis takes place, to ensure that dementia patients are recognised at the earliest possible point in their pathway. We believe that early assessment and diagnosis ensure that dementia patients can be influenced by the best Trust standards of care management.

Educational

- We are integral to the Nottinghamshire Healthcare Representatives Dementia Competencies steering group.
- The fundamental common theme that was recognised by the group was the need to set a 'core' set of educational/ training level competencies that would then meet the needs of different staff groups who are directly or indirectly involved with dementia patients.

Research and Audit

- We have been involved in a national pilot research project relating to dementia patients 'Seeing through their eyes'. This research (Wards 51 and 52) reviewed patient-centred interactions with staff. The pilot was led by a Research Fellow from the Academic Unit of Elderly Care from Bradford Institute and Professor John Young.
- We have participated in the National Audit for Dementia.
- The Trust Dementia Steering Group has engaged in an audit to assess the current position in relation to the recognition of dementia patients admitted to the Trust

Patient Safety

Safeguarding Vulnerable Adults

Description of the Issues and Rationale for Prioritising

Safeguarding Adults is about enabling adults to live safer lives. The 'No Secrets' document published by the Department of Health in 2000 gave guidance to encourage agencies to work together, and for them to produce multi-agency policies for the protection of vulnerable adults, providing a national framework of standards for

good practice. Our aim is to ensure we implement excellent standards in relation to safeguarding.

Our Key Improvements / Achievements

- Our Safeguarding Adults Board has produced a local policy which is available on the intranet and as part of the rolling training programme.
- Two stage test and best interest check list documentation has been devised.
- A training programme for Safeguarding Adults, Mental Capacity and Deprivation of Liberty continues to raise staff awareness.
- An Elder Abuse awareness day took place on 15 June 2010.
- On 16 July 2010, the Trust held a Safeguarding Adults study day titled 'Working Together'. The speakers included Nottinghamshire's Coroner, Police, Social Services, Chair of the Nottinghamshire Safeguarding Adults Board, and Dr Margaret Flynn – author of Serious Case Reviews and the Independent Chair of Lancashire Safeguarding Board.
- As a result of the ongoing training for Safeguarding Adults, there is evidence of raised awareness from the referrals received.
- Lessons learnt from safeguarding concerns have been included in the Trust's Safeguarding training.
- There is increased uptake of Mental Capacity and Deprivation of Liberty training, which has resulted in the use of the Mental Capacity Act in practice.
- The availability of easy read information for Safeguarding, Mental Capacity and Deprivation of Liberty, for patients and carers.

Patient Safety

Safeguarding Children and Young People

Description of the Issues and Rationale for Prioritising

The Safeguarding Children & Young Peoples Governance Meeting (SC&YPGM) provides assurance, advice and guidance to the Trust on all issues related to safeguarding children and young people in order to ensure compliance with key statutory guidance and legislation (HM Government 2010, 2008, 2007, CQC 2010). The SC&YPGM is responsible for developing and maintaining the Safeguarding Children Training Strategy/ Programme to ensure compliance with national recommendations (RCPCH 2010). An annual Safeguarding Children Annual Work Plan of quality has been developed and implementation monitored.

Our Key Improvements / Achievements

- The appointment in January 2011 of a full time Safeguarding Children Midwife.
- The development of a re-admission patient alert system (RAPA) which now alerts a paediatrician if one of their current patients attends Emergency Department.
- A RAPA system has also been developed for the national missing family/children alerts regularly received by the Trust.
- Two new guidelines developed:
  - Guideline for Un-booked Pregnancies (to ensure appropriate social care checks always made).

- Guideline for Child and Adolescent Mental Health Services referrals in patients presenting with deliberate self-harm or acute mental health issues for use in ED to ensure appropriate care.

- In conjunction with the Primary Care Trust, new paediatric liaison criteria were developed for use on the paediatric wards and neonatal unit to ensure the most vulnerable children were provided with additional information sharing and liaison between acute and community services.
- A quick reference guide Safeguarding Babies on NICU – Key Actions was also produced as an additional prompt for busy staff.
- The Social and Domestic Alert sheet used by midwives was also redesigned to meet the Trust's Situation, Background, Assessment and Recommendations (SBAR) format in order to improve the recording of safeguarding information.

Clinical Effectiveness

Further participation in national clinical audits

Description of the Issues and Rationale for Prioritising

During 2010/11, 42 National Clinical Audits (NCA) and 4 National Confidential Enquiries (NCEs) covered NHS services that Sherwood Forest Hospitals NHS Foundation Trust provides. We participated in 81% (34/42) of NCAs and 100% (1/1) NCEs which we were eligible to participate in.

Our Key Improvements / Achievements

- The 10/11 list of NCA has substantially increased from 17 to 41. It is likely that another increase will follow for 11/12.
- Participation in National Audits is not mandatory, however, Trusts should view a well designed and effective national audit program as an essential tool for them to improve services and assess performance.
- Rather than just 'increasing' participation as a priority, we are now ensuring that Trust resources are focused on key national audits following robust assessment of the quality/value of a 'national audit' by the Clinical Audit Committee.
  - All national deadlines for registration and data submission were achieved.

Internal Audit

- The Trust's Internal Audit report showed that we have 'significant assurance' regarding the robust nature of clinical audit processes and systems, with a few minor weaknesses which are being addressed by an action plan. A local benchmarking report produced by Internal Audit also demonstrated that we have the highest compliance against national performance indicators for clinical audit when compared to our neighbouring Trusts.

Annual Clinical Audit Assessment Report 2009/10

- A detailed report for the previous year was produced which incorporated for

the first time a quality scoring system to provide us with a gauge as to the quality and value of audits

undertaken. The 2010/11 report is currently being compiled.

Patient Safety

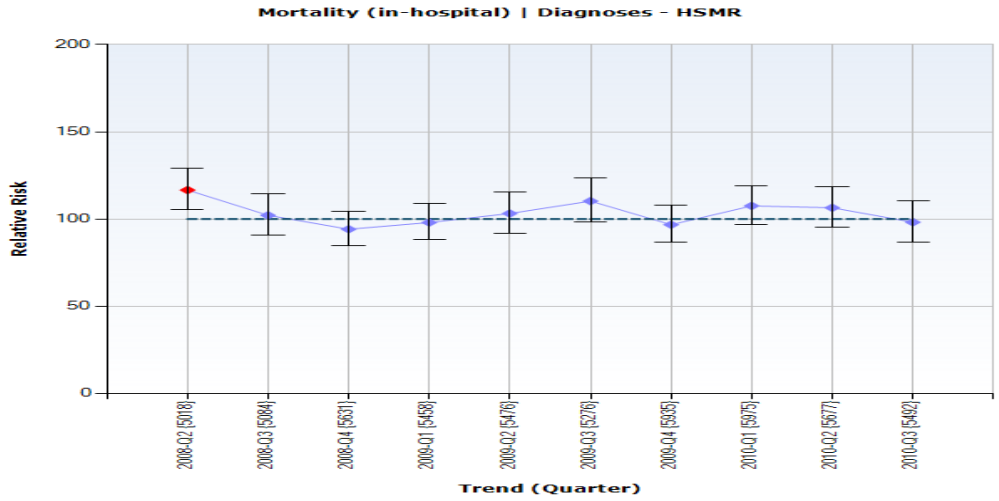
To implement a monthly review of Hospital Standardised Mortality Ratio

Description of the Issues and Rationale for Prioritising

The HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death - for example, heart attacks, strokes or broken hips. HSMR relates to the 56 diagnoses that account for 80% of in hospital deaths across England. Dr Foster mortality data is an important indicator of patient safety within our hospitals.

Our Key Improvements / Achievements

- Prior to June 2010 the Trust reacted to alerts generated by Dr Foster, Imperial College or the Care Quality Commission (CQC). These alerts required a formal response within a short timescale. As soon as an alert is generated, an investigation is commissioned by our Clinical Governance Committee. Findings are reported within three months.
- During 2010, there were nine diagnosis alerts and four procedure alerts. Six of the diagnosis alerts required further investigations. All six investigations were supported by an action plan, tracked by CGC until complete.
- Three of the four procedure alerts required further investigation, with two of these requiring improvement plans. All actions are now complete.
- We have consistently stayed within acceptable scores for our HSMR. Our HSMR as of March 2011 was 99.6%.



- In the patient safety indicators, Dr Foster named our coding outcome as: **'**High adverse events, high coding rate**'.** The best position to be: 'low adverse events, high coding' and the worst position is 'high adverse events, low coding'. This position was reported as a good news story

because it demonstrated that we record a good level of secondary codes, which should be interpreted as a Trust who has a high level of openness and quality coding.

Patient Experience

To improve patient's dignity in theatre with more effective theatre gowns

We have altered our practice regarding transfer to theatre. Patients (if able) are encouraged to walk or travel in a wheelchair to theatre using their own dressing gown for modesty purposes.

Clinical Effectiveness

To improve the number of procedures listed in the BADS (British Association of Day Surgery) handbook (day case procedures)

Description of the Issues and Rationale for Prioritising

Day surgery is best defined as 'the admission of selected patients to hospital for a planned surgical procedure, returning home on the same day". Day case surgery is becoming more common and popular, with approximately 70% of all surgery performed as day surgery. The NHS Institute has worked with day surgery clinicians and the British Association of Day Surgery (BADS), to identify a list of procedures that can easily be done as day cases.

Our Key Improvements / Achievements

- We are achieving the overall national target for BADS recommended day case procedures.
- In certain specialties, day case activity is above the expected day case rate as outlined in the third edition of the procedure directory e.g. ophthalmology, maxillofacial surgery, orthopaedics.
- Our day case rate for laparoscopic cholecystectomy surgery has improved significantly from <10% to 40%. This includes patients with significant co-morbidities where the expectation for same day discharge is less.
- There has been a specific focus on achieving higher day case rates for two high volume procedures; namely tonsillectomy and laparoscopic cholecystectomy.

Clinical Effectiveness

To reduce the number of under 17 year old accident and emergency attendees who are admitted into hospital.

Description of the Issues and Rationale for Prioritising

The aim of this quality measure is to reduce the number of children (age 17 and under) with milder, self limiting diseases being admitted to children and young people's wards, following their attendance to the Emergency Department. Our work is part of an East Midlands wide project specifically reviewing children under 17 attending emergency departments.

Our Key Improvements / Achievements

- We have recently implemented a clear algorithm which enables us to quickly identify patients who we feel can be safely discharged home from the Emergency Department.
- We are developing clear nursing guidelines in relation to the early administration of antipyretic medication (temperature reducing) and oral fluids, to avoid delays for our patients.
- We are developing information to enable parents to be confident to be able to manage common conditions at home.

Clinical Effectiveness

To reduce the mean medical length of stay

Description of the Issues and Rationale for Prioritising

By reducing the time patients spend in hospitals, their overall experience is improved and the risk of healthcare associated infection and hospital acquired pressure ulcers is decreased. It is known that patients admitted for treatment with the same condition may experience considerable variation in their length of stay.

The East Midlands aim to reduce the mean length of stay for medical patients, thereby improving patient outcomes, whilst reducing the use of resources.

Our Key Improvements / Achievements

To support the reduction in length of stay for medical patients, we have concentrated on orchestrating discharge, through improving our discharge processes. We currently use Jonah (a predictive planning tool) throughout SFHFT to support discharge planning, which allows ward teams to proactively manage the patient's discharge process. To complement this and improve our discharge processes we have:

- Implemented weekly discharge performance meetings to both analyse and future plan; length of stay, morning discharges and discharges by day of the week.
- Strengthened our multi-agency meetings between health and social care. These are held weekly to rectify constraints within the patient pathway, which would delay a timely discharge.
- Initiated early morning discharge board rounds to identify patients who could be discharged that day.
- Implemented nurse led discharge.

Clinical Effectiveness

Reduction in emergency readmissions for people with long term conditions

Description of the Issues and Rationale for Prioritising

In collaboration with the East Midlands, the aim of this work is to improve the quality of care for people with long term conditions such as chronic obstructive pulmonary disease, asthma, diabetes, epilepsy, renal disease, congestive cardiac failure and angina. Patients with poorly managed long term conditions may require emergency treatment that could otherwise be prevented through disease management.

Our Key Improvements / Achievements

- We have increased the amount of consultant support within our Emergency Department.
- Between January and March 2011, we have reduced GP admissions by 20%.

Clinical Effectiveness

To improve our post stroke death and dependency rate

Description of the Issues and Rationale for Prioritising

Since King's Mill Hospital gained accreditation in August 2009 as a primary stroke centre, work continues to further improve the service. Using a structured stroke service improvement programme we have developed specific work streams for transient ischemic attack (TIA-mini-stroke), stroke pathways and cross county partnership working.

Our Key Improvements / Achievements

- We have specifically developed a stroke care pathway to ensure stroke diagnosis patients are admitted directly to the Acute Stroke Unit and taken to Nottingham City Hospital (if eligible) for thrombolysis.
- There has been continuous monitoring of stroke care and the following table shows data relating to dependency scores. The target was for 95% of all stroke patients to have their dependency scores undertaken within 24 hours of admission, and within 24 hours prior to discharge from hospital.
- This target has been successfully achieved over the last six months.

