Sherwood Forest Hospitals NHS
NHS Foundation Trust

ANNUAL REPORT 2008/09

Contents

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Sherwood Forest Hospitals NHS foundation trust

ANNUAL REPORT 2008/09

Foreword from the chairman and chief executive

We are delighted to be able to commend to you our Annual Report for 2008/09.

This year for the first time we have published a separate annual review and calendar that highlights a number of the key events of an