	Qtr 1 10/11 105 pts	Qtr 2 10/11 96 patients	Qtr 3 10/11 103 patients	Qtr 4 10/11 98 patients
% of stroke patients with no change in dependency from admission to discharge		7%	16%	9%
% of stroke patients with improved dependency levels		76%	73%	79%
% of stroke patients with dependency scores done within 24 hrs of admission		92%	99%	95%
% of stroke patients with dependency scores done within 24 hrs prior to discharge		71%	97%	95%
% of patients discharged with greater dependency		0%	1%	6%

- We have continued to develop a High Risk TIA service.
- To ensure we are delivering the best service and outcome possible, we continue to monitor stroke elements for Sentinel key performance indicators, Accelerated Stroke Improvement indicators, CQUIN key performance indicators and Best Practice Tariff.

Clinical Effectiveness

Improvements in national sentinel process of stroke care audit scores

Description of the Issues and Rationale for Prioritising

During 2010/11 we have measured ourselves against nine Sentinel Key Performance Indicators (KPI's) which would demonstrate whether we are continuing to improve the care we offer patients who have suffered a stroke.

Our Key Improvements / Achievements

- Over the last year, the results from the ongoing measurement against the nine Sentinel Audit KPI's demonstrate continual improvement in nearly all indicators.
- The % of patients whose care achieves all nine indicators has improved from 14% to 72% over the last year.
- Patients receiving a brain scan within 24 hours of stroke were previously

identified as an area of concern. This year there has been sustained performance above the top quartile all year, whereas now 95% of our stroke patients receive a brain scan within 24 hours of a stroke.

National sentinel process of care audit scores progress report

		National quartiles							
		25% of sites score below	median score	25% of sites score above	Baseline - Sentinel Audit October 2008	qtr 4 09/10 98 pts	Qtr 1 10/11 105 pts	Qtr 2 10/11 96 patients	Qtr 3 10/11 103 patients
Indicator 1	Patients spend at least 90% of stay on a stroke unit	44%	56%	69%	66%	75%	76%	74%	98%
Indicator 2	Screening for swallowing disorders <24 hours after admission	58%	73%	88%	74%	78%	87%	90%	97%
Indicator 3	Brain scan within 24 hours of stroke	44%	57%	70%	41%	82%	89%	94%	95%
Indicator 4	Aspirin or clopidogrel by 48 hours after stroke	77%	88%	96%	87%	71%	77%	87%	97%
Indicator 5	Physiotherapist assessment within 72 hours of admission	74%	88%	94%	78%	82%	86%	95%	97%
Indicator 6	OT assessment within 4 working days of admission	43%	69%	85%	15%	71%	81%	82%	79%
Indicator 7	Patient weighed during admission	61%	76%	87%	83%	91%	93%	96%	100%
Indicator 8	Patient mood assessed by discharge	43%	68%	87%	72%	63%	79%	96%	99%
Indicator 9	Rehabilitation goals agreed by the multidisciplinary team	80%	92%	97%	78%	95%	89%	96%	99%
	% patients who achieve all 9 indicators					14%	27%	48%	72%

Patient Experience

To improve patients meals service, specifically meals for patients with compromised nutrition

Description of the Issues and Rationale for Prioritising

Malnutrition is both a cause and a consequence of ill-health. In February 2006, the National Institute for Clinical Excellence (NICE) produced guidance "Nutrition Support in Adults" as older people and those with any long-term medical or psycho-social problems are often chronically underweight and so are vulnerable to acute illness. Age Concern has published two reports 'Hungry to be Heard' and 'Still Hungry to be Heard' calling for improved nutritional care of the elderly in hospitals. Age UK has requested for all hospital wards to implement 'seven steps to end malnutrition'.

Our Key Improvements / Achievements

- We have implemented the nationally recommended Malnutrition Universal Screening Tool (MUST).
- Nutrition education is now part of the nurse induction programme and ward based sessions with all staff grades are ongoing.
- In support of Age UK Campaign 'seven steps to end malnutrition', we have introduced mealtime assistants onto all of our Care of the Older Person wards. These volunteers are trained to assist with feeding and provide help at mealtimes.
- The Essence of Care Nutrition Benchmark, completed in October

2010, shows an overall improvement (85%). There is an improvement in all factors with the exception of Factor 10 (eating to promote health) which scored 57%.

- As recommended by Age Concern, we have developed red tray guidance (when to support patients with eating).

Patient Experience

To improve our ambulance turnaround times

Description of the Issues and Rationale for Prioritising

This is a local initiative in partnership working with East Midlands Ambulance Service (EMAS) to address the concerns regarding length of time it takes to transfer responsibility of care from EMAS staff to hospital staff at each organisation's Emergency Department.

Our Key Improvements / Achievements

- Excellent performance at our Newark Hospital site
- We have made this objective a key priority for 2011/12

Commission annually.

Patient Experience

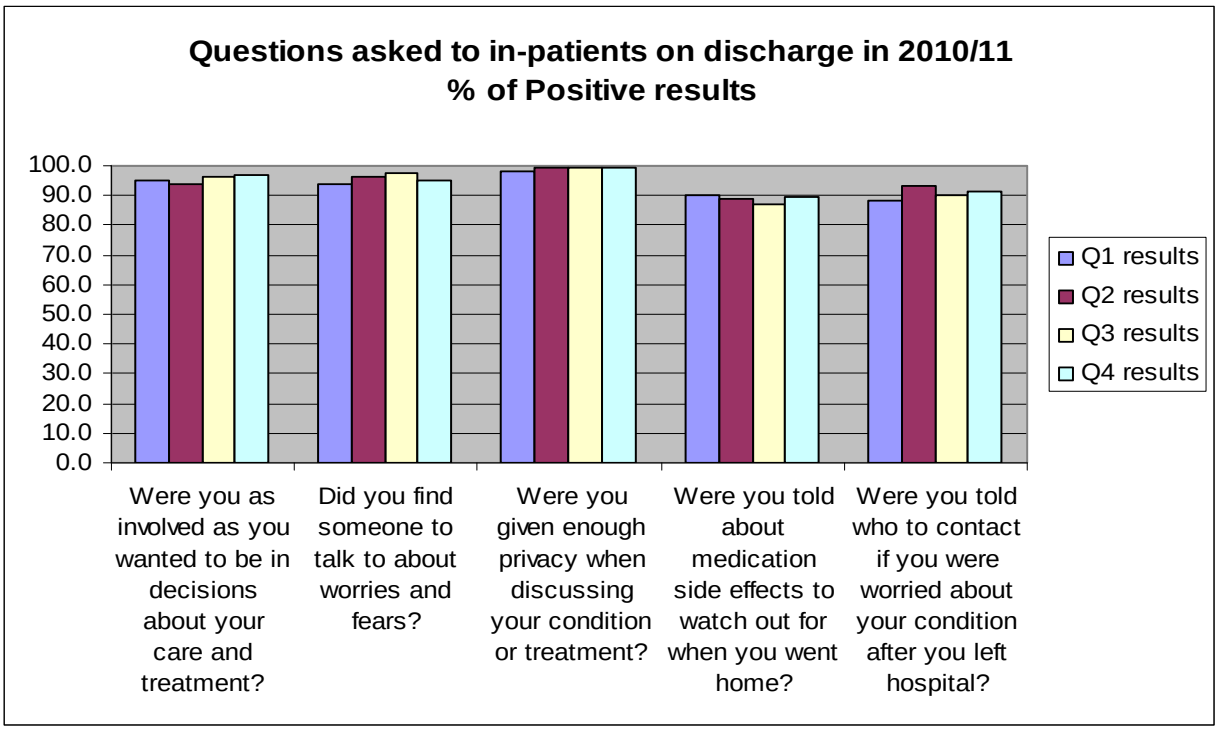
To improvement against the five national indicator measures

Description of the Issues and Rationale for Prioritising

These five questions are national CQUIN indicators called responsiveness to patients need and capture the patients experience in relation to their personal needs. All hospitals are required to capture this data and the questions are generated from the national inpatient survey carried by the Care Quality

Our Key Improvements / Achievements

The questions shown in the graph below have been asked to patients on discharge from hospital. The results are available per ward and have been shared with staff to enable them to make any improvements. Quarter 1, for example, relates to April, May and June 2010.



We are very happy with these results as it shows that we are meeting patient's expectations. We have highlighted the need to make sure patients know about the medication side effects. We have also improved patient information which includes a section with contact details.

Patient Experience

To participate and develop action plans in relation to the East Midland Patient Experience project

The East Midlands Patient Experience Service (EMPES) is a system that aims to bring together patient experience and outcome data to enable us to continuously improve services. This service is being run across the East Midlands and has been collecting data from patients who have had either varicose vein, hernia, hip or knee replacements operations. Sherwood Forest Hospitals NHS Foundation Trust has participated in this data collection that began in the latter part of the year. We wish to thank those patients who have taken the time to provide us with feedback.

Patient Experience

Continue to use real time data to improve the customer experience and identify themes and trends for service improvement

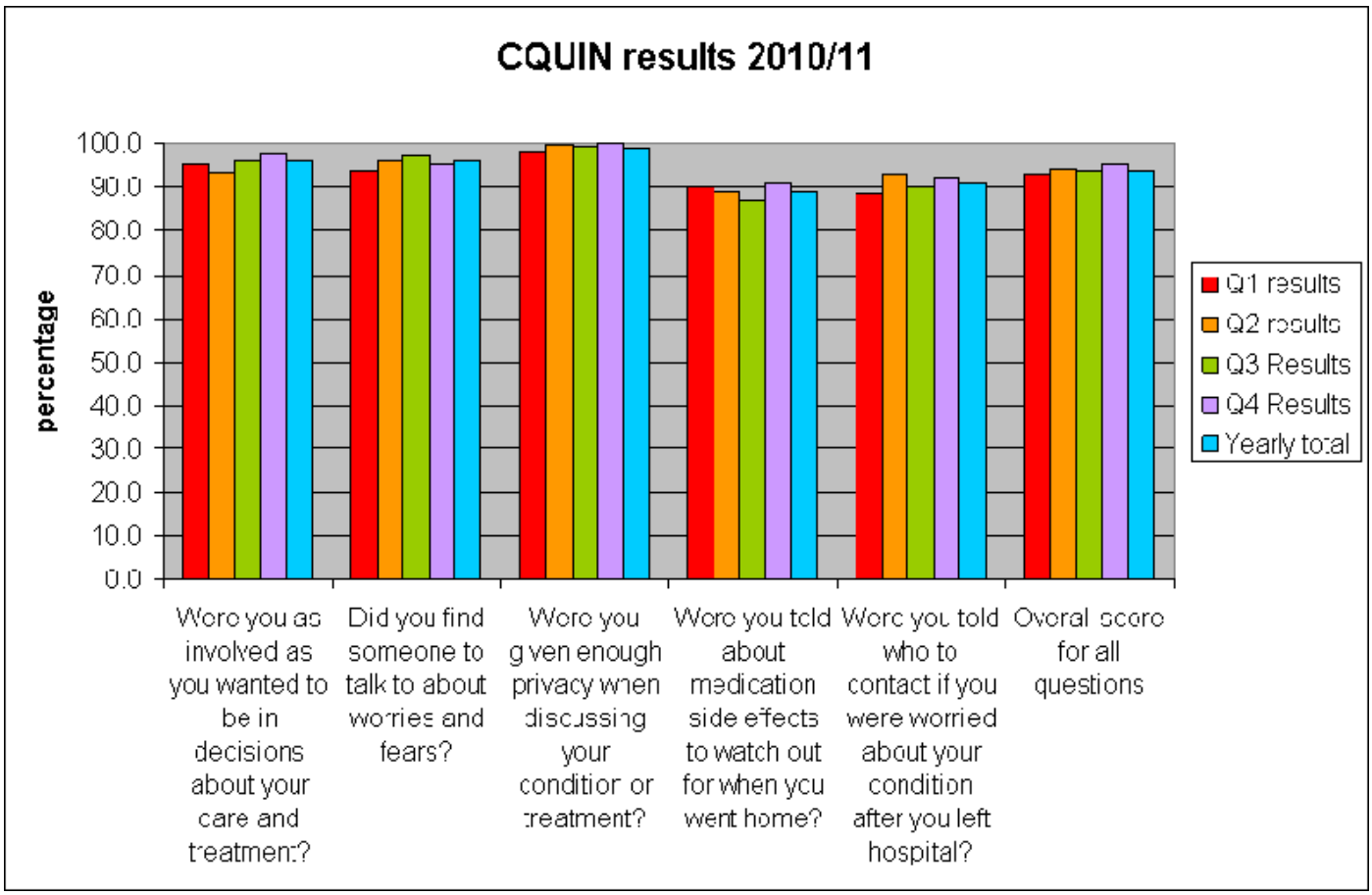
Description of the Issues and Rationale for Prioritising

During the last year we have asked people who have attended the outpatients department a set of questions and the results are shown below.

Our Key Improvements / Achievements

8,627 people were asked the questions, with most results improving month on month. There has been an issue identified regarding people not knowing why they have to wait over 30 minutes. Clinic staff have been asked to explain the reason for the delay to people, posters have been developed and electronic screens are in the process of being purchased. The main aim is to see people within 30 minutes

.



Plans for 2011/12

The questions asked to outpatients will change and questions will be asked to ensure we are achieving the pledges we have developed with patient and carers.

Pledges to Patients and Carers

- **We will listen to you**
  - (your individual needs and concerns, and respond to them)
- **We will work together as a team**
  - (and with you, to give you the best care)
- **We will show kindness and compassion**
  - (treating each of you with dignity and respect)
- **We will communicate effectively**
  - (at the right time and in a way that is easy to understand)
- **We will care for you in a safe and clean environment**

The questions to be asked for 2011 will be:

- Were our staff courteous and helpful?
- Do you feel you were treated as an individual?
- Do you feel you were given enough information?
- How would you rate the cleanliness of the hospital?
- If a family member or friend required hospital care would you recommend us?

Patient Experience

To continue to develop the role of volunteers in enhancing the customer experience

Volunteers continue to enhance and complement the services provided at our hospitals. Support is provided in 29 departments and services.

Our Key Improvements / Achievements

- Volunteers provide a key front of house service and we have improved our communication strategy to ensure that the team receives timely notification of change and information.
- Volunteers assist with the collection of valuable real time data. A selected team receives training and support from our Patient Advice and Liaison Service team to enable data collection can be used to inform service improvements.

Internal vehicle provision

- Hours of the service extended to meet demand for visiting during evenings and weekends.

Extending Café operating hours

- Operating hours have extended to meet the needs of the patient and visitors

Meet and Greet volunteer role developed for Welcome Treatment Centre

- Volunteers are available to befriend and support patients attending outpatient services. This includes the provision of a refreshment service for both patients and their carers.

Day case support volunteer

- Volunteers are available to provide support and assistance to the patients and their carers as they await/recover from treatment.

Health care of the older person support volunteer

- Volunteers have been recruited to support meal times on the health care of the older persons ward to encourage patients to eat and drink. Social interaction is often required during meal time.

Our Assurances

Review of services

During 2010/11, Sherwood Forest Hospitals NHS Foundation Trust provided 50 Clinical services. The Board of Directors at Sherwood Forest NHS Foundation Trust has reviewed data made available to it in relation to the quality of care of services.

The income of clinical services represented 75 % of the total income generated from the provision of services by the Trust for 2010/2011.

Audit and Research

During 2010/2011, **42** national clinical audits (NCA) and **4** national confidential enquiries (NCEs) covered NHS services that Sherwood Forest Hospitals NHS Foundation Trust provides.

During that period Sherwood Forest Hospitals participated in **79% (33/42)** NCAs and **100% (1/1)** NCEs of which it was eligible to participate in. The national clinical audits and national confidential enquiries that SFH participated are listed below.

Participation in National audits

Title and organisation	***Number of cases or continuous / % submitted of expected total***
Perinatal mortality (CEMACH)	Continuous 100%
Neonatal intensive and special care (NNAP)	Continuous 100%
Paediatric fever (College of Emergency Medicine)	N=50 100%
RCPH National Childhood Epilepsy Audit	*Audit currently underway*
Diabetes (RCPH National Paediatric Diabetes Audit)	N=117 100%
Emergency use of oxygen (British Thoracic Society)	N=72 100%
Adult community acquired pneumonia (BTS) 2011	*Audit currently underway*
Non invasive ventilation (NIV) - adults (BTS) 2011	*Audit currently underway*
Cardiac arrest (National Cardiac Arrest Audit)	Continuous 100%
Vital signs in majors (College of Emergency Medicine)	N=50 100%
Adult critical care (Case Mix Programme) ICNARC	Continuous 100%
Potential donor audit (NHS Blood & Transplant)	Continuous 100%
Heavy menstrual bleeding National Audit	*Audit currently underway*
Ulcerative colitis & Crohn's disease (IBD Audit)	*Audit currently underway*
Adult asthma (British Thoracic Society)	
Hip, knee and ankle replacements (NJR)	Continuous 100%
Elective surgery (National PROMs Programme)	Continuous 100%
Adult cardiac interventions audit PCI/ BCIS	Continuous 100%
Peripheral vascular surgery (NVD Database)	Continuous 100%
Carotid interventions (Carotid Intervention Audit)	Continuous 100%
Familial hypercholesterolaemia Audit	N=9 100%
Acute Myocardial Infarction & other ACS (MINAP)	Continuous 100%
Heart failure (Heart Failure Audit)	Continuous 100%
Acute stroke (SINAP)	*Audit currently underway*
Stroke care (National Sentinel Stroke Audit)	N=56 93%
Renal colic (College of Emergency Medicine)	N=50 100%

Lung cancer Audit	Continuous	100%
Bowel cancer Audit Programme	Continuous	100%
Head & neck cancer (DAHNO)	Continuous	100%
Hip fracture (National Hip Fracture Database)	Continuous	100%
Severe trauma (Trauma Audit & Research Network)		
National Falls & Bone Health Audit	N=26	100%
National Audit of Dementia	N=40	100%
Platelet use	N=5	100%

The reports of two National Clinical Audits were reviewed by the provider in 2010/11 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided:

- Improve education of frontline staff
- Improve senior clinicians' input/involvement
- Improve training for clinical staff
- Policy development to address gaps

A further 10 national Clinical Audits are awaiting final reports and action plans.

The reports of 34 Local Clinical Audits were reviewed by the provider in 2010/11 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided:

- Review and update relevant guidance.
- Recommendations are taken forward by the appropriate clinical team.
- Review patient pathways.
- Ensure training and education is addressed as required.

In 2011/2012 the Trust will ensure that the audit programme reflects the Trust vision with a strong focus on the three domains for quality of care.

Clinical Research

The number of patients receiving NHS services provided by Sherwood Forest Hospitals NHS Foundation Trust that were recruited during 20010/11 to participate in research approved by a research ethics committee was 250. This demonstrates a sustained increase over the last three years.

Sherwood Forest Hospitals NHS Foundation Trust				
NHS Year	**2008/2009**	**2009/2010**	**2010/2011**	**Grand Total**
Sum of Total	**64**	**135**	**250**	**449**

Sherwood Forest Hospitals NHS Foundation Trust				
NHS Year	**2008/2009**	**2009/2010**	**2010/2011**	**Grand Total**
Design Type				
Interventional	19	22	40	81
Observational	45	113	210	368
Grand Total	**64**	**135**	**250**	**449**

Source:
05010015020025030 0Total**Total NIHR portfolio recruitment at SFH by NHS Year**2008/20092009/20102010/2011050100150200250InterventionalObservational**NIHR portfolio recruitment at SFH by Design Type & NHS Year**2008/20092009/20102010/2011

Commission for Quality and Innovation (CQUIN)

A proportion of Sherwood Forest Hospital's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals and NHS Nottinghamshire County Primary Care Trust through the Commissioning for Quality and Innovation payment framework. Quality payments were received and in addition, the Trust received an incentive payment for a stretch target for C Difficile rates, which it has also achieved.

The monetary total for the amount of income conditional upon achieving the quality improvement and innovation goals for 2010/11 was £2,688,000 and £150,000 for achieving C Difficile targets; the total amount achieved was £2,028,085.

Care Quality Commission (CQC)

Under Section 11 of the Health and Social Care Act 2008, the Trust is required to register with the Care Quality Commission (CQC) in order to provide regulated activities associated with health care. The Trust has been registered (from 1 April 2010) by the CQC to provide the following regulated activities:

- Diagnostics and screening procedures
- Family planning
- Maternity and midwifery services
- Nursing Care
- Surgical procedures
- Treatment of disease, disorder or injury
- Termination of pregnancy

The Trust has to maintain compliance with sixteen out of twenty eight regulations (outcomes) which relate to essential standards of quality and safety in order for its registration with the CQC to remain without conditions.

The Care Quality Commission has not taken enforcement against Sherwood Forest Hospitals during 2010/11.

During 2010/11 the Trust successfully removed conditions applied at the end of 2009/10. These conditions were related to **Outcome 16** (reg10) assessing and monitoring the quality of service provision:

> **Condition 1 -** The Trust must ensure that effective systems to assess and monitor the quality and safety of service provision are in place across all services by 31 July 2010. Evidence must be available to demonstrate this from 31 July 2010.
>
> **Condition 2 -** The Trust must ensure that the Integrated Critical Care Unit has in place a system of clinical governance that supports continual improvement and clinical excellence by 31 May 2010. Evidence must be available to demonstrate this from 31 May 2010.

Sherwood Forest Hospitals' agreed Actions Plans to ensure that concerns identified by the CQC were resolved by the end of July 2010.

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

To review progress against the conditions, Sherwood Forest Hospitals was subject to an unannounced review by the Care Quality Commission in early August 2010. This was an extremely successful visit and conditions against our registration were quickly removed.

As part of the CQC's planned assessments, in March 2011, the Trust submitted compliance assessments for King's Mill and Newark Hospitals on outcomes **2,6,7,8,10,13** and **16** as well as answering specific questions on Outcomes **12,17** and **21**.

As part of the national programme assessing outcomes **1** & **5,** we received an unannounced visit to Newark Hospital specifically looking at dignity and nutrition for older people. We are still awaiting our report but verbal feedback on the day of the visit was very positive.

Data Quality

Sherwood Forest Hospitals NHS Foundation Trust submitted records during 20010/11to the secondary users service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

- which include the patient's valid NHS number was 99.8% for admitted patient care; 99.9% for outpatient care; 96.7% for accident and emergency care
- which includes the patient's valid GP registration code was 100% for admitted patient care; 100% for outpatient care; and 99.7% for accident and emergency care

Information Governance

The following describes the progress against the Information Governance Toolkit version 8. This represents a significant change in requirements from the previous year's toolkit.

It is important to note that the work has focused on the Key Requirements, of which there are 22, which apply to the Statement of Compliance. This is an

essential licensing requirement for Foundation Trusts.

The Trust's position is that we have achieved Level 2 across 21 of the 22 Key requirements, with an action plan in place for requirement 8-307. As a Foundation Trust we are therefore currently within our terms of authorisation.

Out of the scores for the 22 Key requirements, Internal Audit agreed that the Trust had achieved compliance i.e. Level 2 or above, with 21 requirements and noted that the Trust had provided strong evidence that demonstrated a reasonable level of assurance in relation to Information Governance processes. One Key Requirement (8-307) will remain at a Level 1 for this financial year. This requirement relates to the appointment of Information Asset Owners and Administrators and the development of a formal reporting structure for managing risks in relation to information assets within the Trust. This will form part of the work plan for 2011/12 to ensure that this requirement will meet Level 2 prior to 31st March 2012.

For all remaining requirements that have not achieved a minimum of Level 2, i.e. nine requirements, these will be incorporated into the work plan which will support the delivery of these standards during financial year 2011/12. Overall, with both Key and remaining requirements combined to create 45 requirements, the Trust has scored six requirements at a Level 3, twenty nine at a Level 2, seven at a Level 1 and three requirements at a Level 0. This provides Sherwood Forest Hospitals NHS Foundation Trust with an overall percentage of 58% which, although is comparable with other Trusts in the East Midlands, is viewed by Connecting for Health as 'Not Satisfactory.'

The work plan for 2011/12 will result in compliance across all Key Requirements, with regular reports provided to Performance and Information Committee, to Risk Management Group from a risk perspective, and as a regular report to Audit Committee, detailing the overall progression of the IG Toolkit.
The Trust's position is that we have achieved Level 2 across 21 of the 22 Key requirements, with an action plan in place for requirement 8-307. As a Foundation Trust we are within our terms of authorisation.

Payment by Results

During 2010/11 the Trust was not subject to a an Inpatient or Outpatient PbR Audit by the Audit Commission, they have moved to a more risk based approach on areas reviewed over the last three years and are focusing resources on Trusts that need to improve the most. Sherwood Forest Hospitals is within the top 5% performing Trusts with regards to clinical coding data accuracy and capture. As an organisation we constantly strive for high quality robust data. The Trust commissioned an external audit by CHKS which took place during March 2011; the remit was to review 200 sets of case-notes. The Clinical Coding audit resulted in an Information Governance Requirement attainment level of 2. The results should not be extrapolated further than the actual sample audited.

Primary Diagnosis - 12 errors from 200
Primary Diagnosis Codes = 6.0%
Secondary Diagnosis - 27 errors from 618
Secondary Diagnosis Codes = 4.4%
Primary Procedures - 7 errors from 116
primary procedure codes = 6.0%
Secondary Procedures - 1 error from 169
primary procedure codes = 0.5%

Other Information

NHSLA - CNST Risk Management

During 2010/11 the Trust has maintained CNST level 1 for both general hospital and maternity care. We have had three interim visits, two in general hospital and

one in Maternity and have a workshop planned soon whilst we continue to work towards level 2 assessment in both areas.

Clinical Audit

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

These aims and objective are:

- To deliver an effective Clinical Audit Plan that contributes to the continuous improvement of patient care and health outcomes; by:
    - Aligning clinical audit activity with national and local health priorities as agreed by the Trust, local health communities, Divisions and Service Lines.
    - Ensuring that the rationale for undertaking clinical audit relates to improvements in health care delivery.
    - Providing training, support and advice for SFH staff in relation to clinical audit.
    - Monitoring the governance arrangements through which the quality of clinical audit activity and outputs will be monitored.

Clinical Governance

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

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

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

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

An overview of measures

Patient Safety Metrics

	2010/11	2009/10	2008/9	2007/08
Clostridium difficile year on year reduction	54	96	177	324
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half of the 2003/04 level	0	14	31	36
Never events that occurred within the Trust	**2**	0	0	0
Essence of Care Benchmark Outcomes :			2008-09	Programme 1
Pressure Ulcers	**85%**	N/A*	81%	73%
Record Keeping	**87%**	N/A*	81%	75%
Effective Communication	**Due 2011**	N/A*	84%	77%
Nutrition	**85%**			

Note:- EOC benchmarks are undertaken in a programmed way and were not undertaken 09/10

Patient Experience Metrics

	2010	2009	2008	2007	National average
National PEAT scores (0-5, 5 being excellent):					
*Environment King's Mill Hospital	**5**	4	3	4	4
*Environment Newark Hospital	**4**	4	3	4	4
*Food KMH	**5**	4	4	4	5
Food NH	**4**	4	3	3	5
Essence of Care Benchmark Outcomes:					
	Due	N/A	82%	80%	
Privacy and dignity	**2011**	N/A	81%	77%	
Food and Nutrition	**85%**				
Selected Inpatient Survey Results:					Highest scoring 20% of Trusts
Did you have confidence in the doctors treating you?	**89%**	89%	90%	87%	
Did you have confidence in the nurses treating you?	**89%**	88%	88%	85%	91%
Were you given enough privacy when being examined or treated?	**95%**	96%	95%	91%	88%
Did you find someone on the hospital staff to talk to about your worries and fears?	**62%**	61%	65%	58%	95%
					64%
% of patients who would recommend hospital to a relative/friend	**98%***	87%	80%		

Note:- EOC benchmarks are undertaken in a programmed way and were not undertaken 09/10.

This year's figure is from Day Case patients only.

Clinical effectiveness and National Targets and Regulatory Requirements	2010-11	2009-10	2008-09	2007-08	2009-10 Target
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	**99.6%**	98.8%	99.3%	99.8%	96%
Maximum waiting time of 31 days from decision to treat to start of treatment - subsequent surgical and drug-based treatments	**Drug 99.2%** **Surgery 97.3%**	Drug 99.7% Surgery 94.3**%**	N/A	N/A	Drug 98% Surgery 94%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	**89.7%**	84.5%	94.6%	N/A	85%
Maximum waiting time of 62 day from screening to 1st definitive treatment	**93.1%***	90.5%	N/A	N/A	90%
18-week maximum wait from point of referral to treatment (admitted patients)	94.86%	94% (March 10)*	95% (March 09)	86% (March 08)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	98.12%	98.7% (March 10)*	99% (March 09)	90% (March 08)	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	97.69%	98.7%	98%	98%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	73.44%	63%	60%	78%	68%
Screening all elective inpatients for MRSA	**100%**	93.6%			100%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	**94.2%**	94.4%	99.8%	99.7%	93%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all GP referrals – Breast Symptomatic	**95.1%**	92.8%	N/A	N/A	93%

***Notes:-**With regard to 18 weeks performance for March 10 please be aware that the reduction in achievement is due to the fact that we have revised the methodology used to include the clinical assessment service start date.
-that **changes in the reporting framework took place in Q4 Jan - Mar 11** which means that Consultant Upgrade performance is included with screening, so the 93.1% relates to Q1-Q3 for screening only and Q4 for Consultant Upgrade and screening

External Assurances

NHS Nottinghamshire County is responsible for commissioning high quality services that treat today's ill health alongside services to enable people to live healthier lives in the future. This statement has been requested in accordance with the regulations which state that as the lead commissioner of NHS Services provided by Sherwood Forest Hospitals NHS Foundation Trust they must take reasonable steps to check the accuracy of the information in this document and note other information they consider relevant to quality.

Written Statement from our commissioners: NHS Nottinghamshire County

"NHS Nottinghamshire County monitors quality and performance at the Trust throughout the year. There are monthly quality and performance review meetings and there is frequent ongoing dialogue as issues that arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year. During the year the Trust worked successfully to remove Care Quality Commission (CQC) conditions applied to its registration at the end of 2009/2010 following an unannounced visit by the CQC in August 2010. A further unannounced visit was undertaken at Newark Hospital as part of a national review of dignity and nutrition for older people.

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

The PCT has an appointed Governor at the Trust. This enables the commissioning organisation to better understand the views and concerns of public and staff Governors. It also assists with information exchange between the Trust, commissioners and public representatives and helps to provide additional assurance to corroborate the information within this Quality Account. The Trust has considerable financial and organisational challenges in 2011/2012. Commissioners will seek further assurance of service quality as efficient programmes and workforce changes take effect".

Written Statement from Nottinghamshire County LINk

The LINk feels that this Quality Account is a fair reflection of the healthcare services provided by Sherwood Forest Hospitals. Throughout the document there are clear indicators of improvement and where problems have been identified the LINk feels confident that appropriate action plans have been implemented to aid improvement.

The inclusion of graphs and baseline figures make it easy for LINk to comment on performance and it is clear to see that Sherwood Forest Hospitals are consistently meet or exceed the national target.

The LINk would like to take this opportunity to express how pleased we are to see that hospital practice has been altered to "improve patient's dignity in theatre with more effective theatre gowns" and that there have been significant improvements in clinical effectiveness.

Commentary from the overview and Scrutiny Committee

The committee notified us on 11th May 2011 that they are not intending to review our report this year and therefore we are not expecting any feed back.

Carolyn White
Chief Executive
26 May 2011

Glossary

Term /Abbreviation	Description
Care Quality Commission (CQC)	The independent regulator of Health and Social Care in England. Its aim is to ensure better care for everyone where ever that care is given. They replaced the Health Care Commission
Clinical Governance	Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services
Clinical Negligence scheme for Trusts (CNST)	A scheme for managing negligence claims within the NHS
Clostridium Difficile (C Diff)	Naturally occurring bacteria that causes no harm in healthy people. However some antibiotics used in health care can interfere with the balance of "good" bacteria in the gut. When this occurs the C Diff multiply causing symptoms of diarrhoea and fever.
Commissioning for Quality and Innovations (CQUIN)	A payment Framework to ensure that the income for providers of health care is influenced by the improvement in quality and innovation in care.
Escherichia Coli (E Coli)	Bacteria normally found in the gut but under certain conditions can cause problem and complications.
Health care acquired infections(HCAI's)	A generic name for C Diff ,MRSA etc
Methicillin - Resistant Staphylococcus Aureus (MRSA) Methicillin -Sensitive Staphylococcus Aureus (MSSA)	Staphylococcus Aureus is often found on the skin and nose of 3/10 people. It causes problems when the bacteria enter the body through a break in the skin. Resistant and Sensitive indicate changes in the bacteria which make treatment more difficult.
Monitor	This is the regulator of NHS Foundation Trusts. It is an independent body directly accountable to Parliament.
National Health Service Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA) was established in November 1995, as a Special Health Authority, to administer the "Clinical Negligence Scheme for Trusts" (CNST), and set rigid quality standards for healthcare to aspire to.
National Patient Survey	Undertaken by the CQC to ask patient about how they view their care across a range of settings.
Payment by Results(PbR)	Payment by Results (PbR) was introduced to improve **efficiency,** increase **value for money,** facilitate **choice,** enable service **innovation** and improvements in **quality,** and **reduce waiting times.**
Quality Account	A statutory annual account of quality, which provides external assurances that the Trust board has assessed and monitored quality across services and is driving improvements.
Secondary User Service (SUS)	The NHS data system for recording all NHS patient activity.
Veneous Thrombo embolism	This is a blood clot developing. Whilst in hospital patients are more at risk of them as they are not as mobile as they usually are. If one occurs during a hospital stay it may prolong the length of the stay or lead to increased complications.

ANNUAL ACCOUNTS & FINANCIAL STATEMENT

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Sherwood Forest Hospitals NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the 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 recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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*.

Carolyn White
Chief Executive
26 May 2011

FTC Summarisation Schedules for Sherwood Forest Hospitals NHS Foundation Trust

Summarisation schedules numbers 1 to 39 and the WGA schedules for 2010/11 are attached.

Executive Director of Finance Certificate

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

   - The financial records maintained by the NHS Foundation Trust; and
   - Accounting standards and policies which comply with the *NHS Foundation Trust Financial Reporting Manual* 2010/11 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.

Elaine Konieczny
Acting Executive Director of Finance
26 May 2011

Chief Executive Certificate

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

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

Carolyn White
Chief Executive
26 May 2011

Executive Director of Finance Report

Introduction

This financial overview summarises our performance for the financial year which ended 31 March 2011. There is no relevant information which has not been brought to the auditor's attention as far as the Directors are aware.

In our fourth year as a Foundation Trust against a backdrop of improving patient services, notably through the provision of new facilities and increased access to services, while operating in an increasingly challenging financial environment it is pleasing to report that the Trust has met its financial targets in year with a surplus of £0.6m, before a technical adjustment for impairment of fixed assets totalling £141.9m, which gave an overall reported loss of £141.3.

We achieved a financial risk rating of 3 at year end (a score of 1 being 'high-risk' and 5 'low' risk).

In preparing the annual accounts the Trust is required to assess the basis of their preparation, specifically questioning the status of the Trust as a sustainable trading entity. This assessment takes into consideration all information available about the future prospects of the Trust and also covers financial, governance and mandatory service risks.

Statement of Comprehensive Income (Income and Expenditure)

Total income for the year was £257.8m (£235.9m in 2009/10) representing a growth of 9.3%. This growth included additional funding for inflationary pressures, an increase in emergency activities, and continued delivery of the waiting list targets.

Overall 2010/11 remained a difficult year financially with fluctuations in income and expenditure throughout the year. The Trust was successful in meeting its cost improvement programme, and this remains key as the productivity and efficiency challenge for 2011/12 and 2012/13 is increased yet further as the organisation looks to ensure that it can deliver its financial and operational targets, as part of the cost reduction programme.

Statement of Financial Position (Balance Sheet)

During 2010/11 the Foundation Trust invested significantly in its fixed asset infrastructure by £19.0m (£11.6m in 2009/10). This included £3.7m on upgrading or acquiring new equipment essential for the day-to-day operation of the Trust, £0.6m on improvements in information systems and technology in conjunction with the North Nottinghamshire Health Community, £12.9m on building works, and additions before impairments of £176.06m were recognised within the balance sheet to account for the new hospital funded via a Private Finance Initiative (PFI).

Due to the adoption of IFRS in 2009/10, the PFI scheme is on balance sheet. This has had a significant adverse impact on the balance sheet and net assets due to the associated financing arrangements and losses recognised within the accounts on valuation of the assets as they have been brought into use.

At the 2010/11 year end our cash, cash equivalents and investments were £29.7m representing an improvement against plan of £5.5m, but deterioration of £3.6m from £33.3m at 31 March 2010 due to continuing capital commitments, repayment of PFI financing and movements on working capital.

Charitable Funds

During the financial year we received donations and legacies to our charitable funds of £959k (£724k in 2009/10), which included legacies of £270k (£8k in 2009/10) and a donation for £500k relating to endoscopy redevelopment at Newark Hospital (a further £500k was received in 2009/10 for this same purpose).

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

The Trustees were able to make grants totalling £450k (£458k in 2009/10) to support the activities of the Trust and for the welfare of patients and staff.

Looking Forward

Trading Environment and Financial Risk

As we move into 2011/12 the redevelopment of King's Mill Hospital and Mansfield Community Hospital, together with significant refurbishment and upgrade works at Newark Hospital is complete with all buildings now in use.

As reported in 2009/10, the redevelopment will enable the Trust to operate more efficiently and will bring many benefits to our patients. In particular:

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

- State of the art pathology laboratory, obtaining the efficiency benefits of the latest technology.

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

As reported above additional services will be delivered in 2011/12 due to TCS (Transforming Community Services). The Trust looks forward to embedding these services into current work streams to deliver a seamless patient experience, whilst delivering financial balance on the TCS contract.

Whilst we have delivered financial performance for the year ending 2010/11, there have been significant challenges over the last twelve months in the national economic and political environment, and in our commissioner's projected financial position, which continue to significantly impact on our plans for 2011/12 and beyond.

Nationally, and internationally, the ongoing effects of the 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 coalition government, the NHS continues to face the prospect of a significant and sustained reduction in overall funding in the medium term ranging from 4 to 7% year on year for the next 4 years.

In addition to these national factors challenges remain locally in our commissioner's financial position and in the pricing structure for our patient treatment income. These changes have significantly increased the financial risk for both our commissioners and us.

During 2010/11, we have sought to establish robust risk management processes to mitigate these risks and enable us to manage the impact of reduced income on our services and long term viability. Accordingly, our future projections in respect of growth, tariff inflation, price inflation, interest rates and efficiency requirements have all been revised to take account of this.

We have received external support in preparing our three year plan in order to address the significant financial challenges facing the Trust due to the loss of funding from our main commissioners. Our plans show a deficit for 2011/12 and 2012/13. To address this the Trust is implementing significant cost improvement programmes to ensure a return to financial break even in 2013/14. This will place a significant pressure on our going concern assessment in these years due to a significant deterioration in our liquidity position.

The Directors continue to work with our commissioners to identify further ways to mitigate the risks in our current assumptions to ensure we can deliver the cost reductions required.

Significant risks to the Trust include:

- A significant cost reduction strategy, notably arising from the new hospital development, tariff deflation and a significant reduction in income from our main commissioners due to their demand management initiatives, each of which will require careful management. This remains a key risk within the future financial plans in ensuring the delivery of the productivity/efficiency agenda whilst simultaneously meeting statutory targets and

maintaining strenuous quality standards. The financial plan has been constructed to reflect these parameters as far as possible.

- Income adjustments have been made taking account of projected demographic changes and the demand management schemes already implemented in 2010/11 and those which are being introduced in 2011/12 in primary care which are designed to limit demand for secondary care services. The contract for 2011/12 also assumes the repatriation of service activity from neighbouring Trusts and the independent sector. The risk to the Trust here lies in our ability to reduce costs in line with any income reductions that these developments bring and our ability to influence referral patterns to the Trust.

- Adverse operating risks, particularly in the form of service migration to primary care under the supervision of the local practice based commissioning clusters do exist. The Trust is in continual dialogue with the PCT and with the clusters over this risk.

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

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

General Financial Performance

Improved Efficiency and Value for Money

Our total operating expenses (excluding impairments and depreciation) rose during the year to £228.3m, exceeding plan by £3.6m. Of this £149.2m (65%) was spent on staffing, ensuring we continued to attract and retain our full establishment of 449 medical and dental staff, 1092 registered nurses and midwives, 448 scientific, technical and therapeutic staff and 1498 other health professionals and clinical staff.

Over 13% of our total operating expenses (excluding depreciation) was spent on drugs and clinical supplies helping to ensure that our patients continue to be able to access the latest treatments.

The Trust reported a profit before impairments of £0.56m against a forecast plan of breakeven for the 2010/11.

Our Key Partners

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

In addition, the Trust continued to work with Central Nottinghamshire Hospitals plc and its sub-contractors, and received tremendous support from the Trust's many volunteers and

charitable organisations including the League of Friends, Daffodils, Newark Hospital Volunteers, Lions and the Doughty Foundation.

Going Concern

The next two financial years represent a significant challenge with large cost improvement programmes and demand management initiatives needed to be delivered. Extensive financial modelling of the impact of these pressures has been undertaken in year, and the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operation for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts for 2010/11.

External Audit Service

The Board 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.
We incurred £70.5k in audit service fees in relation to the statutory audit of our accounts for the twelve month period to 31 March 2011 (£49k for period to 31 March 2010). No other audit services were required during the accounting period.

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

Non Audit Services provided by the External Auditor

During 2010/11 we commissioned KPMG to undertake the due diligence for the Trust on 'Transforming Community Services' (TCS). TCS relates to the transfer of services to the Trust under a three year contract from our main commissioner who is the current provider (cost of non audit services was £30k).

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 which had previously been run by Nottinghamshire County PCT.

252 staff are transferring 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.

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 hard to maintain an anti-fraud culture and have a range of policies and procedures to minimise risk in this area. A number of events were held over the year to highlight how staff should raise concerns and suspicions. A number of staff received counter

fraud awareness training. A total of 327 received face to face training as part of their induction training on joining the Trust and 20 staff completed a Counter Fraud e-learning module, giving a total of 347 staff who received training during the year. In addition, the e-learning module was accessed a further 463 times.

Accounting Policies for Pensions and other Retirement Benefits

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

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

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

Elaine Konieczny
Acting Executive Director of Finance
26 May 2011

Annual Accounts 2010/11

FOREWORD TO THE ACCOUNTS FOR THE YEAR ENDED

31 MARCH 2011

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

These financial statements for the year ended 31 March 2011 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 in the form which Monitor has, with the approval of the Treasury, directed.

The previous accounts were for year ended 31 March 2010.

Carolyn White
Chief Executive
26th May 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	Note	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Operating income	*B1*	257,788	235,876
Operating expenses	*B5*	(384,809)	(269,930)
Operating surplus / (deficit)		**(127,021)**	**(34,054)**
Finance costs			
Finance income	*B12*	329	303
Finance costs – financial liabilities	*B12*	(14,645)	(10,204)
Dividends payable on public dividend capital		0	(48)
Net finance costs		**(14,316)**	**(9,949)**
Retained (deficit) for the year		**(141,337)**	**(44,003)**
Other comprehensive income			
Receipt of donated asset	*SOCIE*	1,094	245
Impairments	*SOCIE*	(13,824)	(2,574)
Revaluation gains on property	*SOCIE*	2,851	10,639
Other reserve movements	*SOCIE*	(212)	(387)
Total comprehensive income / (expense) for the year		**(151,428)**	**(36,080)**

The notes on pages 107 to 142 form part of these accounts.

Income and expenditure of £4.09m was recognised in respect of 'ReSource' an East Midlands procurement collaborative which was discontinued on the 31 March 2011. With this exception all revenue and expenditure is derived from continuing operations.

Excluding the impairment charged to the 'Statement of Comprehensive Income' relating to the Private Finance Initiative scheme (PFI), (Note B.5) of £141,893m the underlying surplus for the year was £0.56m.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	Note	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Non-current assets			
Intangible assets	*B14*	1,963	2,674
Property, plant and equipment	*B13*	224,942	262,534
Trade and other receivables	*B18*	1,032	900
Total non-current assets		**227,937**	**266,108**
Current assets			
Inventories	*B17*	2,816	2,844
Trade and other receivables	*B18*	12,375	10,996
Cash and cash equivalents	*B21*	29,685	33,253
Total current assets		**44,876**	**47,093**
Current liabilities			
Trade and other payables	*B19*	(25,469)	(20,456)
Borrowings	*B20*	(4,639)	(3,658)
Provisions	*B23*	(6,779)	(938)
Tax payable	*B19*	(2,989)	(2,968)
Other liabilities		(3,273)	(6,114)
Total current liabilities		**(43,149)**	**(34,134)**
Non-current liabilities			
Trade and other payables	*B19*	(6,039)	(0)
Borrowings	*B20*	(354,670)	(258,229)
Provisions	*B23*	(528)	(595)
Total non-current liabilities		**(361,237)**	**(258,824)**
Total assets employed		**(131,573)**	**20,243**
Financed by taxpayers' equity			
Public dividend capital		84,303	84,303
Revaluation reserve		16,962	27,963
Donated asset reserve		2,456	1,965
Income and expenditure reserve		(235,294)	(93,988)
Total taxpayers' equity		**(131,573)**	**20,243**

The financial statements on pages 112 to 153 were approved by the Board and signed on its behalf by:

Carolyn White
Chief Executive
26 May 2011

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 2010					
As previously stated	84,303	27,963	1,965	(93,988)	20,243
Retained surplus / (deficit) for the year				(141,337)	(141,337)
Net gain / (loss) on revaluation of intangible assets					
Net gain / (loss) on revaluation of property, plant and equipment		(10,973)			(10,973)
Net gain / (loss) on revaluation of available for sale financial assets					
Receipt of donated assets			1,094		1,094
Reduction in donated asset reserve in respect of depreciation, impairment and/or disposal of assets			(603)		(603)
Transfer to income and expenditure in respect of assets disposed of					
Transfer of excess current cost depreciation over historical cost depreciation		(28)		28	
Other recognised gains and losses				3	3
New PDC received					
PDC repaid in year					
PDC written off					
Other transfers between reserves					
Taxpayers' equity at 31 March 2011	**84,303**	**16,962**	**2,456**	**(235,294)**	**(131,573)**

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Note	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Net cash generated from operating activities			
Operating surplus / (deficit) from operations		(127,021)	(34,054)
Depreciation and amortisation		8,609	9,023
Impairments and reversals		141,893	48,185
Net foreign exchange (gain)/loss		0	0
Transfer from donated asset reserve		(388)	(400)
(Increase) / decrease in trade and other receivables		(1,511)	(1,593)
(Increase) / decrease in inventories		28	(526)
(Decrease) / increase in trade and other payables		7,613	(975)
(Decrease) / increase in provisions		5,774	(2,313)
Other movements in operating cash flows		(2,521)	2,817
Net cash inflow from operating activities		**32,476**	**20,164**
Cash flows from investing activities			
Interest received		329	303
Payments to acquire intangible assets		(218)	(484)
Receipt from disposal of intangible assets		0	0
Purchase of property, plant and equipment		(18,821)	(10,525)
Proceeds from disposal of property, plant and equipment		0	0
Net cash inflow / (outflow) from investing activities		**(18,710)**	**(10,706)**
Cash flows from financing activities			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Loans received		0	0
Loans repaid		0	0
Dividend paid		0	0
Capital element of finance lease rental payments		(2)	(32)
Capital element of private finance initiatives		(3,657)	(2,549)
Cash transferred (to)/from other NHS bodies		0	0
Interest paid		0	0
Interest element of finance lease		0	(2)
Interest element of private finance initiative		(14,645)	(10,202)
Public dividend capital paid		(48)	0
Other financing activities		1,018	0
Net cash used in financing activities		**(17,334)**	**(12,785)**
Increase / (decrease) in cash and cash equivalents		**(3,568)**	**(3,327)**
Cash and cash equivalents at 1 April		**33,253**	**36,580**
Cash and cash equivalents at 31 March		**29,685**	**33,253**

NOTES TO THE ACCOUNTS A.

Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Annual Reporting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 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.

Basis of preparation

In accordance with IAS 1 these accounts have been prepared on a going concern basis.

The Directors expect that the NHS Foundation Trust has adequate resources to continue to operate in existence for the foreseeable future.

The Trust recorded a surplus before impairments for 2010/11 of £0.6m however, the initial financial plan proposed by the Trust shows a deficit cash position with effect from the end of June 2012.

The Trust has prepared a programme of actions to mitigate the deficit cash position with due regard to safe, productive and future models of clinical service delivery. In addition the Trust is working closely with its bank to secure an extension to its working capital facility, which will expire in April 2012. The current indications are positive that the bank will agree to the extension.

Regulators and the Trusts External Auditors have been and will continue to be kept informed throughout the development and implementation of those actions.

However 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.

1. Consolidation

1.1 Subsidiaries

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

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year (except where a subsidiary's financial year end is before 1 January or

after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated).

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

1.2 Associates

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

1.3 Joint ventures

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

1.4 Joint operations

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

2. Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Where income has not been received prior to the year end but the provision of a healthcare service has commenced, i.e. partially completed patient spells, then income relating to the patient activity is accrued.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

3. Expenditure on employee benefits

3.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken

by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

3.2 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme, liabilities, therefore, the scheme is accounted for as a defined contribution scheme. Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

4. Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

5. Property, plant and equipment

5.1 Recognition

Property, plant and equipment is capitalised where:

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

5.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. All property assets are reviewed by an independent valuer to ensure that where of a material value; components of property assets are separately reported and depreciated accordingly.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure

is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Currently assets are depreciated at the following rates.

- 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 the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation

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 ARM, 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.

5.3 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable 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.

5.4 Donated assets

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

5.5 Private finance initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

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

6. Intangible assets

6.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised and expenditure on development is capitalised only where all of the following can be demonstrated:

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

Software

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

6.2 Measurement

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

Subsequently intangible assets are measured at fair value. 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’.

6.3 Amortisation

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

7. Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

8. Inventories

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

9. Financial instruments and financial liabilities

9.1 Recognition

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

9.2 De-recognition

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

9.3 Classification and Measurement

Financial assets are categorised as 'fair value through income and expenditure', 'loans and receivables' or 'available-for-sale financial assets'. Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

9.4 Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

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

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

9.5 Loans and receivables

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

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest rate method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest rate method and credited to the Statement of Comprehensive Income.

9.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest rate method.

The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest rate method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

9.7 Determination of fair value

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

9.8 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.

10. Leases

10.1 Finance leases

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

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

10.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

10.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

11. Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the

estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, 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.

11.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the
NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is £19.696m (2009/10 £17.676m).

11.2 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims, are charged to operating expenses when the liability arises.

12. Contingencies

Contingent assets, that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

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

Contingent liabilities are defined as:

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

13. Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held within the 'Government Banking Services' accounts. The Trust does not

currently pay any PDC as it has negative net relevant assets, due to the impairment of the main PFI.

14. Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.
Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

15. Corporation Tax

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

16. Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

17. Third party assets

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

18. Cash and cash equivalents

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

19. Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks.

B. Notes to the accounts

***1.* Operating Income**	**Year ended 31 March 2011**	Year ended 31 March 2010
***1.1* Income from activities**	**£000**	£000
NHS Trusts	1,724	1,230
Primary Care Trusts	190,197	183,972
Department of Health	0	75
NHS other	0	46
Non NHS:		
- Private patients	182	183
- NHS injury scheme [1]	1,221	977
	193,324	**186,483**

[1] NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection. (7.8% 2009/10)

1.2 Analysis of income from activities

	£000	£000
Inpatient - elective income	41,613	41,700
Inpatient - non elective income	65,949	67,206
Outpatient income	40,757	41,036
A & E income	9,496	8,615
Other NHS clinical income	32,382	25,461
Private patient income	182	183
Other non protected clinical income	2,945	2,282
Total income from activities	**193,324**	**186,483**

1.3 Other operating income

	£000	£000
Research and development	359	333
Education and training	11,880	11,394
Charitable and other contributions to expenditure	450	458
Transfer from donated asset reserve in respect of depreciation	388	400
Non patient care services to other bodies	17,583	16,939
Other income	27,753	19,869
Reversal of impairments	6,051	0
Total other operating income	**64,464**	**49,393**
Income from continuing operations	**257,788**	**235,876**

1.4 Income from mandatory services

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Income from activities	193,324	186,483
Less: NHS injury cost recovery scheme	(1,221)	(977)
Private patient income	(182)	(183)
	191,921	**185,323**

2. Private patient income

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000	Base Period £000
Private patient income	182	183	198
Total patient related income	193,324	184,482	101,221
Proportion (as a percentage) [1]	0.09%	0.10%	0.20%

[1] 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 0.09% of its patient related income from private patients during the year ended 31 March 2011, which is within the limit which Monitor has set at 0.20%.

3. Segmental analysis

Sherwood Forest Hospitals NHS Foundation Trust acts as a lead body for East Midlands Procurement Hub and the Nottinghamshire Health Informatics Service. Income and expenditure for these functions is not material to the overall accounts and has not therefore been separately disclosed. Expenditure is broadly in line with income for both of these bodies. In line with the Monitor NHS Foundation Trust Annual Reporting Manual all income and assets are reported as healthcare and can therefore be reviewed in the Statement of Financial Position and Statement of Comprehensive Income. The operations of the East Midlands Procurement Hub were discontinued on 31 March 2011 and its income and expenditure has been disclosed as a note to the Statement of Comprehensive Income.

4. Income generation activities

The Trust undertakes some minor income generation activities with an aim of achieving profit, which is then used in patient care. These are not material transactions in terms of the overall income of the Trust.

5. Operating expenses

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Services from Foundation Trusts	239	184
Services from other NHS Trusts	1,785	1,042
Services from other NHS bodies	1,285	964
Purchase of healthcare from non NHS bodies	438	712
Employee expenses – executive directors	730	651
Employee expenses – non executive directors	137	122
Employee expenses – staff	148,341	144,922
Drugs	13,101	10,684
Supplies and services – clinical	17,094	16,597
Supplies and services – general	1,230	811
Establishment	2,593	2,953
Transport	168	199
Premises	12,196	11,166
Provision for impairments of receivables	27	(35)
Depreciation of property, plant and equipment	7,680	8,143
Amortisation of intangible assets	929	878
Impairments of property, plant and equipment	147,944	48,185
Auditor's services – statutory audit	70	49
Other auditors' remuneration	14	23
Clinical negligence	3,519	3,112
Loss on disposal of investments	0	0
Loss on disposal of property, plant and equipment [1]	304	119
Legal fees	672	125
Consultancy services	1,847	2,062
Decommissioning / Workforce transformation[3]	1,995	468
Training, courses and conferences	624	858
Early retirements	55	56
Hospitality	195	246
Losses, ex gratia and special payments	12	220
Other[2]	19,585	14,414
Operating expenses of continuing operations	**384,809**	**269,930**

[1] The losses noted above all relate to plant, property and I.T equipment which are all non protected assets.
[2]This includes payments made to the Trusts PFI Partner. Details of our PFI schemes are detailed in note 20.3 and 20.4.
[3]This includes the decommissioning of Resource an East Midlands procurement collaborative which was discontinued on the 31 March 2011 £711k.

***6.* Operating leases (excluding off balance sheet PFI)**	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
***6.1* As lessee**		
Minimum lease payments - plant and machinery	456	491
Total	**456**	**491**
***6.2* Future minimum lease payments due**	**£000**	£000
Payable		
Not later than one year	295	300
Between one and not later than five years	316	575
Later than five years	214	246
Total	**825**	**1,121**
***6.3* As lessor**	**£000**	£000
Rents recognised in period	461	500
Total	**461**	**500**
***6.4* Total future minimum lease payments**	**£000**	£000
Receivable		
Not later than one year	58	269
Between one and not later than five years	219	265
Later than five years	488	686
Total	**765**	**1,220**

***7.* Limitation on auditors' liability**	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
Limitations on auditors' liability	500	1,000

This limit is subject to our Auditors' general terms and conditions of engagement and covers loss or damage suffered arising out of or in connection with the services provided.

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2011 £000	Permanently employed £000	Other £000	Year ended 31 March 2010 £000
Salaries and wages	119,272	119,272	0	115,847
Social security costs	8,698	8,698	0	8,600
Employer contributions to NHS pension scheme	14,189	14,189	0	13,541
Other pension costs	0	0	0	56
Termination benefits	92	92	0	605
Agency costs	6,821	0	6,821	6,924
	149,072	**142,251**	**6,821**	**145,573**

8.2 Average number of persons employed

	Year ended 31 March 2011 Number	Permanently employed Number	Other Number	Year ended 31 March 2010 Number
Medical and dental	449	389	60	443
Administration and estates	904	899	5	903
Healthcare assistants and other support staff	594	594	0	570
Nursing, midwifery and health visiting staff	1,092	1,047	45	1,042
Scientific, therapeutic and technical staff	448	447	1	444
	3,487	**3,376**	**111**	**3,402**

9. Retirements due to ill-health

During 2010/11 there were 5 (2009/10 4) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £141k (2009/10 £259k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

10. Better Payment Practice Code

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2011 Number	£000	Year ended 31 March 2010 Number	£000
Total non-NHS trade invoices paid in the year	51,891	113,359	53,962	93,081
Total non-NHS trade invoices paid within target	50,279	111,896	50,673	89,413
Percentage of non-NHS trade invoices paid within target	97%	99%	94%	96%
Total NHS trade invoices paid in the year	1,547	14,130	1,679	17,904
Total NHS trade invoices paid within target	1,405	13,371	1,584	17,604
Percentage of NHS trade invoices paid within target	91%	95%	94%	98%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11. The Late Payment of Commercial Debts (Interest) Act 1998

No amounts have been included in finance costs (200910 nil) and no compensation has been paid to cover debt recovery costs under this legislation

12. Finance income

12.1 Interest receivable

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Bank accounts	329	303
Total	**329**	**303**

12.2 Finance costs

	£000	£000
Interest on loans	0	2
Interest on obligations under PFI finance leases	14,645	10,202
Total	**14,645**	**10,204**

13. Property, plant and equipment

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: at 1 April 2010	**16,010**	**308,161**	**884**	**79,257**	**27,154**	**0**	**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**	**0**	**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**	**0**	**2,916**	**146**	**311,712**
Net book value at 31 March 2011									
Purchased	17,977	24,9999	765	788	11,903	0	1,802	196	58,430
Donated	0	1,077	0	0	1,336	0	13	20	2,446
PFI	0	164,066	0	0	0	0	0	0	164,066
Finance lease	0	0	0	0	0	0	0	0	0
Total at 31 March 2011	**17,977**	**190,142**	**765**	**788**	**13,239**	**0**	**1,815**	**216**	**224,942**
Protected	**14,462**	**189,542**	**0**	**0**	**0**	**0**	**0**	**0**	**204,004**
Non protected assets	**3,515**	**600**	**765**	**788**	**13,239**	**0**	**1,815**	**216**	**20,938**

Prior year:

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation: at 1 April 2009	18,584	291,077	0	4,406	25,122	0	4,286	197	343,672
Additions purchased		5,675	152	76,354	3,754		411	44	86,390
Additions donated					240		5		245
Impairments	(2,574)								(2,574)
Reclassifications		770	732	(1,503)	30		620	(1)	648
Revaluation surpluses		10,639							(10,639)
Other in year revaluation									
Reclassified as held for sale									
Disposals					(1,992)		(783)		(2,775)
At 31 March 2010	**16,010**	**308,161**	**884**	**79,257**	**27,154**	**0**	**4,539**	**240**	**436,245**
Depreciation at 1 April 2009	0	104,936			12,089		2,525	77	119,627
Provided during the year		4,690			2,778		645	30	8,143
Impairments		47,936	249						48,185
Reversal of impairments									
Reclassifications		(2)			17		410	(1)	424
Revaluation surpluses									
Other in year revaluation									
Reclassified as held for sale									
Disposals					(1,896)		(772)		(2,668)
Depreciation at 31 March 2010	**0**	**157,560**	**249**	**0**	**12,988**	**0**	**2,808**	**106**	**173,711**
Net book value at 31 March 2010									
Purchased	16,010	31,357	635	2,381	12,296	0	1,711	134	64,524
Donated	0	67	0	0	1,865	0	20	0	1,952
PFI	0	119,177	0	76,876	0	0	0	0	196,053
Finance lease	0	0	0	0	5	0	0	0	5
Total at 31 March 2010	**16,010**	**150,601**	**635**	**79,257**	**14,166**	**0**	**1,731**	**134**	**262,534**
Protected	**14,370**	**150,001**	**0**	**0**	**0**	**0**	**0**	**0**	**164,371**
Non protected assets	**1,640**	**600**	**635**	**79,257**	**14,166**	**0**	**1,731**	**134**	**98,163**

14. Intangible assets

	Software licenses and trademarks 2010/11 £000		**Software licenses and trademarks 2009/10 £000**
Cost or valuation at 1 April 2010	**5,138**	Cost or valuation at 1 April 2009	5,681
Revaluation		Revaluation	
Impairments		Impairments	
Reclassifications		Reclassifications	(648)
Revaluation surpluses		Revaluation surpluses	
Additions purchased	218	Additions purchased	415
Additions internally generated		Additions internally generated	
Additions donated		Additions donated	
Reclassified as held for sale		Reclassified as held for sale	
Disposals	(42)	Disposals	(310)
Gross cost at 31 March 2011	**5,314**	Gross cost at 31 March 2010	**5,138**
Amortisation at 1 April 2010	**2,464**	Amortisation at 1 April 2009	2,306
Provided during the year	929	Provided during the year	878
Indexation		Indexation	
Impairments		Impairments	
Reversal of impairments		Reversal of impairments	
Reclassifications		Reclassifications	(424)
Other revaluation		Other revaluation	
Reclassified as held for sale		Reclassified as held for sale	
Disposals	(42)	Disposals	(296)
Amortisation at 31 March 2011	**3,351**	Amortisation at 31 March 2010	**2,464**
Net book value: at 31 March 2011		Net book value: at 31 March 2010	
Purchased	1,953	Purchased	2,661
Donated	10	Donated	13
Total at 31 March 2011	**1,963**	Total at 31 March 2010	**2,674**

15. Impairments

Impairments in the period arose from:	**Tangible**	
	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Impairments charged to operating expenditure	147,944	48,185
Reversal of impairments	(6,051)	0
Impact on retained deficit for the year	**141,893**	48,185
Reduction in revaluation reserve due to impairments	**13,823**	2,574
Revaluation gains recognised in the revaluation reserve	**(2,852)**	0
Movement on revaluation reserve	**10,971**	2,574
Total impact on Statement of Comprehensive Income	**152,864**	50,759

All impairments in year reflect the general economic conditions relating to the fall in property prices. No impairments were recognised relating to intangible assets.

16. Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were:

	Year ended 31 March 2011	Year ended 31 March 2010
	£000	£000
Property, plant and equipment	28	561
Intangible assets	21	33
Total	**49**	**594**

17. Inventories

	Year ended 31 March 2011	Year ended 31 March 2010
	£000	£000
Drugs	997	849
Materials	1,806	1,982
Energy	13	13
Total	**2,816**	**2,844**

17.1 Inventories recognised in expenses

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Inventories recognised as an expense in the period	21,337	20,446
Total	**21,377**	**20,446**

18. Trade and other receivables

	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Current (falling due within one year)		
NHS receivables	6,473	8,010
Other trade receivables	60	90
Provision for the impairment of receivables	(107)	(65)
Prepayments	327	372
Accrued income	3,995	49
Other receivables	1,627	2,540
Total current trade and other receivables	**12,375**	**10,996**
Non-current (falling due after more than one year)		
NHS receivables	1,048	984
Other trade receivables		
Provision for the impairment of receivables	(126)	(170)
Prepayments	83	86
Other receivables	27	0
Total non-current trade and other receivables	**1,032**	**900**
Total trade and other receivables	**13,407**	**11,896**

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 £3.2m, however, the Trust is aware of no reason why these are not recoverable. The Trust does not hold any collateral over the balances.

***18.1* Movement in the provision for the impairment of receivables**	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
Balance at 1 April	235	272
Increase in provision	72	5
Amounts utilised / reversed	(74)	(42)
Balance at 31 March	**233**	**235**

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 (9.6%). No provisions are made for NHS debtors.

19. Trade and other payables

Current (falling due within one year)	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
Receipts in advance	2,445	387
NHS payables	2,797	1,852
Non-NHS trade payables – capital	3,407	3,362
Tax and social security costs	2,989	2,968
Accruals	11,367	10,677
Other payables	5,453	4,178
Total current trade and other payables	**28,458**	**23,424**
Non current (falling due after one year)		
Receipts in advance	2,600	0
Non-NHS trade payables – capital	3,439	0
Total non-current trade and other payables	**6,039**	**0**

20. Borrowings

Current	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
Finance lease liabilities	0	2
Private finance initiative (PFI) contract	4,639	3,656
Total current	**4,639**	**3,658**
Non-current		
Private finance initiative (PFI) contract	354,670	258,229
Total non-current	**354,670**	**258,229**
Total borrowings	**359,309**	**261,887**

20.1 Amounts payable under finance leases

PFI obligations	**Minimum lease payments**	
	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Gross PFI liability	359,309	261,885
Of which liability is due:		
Within one year	4,639	3,656
Between one and five years	21,093	20,052
After five years	333,577	238,177
Net PFI liability	**359,309**	**261,885**

Equipment finance lease obligations	**Minimum lease payments**	
	Year ended 31 March 2011 £000	Year ended 31 March 2010 £000
Gross liability	0	2
Of which liability is due:		
Within one year	0	2
Between one and five years		
Finance lease liability	**0**	**2**

The Trust does not consider there to be any difference in the present value of minimum lease payments to the value of the minimum lease payments.

20.2 Finance lease receivables

The Trust has no finance leases where it is the lessor in operation.

20.3 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 as the transaction does meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual (ARM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme '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 the 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 2011:

	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet – gross	260
Amortisation of PFI deferred asset[1]	(130)
Net charge to operating expenses	**130**

[1]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 2011/12 relating to the unitary charge to Leicester Housing Association.

	£000
PFI scheme which expires in 2035	256

In addition to the commitments in 2011/12 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.	436

The 35 year contract started in September 2000 and will end in September 2035.

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 (ARM) issued by Monitor, and 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 Trusts buildings 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, 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	3,281	0
Amounts included within depreciation in respect of PFI transactions deemed to be on-balance sheet	2,712	14
Amounts included within interest payable in respect of PFI transactions deemed to be on-balance sheet	14,604	41
Total charge to operating statement	**20,597**	**55**

The Trust is committed to make the following payments in 2011/12 relating to the capital funding repayment, the associated interest and the unitary charge.[1]

	MAS £000	**LHA £000**
PFI scheme which expires;		
Day nursery (contract end April 2025)		43
MAS PFI (contract end March 2043)	40,508	

In addition to the commitments in 2011/12 the Trust has the following commitments in respect of the Capital element of the PFI to the end of the respective schemes.

• Not later than one year;	4,601	39
• Later than one year and not later than five years; and	20,912	181
• Later than five years.	332,711	865

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	32	16

[1] The 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.

21. Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	33,253	36,580
Net change in year	(3,568)	(3,327)
Balance at 31 March	**29,685**	**33,253**
Made up of		
Cash with the Government banking service (RBSG / Citibank) / Office of Paymaster General	29,680	33,248
Cash in hand	5	5
Cash and cash equivalents	**29,685**	**33,253**

22. 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."

As part of the year end process, estimates have been made regarding outstanding income, expenditure and provisions. No estimates have been made regarding land and buildings as these have all been revalued in year. The Trust is not aware of any material uncertainty within these estimates which would Impact on the figures disclosed within the primary statements and notes to the accounts.

23. Provisions for liabilities and charges

	Pensions relating to other staff £000	Legal claims £000	Other £000	31 March 2011 Total £000
At 1 April 2010	527	146	860	1,533
Arising during the period	48	4,437	1,898	6,383
Utilised during the period	(48)	(120)	(7)	(175)
Reversed during the period	(59)	(34)	(341)	(434)
Unwinding of discount				
At 31 March 2011	**468**	**4,429**	**2,410**	**7,307**
Expected timing of cashflows				
Within one year	48	4,429	2,300	6,777
Between one and five years	192	0	32	224
After five years	228	0	78	306
	468	**4,429**	**2,410**	**7,307**

	Current		Non-current	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Pensions relating to former staff (excluding directors)	50	51	418	476
Other legal claims	4,429	146	0	0
Other	2,300	741	110	119
Total	**6,779**	**938**	**528**	**595**

£19.696m is included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the Trust (31/03/10 £17.676m).

24. Contingent liabilities

	31 March 2011 £000	31 March 2010 £000
Gross value	39	143
Amounts recoverable	0	0
Net contingent liability	**39**	**143**

This relates to clinical negligence un-provided liabilities.

Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The directors consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

25. Prudential borrowing limit

The Trust has a maximum cumulative long term borrowing limit of £362.9 million.
Monitor has also authorised the Trust to have a £15m working capital facility in place. The Trust did not exercise this option in year.

	Year ended 31 March 2011 Actual	Approved	Year ended 31 March 2010 Actual	Approved
Minimum dividend cover – times	N/A[1]	>1.0 times	278.5	>1.0 times
Minimum interest cover – times	1.5[2]	>2.0 times	2.3	>2.0 times
Minimum debt service cover – times	1.2[2]	>1.5 times	1.8	>1.5 times
Maximum debt service to revenue %	7.3	<10.0%	5.4	<10.0%

[1]No dividends payable due to negative net relevant assets following the impairment of PFI assets.
[2]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 £359.3m This limit is adjusted annually as it currently exceeds the normal 'tier 2' calculated limit.

26. Management Costs

	£000	£000
Management costs	7,267	7,014
Income (net of NMET[1] income)	240,223	224,654
Percentage	3.03%	3.12%

[1]This relates to income received for continuous professional development and training relating to Doctors and Nursing staff.

27. Financial instruments and related disclosures

	Carrying value 31 March 2011 £000	Carrying value 31 March 2010 £000
Current financial assets		
Cash and cash equivalents	29,685	33,253
Trade and receivables	8,053	10,405
Non-current financial assets		
Trade and receivables	922	984
Total financial assets	**38,660**	**44,642**
Current financial liabilities		
Financial liabilities measured at amortised cost:		
PFI Finance leases	4,639	3,658
Trade and other payables	31,731	29,538
Provisions under contract	7,307	1,533
Non-current financial liabilities		
Financial liabilities measured at amortised cost:		
PFI Finance leases	354,670	258,229
Total financial liabilities	**398,347**	**292,958**

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

28. Changes to Accounting Standards

The Trust is aware of proposed changes to accounting standards which are relevant to this Trust such as IAS 24, related parties, IFRS 9 financial assets and IFRS 7 reclassification of financial instruments. Based on the current proposals, any changes implemented would have no impact on the financial statements as presented.

29. Exit packages

	2010/11			2009/10		
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	8	0	8	1	0	1
£10,00 - £25,000	14	0	14	3	0	3
£25001 - £50,000	3	0	3	1	0	1
£50,001 – £100,000	1	0	1	0	0	0
£100,000 - £150,000	1	0	1	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
£200,001 - £250,000	1	0	1	1	0	1
Total number of exit packages by type	28	0	28	6	0	6
Total cost (£000)	**831**	**0**	**831**	**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 9.

30. Post year-end events

The Trust entered into a three year contract with effect from the 1st May 2011 to run inpatient and outpatients services at Mansfield and Ashfield community hospitals, sexual health and stroke early supported discharge services which had previously been run by Nottinghamshire County PCT under the national 'Transforming Community Services' strategy. This is not considered to have an adverse effect on the reported position and the Trust is not aware of any other events since the close of the accounting period, which would affect the position reported, or the Trust's assessment on its going concern basis.

The full year income to support these services is approximately £14.3m and 252 staff are also transferring to the Trust. Due diligence was undertaken prior to agreement to ensure that all risks were identified and mitigated.

31. Third party assets

The Trust held nil (£580.00 in 2009/10) as cash in hand or at bank at 31 March 2011 on behalf of patients.

32. Related party transactions

Sherwood Forest Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Sherwood Forest Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent entity.

The Trust has also received revenue and capital payments from Sherwood Forest Hospitals Charitable Funds for which a number of Trustees are also members of the 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.

Details of the significant entities with NHS organisations are listed overleaf:

	2010/11 Income £000	2010/11 Expenditure £000	2009/10 Income £000	2009/10 Expenditure £000
Bassetlaw PCT	1,279	58	1,129	0
Department of Health	69	0	977	0
Derby City PCT	362	14	334	2
Derby County PCT	20,756	271	19,870	6
Derby Hospitals NHS Foundation Trust	367	19	308	44
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	12	68	12	173
East Midlands Ambulance Services NHS Trust	3	5	4	1,024
East Midlands Strategic Health Authority	11,846	48	11,365	0
Kettering Foundation Trust	80	0	60	0
Leicester County and Rutland PCT	8,904	7	8,474	33
Leicester City PCT	142	0	72	0
Leicester Partnership Trust	72	127	64	126
University Hospitals Leicester Trust	401	59	168	59
Lincolnshire PCT	4,650	0	4,126	0
Moorfield's Eye Hospital NHS Foundation Trust	0	0	0	35
NHS Blood and Transplant	0	982	1	1,052
NHS Business Services Authority	0	1,049	0	679
NHS Litigation Authority	0	3,519	0	3,112
Northampton Teaching PCT	281	0	271	0
Northampton Trust	138	0	103	0
Nottingham University Hospitals NHS Trust	3,706	1,943	3,466	1,411
Nottingham City PCT	4,198	464	4,170	43
Nottinghamshire County PCT	176,122	2,364	168,496	1,305
Nottinghamshire Healthcare NHS Trust	1,711	393	1,584	303
NHS Purchasing and Supply Agency	0	5,979	3	5,423
Sheffield Children's NHS Foundation Trust	40	104	35	51
Sheffield Teaching Hospitals NHS Foundation Trust	1	56	0	36
United Lincolnshire Hospitals NHS Trust	231	1	190	2

33. Senior managers disclosure

33.1	2010/11				2009/10			
Name and title	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1000)**	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1000)**
Executive Directors								
Mrs C. White (Interim Chief Executive) Appointed 1 December 2009.	**155-160**	**0**	**5,900**	**22**	45-50	0	2,100	7
Mrs C. White (Executive Nursing Director) Figures for comparative purposes to 30 November 2009.	**N/A**	**N/A**	**N/A**	**N/A**	55-60	0	3,000	9
Dr N. Ali (Executive Medical Director) In post from 26 July 2010.	**15-20**	**105-110**	**0**	**12**	N/A	N/A	N/A	N/A
Mrs S. Bowler (Interim Executive Director of Nursing and Quality) Seconded to the Trust from 1 May 2010. Salary reflects recharge paid in 2010 / 11.	**95-100**	**0**	**0**	**0**	N/A	N/A	N/A	N/A
Ms J. Warder (Chief Operating Officer)	**115-120**	**0**	**4,300**	**17**	90-95	0	4,100	13
Mr L. Bond (Executive Director of Finance)	**115-120**	**0**	**4,000**	**16**	110-115	0	3,800	16
Ms K. Fisher (Executive Director of Human Resources)	**95-100**	**0**	**500**	**13**	90-95	0	0	13

	2010/11				2009/10			
Name and title	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1000)**	**Salary (bands of £5000)**	**Other remuneration (bands of £5000)**	**Benefits in kind (nearest £100)**	**Employer pension contributions (nearest £1000)**
Mr J. Worrall (Chief Executive) In post to 30 November 2009 included for comparative purposes.	**N/A**	**N/A**	**N/A**	**N/A**	95-100	0	4,400	11
Dr M. Mowbray (Executive Medical Director) In post from 1 April 2010 to 11 July 2010.	**5-10**	**35-40**	**7,000**	**5**	25-30	175-180	7,500	0
Non-Executive Directors								
Ms T. Doucet	**45-50**	**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**	0-5	N/A	N/A	N/A
From 1 December 2009 **Mr S. Pearson** To 31 December 2009 included for comparative purposes.	**N/A**	**N/A**	**N/A**	**N/A**	05-10	N/A	N/A	N/A

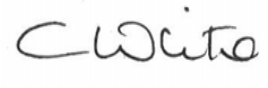
Benefit in kind relates to lease car allowances.

33.2	2010/11					2009/10				
Name and Title	**Real increase during the year in pension and lump sum at age 60 (bands of £2500)**	**Total accrued pension (incl. lump sum) at age 60 at 31 March 2011 (bands of £2500)**	**Value of cash equivalent transfer value as at 1 April 2010 (nearest £1000)**	**Real increase in cash equivalent transfer value during the year ended 31 March 2011 (bands of £1000)**	**Value of cash equivalent transfer value at the end of the reporting period - 31 March 2011 (bands of £1000)**	**Real increase during the year in pension and lump sum at age 60 (bands of £2500)**	**Total accrued pension (incl. lump sum) at age 60 at 31 March 2010 (bands of £2500)**	**Value of cash equivalent transfer value as at 1 April 2009 (nearest £1000)**	**Real increase in cash equivalent transfer value during the year ended 31 March 2010 (bands of £1000)**	**Value of cash equivalent transfer value at the end of the reporting period - 31 March 2010 (bands of £1000)**
Executive Directors										
Mrs C. White	**82.5-85**	**217.5-220**	**608**	**289**	**912**	15-17.5	130-132.5	492	103	608
Dr N. Ali	**2.5-5**	**197.5-200**	**970**	**(37)**	**939**	N/A	N/A	N/A	N/A	N/A
Mrs S. Bowler	**45-47.5**	**152.5-155**	**442**	**122**	**576**	N/A	N/A	N/A	N/A	N/A
Ms J. Warder	**37.5-40**	**152.5-155**	**539**	**(38)**	**514**	5-7.5	110-112.5	375	44	428
Mr L. Bond	**2.5-5**	**100-102.5**	**321**	**(46)**	**283**	12.5-15	92.5-95	258	57	321
Ms K. Fisher	**5-7.5**	**137.5-140**	**428**	**71**	**509**	12.5-15	127.5-130	450	77	539
Mr J. Worrall	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	10-12.5	235-237.5	1,103	100	1,281
Dr M. Mowbray	**(5)-(7.5)**	**215-217.5**	**1,192**	**(54)**	**1,030**	32.5-35	230-232.5	951	216	1,192

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 defined benefit pension liability for some of the Senior Managers has reduced in value this year due to the Governments Emergency Budget announced 22 June 2010. The Government announced that the Consumer Prices Index (CPI) would be used to calculate the minimum pension increases for index-linked pensions rather than the Retail Prices Index that has been used previously.

Mrs D. Weremczuk and Mr A. Molyneux were Executive Directors for a day but are not included in the Senior Managers disclosure as it is not considered material.
The Trust has made payments to a related party of Dr. N. Ali totalling £22,600 (room hire Podiatry clinics). Dr. Ali is a Director and Shareholder and the relationship has been identified in the register of interests. Of the total payments identified £1,000 remains to be paid as at 31/03/2011.



Carolyn White, Chief Executive26 May 2011

Statement of Internal Control 2010/11 Scope of Responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Responsibility for the effectiveness of organisational systems of control and risk management rests with the Board of Directors and the Chief Executive as Accounting Officer. However, specific responsibilities are delegated to other directors and senior managers through the Trust's risk management policy and scheme of delegation.

Management structures are in place within the organisation headed by myself as Accounting Officer. During 2010/11 and operating within that structure with the specific remit to manage risk, were the risk management committee (non-clinical), which is chaired by the Executive Director of Finance, and the Clinical Governance Committee, co-chaired by the Executive Medical Director and Executive Director of Nursing and Quality. These were the principal committees charged with managing risk and clinical governance across the Trust.

A review of the Trust's risk management policy was initiated at the end of 2010/11 to ensure that the Trust's arrangements reflected the Trust's new management structures. As a result, the roles of the Risk Management Group, the Clinical Governance Committee and the Executive Board are being realigned

The Risk Management Group and the Clinical Governance committee have dual reporting responsibility as they report routinely to the Audit Committee in order to provide assurance over the effectiveness of their systems but also to the Executive Board. The Executive Board is the most senior operational group within the organisation and is chaired by myself.

The Audit Committee is a non executive sub committee of the Board, meets at least quarterly and is responsible for
ensuring that systems and processes are in place for managing all aspects of governance across the organisation. This extends beyond finance and corporate governance to include information and clinical governance. Its remit covers the setting and monitoring of the internal audit plan, external audit plan and also the annual counter fraud plan together with ongoing review of all associated action plans. The Audit Committee chairman reports after every meeting to the Board of Directors.

The Board of Directors receive further assurance on financial issues from the investments committee.

During 2010/11, the Investments Committee dealt specifically with investment decisions and associated risks faced by the Trust. It received reports covering areas ranging from the Trust's charitable fund operations to the progress of the new hospital development. This committee assisted the Board of Directors in forming plans to action or mitigate against identified risks in these areas. The Investments Committee also reported after every meeting to the Board of Directors;

The role of the Investments Committee is being revised as part of the review of the Trust's governance and risk management structure, where it will be replaced by a Finance Committee. The Finance Committee will have an increased focus on the forward financial and related operational risks.

Staff are trained and equipped to manage risk in a number of ways:

- The management and divisional structures are well established and clear responsibilities for governance and risk management at board, corporate and divisional level are clearly identified

- Awareness training on risk management, risk assessment, incident reporting and awareness of counter fraud are included in the Trust's core induction programme which must be attended by all staff on their first day of work and in a programme of ongoing development

- Compliance with the risk management policy supports the assessment and management of risk at all levels in the organisation. This is supplemented by a number of other policies and procedures which are in place within the organisation. Examples include:
  - o accident and incident reporting
  - o handling complaints and claims
  - o managing health and safety
  - o dealing with fraud and corruption
  - o Major incident planning and business continuity plans

Clearly, all Trust employees have a part to play in managing risk including reporting incidents, accidents and near misses; complying with all Trust policies and procedures; attending training, including new joiner induction sessions as stated in the Trust's mandatory training plans and being familiar with emergency procedures.

The Trust aims to ensure that it learns from good practice through:

- Employing a system of Root Cause Analysis (RCA) to review processes and significant incidents in order to identify ways of reducing risks and learning from experiences. RCA has been used extensively during 2010/11 with health care acquired infections,
- breaches of same sex accommodation standards, information governance breaches and serious untoward incidents. The Trust also links with partner organisations to provide appropriate education and training in this area

- Developing and progressing action plans arising from external reviews such as the NHS litigation authority assessment standards, Care Quality Commission (CQC) reports and PEAT

- Implementing good practice guidance such as that contained within the NPSA patient safety alerts

- Continually review the Trust's ability to respond to a major incident. The Trust has an emergency planning group and an influenza pandemic plan. In addition, it conducted a live training exercise and tested its fire contingency plans within the new hospital building

Risk and Control framework

Risk management is a core discipline within the organisation's activities with risks routinely being reported, using a standard reporting tool, throughout the different levels of the organisation. This 'bottom up approach to risk management is complemented by the 'top down' Board Assurance Framework. The Board Assurance Framework lists the principal risks to the achievement of corporate objectives as identified in the Trust's Annual Plan and identifies and evaluates the systems of control in place to manage these risks and the assurance that these risks are being managed effectively.

The Board of Directors recognises the importance of involving public stakeholders in the management of risks that may impact on them and has established mechanisms to enable this involvement:

- The clinical governance committee includes 2 public Governors

- A number of Trust wide committees have public representatives as members – for example, the Infection Control Committee, and the strategic PEAT Committee

- Summaries of monthly performance are provided through team briefing and Governors are provided with updates on performance issues at their meetings

- The Board of Governors has established a number of committees that receive assurance in relation to the management of the risks associated with key aspects of the Trust's work. For example, the performance and strategy committee of the board of Governors reviews all of the Trusts performance issues

During 2010/11 the Board Assurance Framework was considered regularly by the Board of Directors. Gaps identified related to a wide range of risks, including financial risks (for example the performance of the Trust's cost improvement programmes (CIPs) and managing fluctuations in patient flows and

demand); reputational and safety risks (for example gaining adequate assurance relating to retained estate issues); and regulatory risks (for example maintaining CQC registration and governance ratings).

The Board of Directors also recognises the regulation risks associated the governance thresholds contained in the Compliance Framework 2011/12, especially the Clostridium.difficile reductions, the Accident and Emergency indicators and 62 day cancer waits.

The Trust is working as part of a very financially challenged local health economy. Our main commissioners, NHS Nottinghamshire County, who account for 86% of our acute clinical income, are committed to saving £144m over the next four years. Like-for-like clinical income from our acute contract in 2011/12 is expected to be £14.1m less than 2010/11 outturn. This has led to a significant decrease in the Trust's forecast acute income from 2011/12 onwards, and as a result the Trust is forecasting deficits for the next two financial years.

Operating losses have a consequential impact upon cash resources. As such the Trust is likely to have to rely on the use of its committed working capital facility in 2012/13 to support its operations. The Trust is currently in negotiations to ensure the availability of this facility after April 2012, when the current working capital facility expires.

The Trust is working closely with all of its health partners to ensure that risk to patients is mitigated as far as possible.

To help address the forecast financial position the Trust has appointed and worked with external advisors in 2010/11 to develop the long term financial model (LTFM), and a Turnaround Plan to address the financial challenges that it faces. This has included the modelling of upside and downside scenarios to assess their impact on the deliverability of the overall Plan.

The Plan has identified significant cost improvement requirements to ensure a return to break even in 2013/14. Delivery of the cost improvement programme will be managed through a structured and appropriately governed Project Management Office (PMO). It should be noted that the £9.5m CIP target for 2010/11 was delivered in full. Only £1.8m of this was delivered on a non-recurrent basis and this has been taken into account in our 2011/12 financial planning process.

Information Governance

The Trust's risk management policy equally applies to the management of data security. The Executive Director of Finance has board level responsibility for governance and risk management systems and processes including those associated with information. He acts as the senior information risk owner and can confirm that the organisation is compliant with 21 of the 22 key requirements of the information governance toolkit (version 8) at level 2. This was confirmed by internal audit. The Trust has agreed a plan to achieve compliance with all standards at level 2 by the end of 2011/12.

During 2010/11, the Trust reported one serious untoward incident relating to a breach of confidentiality. In January 2011, an employee disclosed personal details of a number of patients to an unauthorised third party in error. The incident was reported to the Information Commissioner's Office (ICO) and a full internal investigation was undertaken.

The patients affected by this breach were informed and a number of actions have been taken with the staff concerned.

The ICO has confirmed that it is satisfied with the actions taken by the Trust.

Registration with the Care Quality Commission (CQC)

The Trust is fully compliant with the requirements of the CQC.

The Trust was registered with the CQC from the 1 April 2010. Two conditions were attached to the Trust's registration as follows:

- Condition 1 – related to concerns that the Trust had inadequate systems to assess and monitor the quality and safety of service provision and the Trust was required to implement an action plan and provide evidence of improvement by the 31 July 2010

- Condition 2 – related to clinical governance arrangements within the Integrated Critical Care Unit (ICCU) and the Trust was required to provide an action plan and evidence of improvement by the 31 May 2010

During the first 2 quarters of 2010/11 the Trust reviewed and updated its clinical governance structures, and both conditions were removed by the end of July 2010.

Equality and Diversity

Control measures are in place to ensure that all of the Trust's obligations under equality, diversity and human rights legislation are complied with. These include a Single Equality Scheme 2008 – 2010, (that has recently been replaced by a Single Equality Scheme 2011 – 2015) and a Diversity and Inclusivity Committee that monitors compliance with the Equality Scheme and which reports annually to the Board of Directors.

The Trust has introduced a process for conducting Equality Impact Assessments (EqIAs) and a Diversity and Inclusivity Committee regularly monitors progress with these assessments. Initially, EqIAs have been conducted on key policies within the Trust and are now being carried out on a wide range of policies across the Trust.

NHS Pension Scheme

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

Carbon Reduction and Sustainability

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

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

The Board of Directors reviews the economy, efficiency and the effectiveness of the use of resources through monitoring processes. On a monthly basis the Executive Team reviews the performance of operational management through regular performance management meetings and regular reports are provided to the Board of Directors on progress against the Trust's overall financial performance

Internal audit reports, reports from external audit, (principally the audit of the Annual Accounts and the production of the Annual Management Letter), and regular reports from the Local Counter Fraud Specialist to the audit committee have also provided the Board of Directors with assurance that the Trust's assurance mechanisms are sound and effective.

Annual Quality Report

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

The Board is assured that appropriate steps have been put in place to assure the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- the content of the Quality Report is consistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners
    - Feedback from Governors
    - Feedback from LINks
    - The 2010 National Patient Survey
    - The 2010 National Staff Survey
    - CQC Quality and Risk Profiles dated Sept 2010 –May 2011
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed

definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting

- guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://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.

Review of effectiveness

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

I have also been advised by the following processes:

- Regular review by the Board of Directors of the Board Assurance Framework and of the risk register

- Regular reports from the Audit Committee to the Board of Directors on issues of internal control and regular review of the minutes of audit committee meetings;

- Regular reports from Internal Audit, to the Audit Committee on matters of internal control as described in the internal audit plan

- The head of Internal Audit Opinion which provides significant assurance over the system of internal control

- Consideration of Board of Directors' meeting agendas, papers and the quarterly Board Assurance Framework updates that provide me with evidence of the effectiveness of controls

- The outcome of visits, reports and assessments of external independent agencies including:

    - Our achievement of a financial risk rating of 3 from Monitor at the 2010/11 year-end

    - Retention of NHSLA standard 1 for acute services and for maternity services

    - Full registration with the Care Quality Commission

- Maintenance of Improving Working Lives Practice + status
- PEAT inspections
- Clinical Pathology accreditation
-
- Maintenance of Investors In People status
- Positive Postgraduate Dean report on training activities
- Positive report from the Healthcare Commission's ratings of Trusts, confirming ratings of 'good' for our services and 'excellent' for our use of resources
- Positive outcomes from CQC visits especially regarding the removal of the 2 registration conditions, in July 2010

I have also been advised on the implications of the result of my review of the effectiveness of the system of internal control by receiving the minutes and action plans of the key groups for promoting risk management as identified above. In addition I am aware of the importance of the following:

- The Board of Directors' role to provide active leadership of the Trust within a framework of prudent and effective controls that enable risk to be assessed and managed
- The role of the Audit Committee, as part of an integrated committee structure, which is pivotal in advising the Board of Directors on the effectiveness of the system of internal control. Any significant internal control issues would be reported to the Board of Directors via the Audit Committee
- The role of the Executive Management Board in assisting me in ensuring a comprehensive and coherent framework of risk management that integrates clinical, non-clinical and corporate governance
  - Directors' and managers' roles and responsibilities
  - The Trust's internal auditors, who provide regular reports to the Audit Committee and full reports to the Executive Director of Finance and line managers within the Trust. The Audit Committee also receives details of any actions that remain outstanding following the follow up of previous audit work. The Executive Director of Finance also meets regularly with the internal Audit Manager
  - The Trust's external auditors, who provide an annual management letter and regular progress reports to the Audit Committee

Conclusion

As Accounting Officer and based on the information provided above I am assured that the only significant control issues currently faced concerns the Trust's future forecast financial position. The Board of Directors has worked extensively with independent external advisers to assure itself that its forecasts are robust and that the actions required within the plan are deliverable. Current plans forecast a deficit for the next two financial years, and to

ensure a return to break even in 2013/14 the delivery of a significant cost improvement programme. The Trust fully met its CIP target in
2010/11 and is confident that, whilst challenging, the forecast CIP programme can be delivered. The delivery of the plan will require a significant amount of restructuring. The launch of a formal 90 day staff consultation on the strategic workforce review (SWR) on the 4 April 2011 provides evidence of the commitment being placed by the Board of Directors on the delivery of that plan. Key within this will be the use of quality impact assessments to provide additional assurance that clinical quality and safety is not being adversely affected as a result of the reductions to the cost base

I am satisfied that the actions being put in place will be sufficient to rectify these issues.

Finally, we recognise that there is an uncertain level of financial risk within the wider health community and the Trust will continue to work its local partners to ensure that this risk is managed appropriately and that the quality of services provided is considered paramount at all times.

Carolyn White
Chief Executive
26 May 2011
(on behalf of the Board)

External Audit Opinion

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 2011 on pages 112 to 153. 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 104 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' affairs as at 31 March 2011 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.

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 Statement on Internal Control 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 Statement on Internal Control that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts 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
6 June 2011

Independent auditor's report to Monitor on the Sherwood Forest Hospitals NHS Foundation Trust NHS Foundation Trust consolidation schedules

We have examined the NHS Foundation Trust Consolidation Schedules (FTCS) numbered FTC 1 to FTC 39 of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2011, 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 these consolidation schedules are consistent with the statutory financial statements on which we have issued an unqualified opinion and certificate[1].

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

6 June 2011

[1] Paragraph 5.6 of the March 2011 Audit Code states that this statement should refer to any qualification of the certificate or opinion on the accounts.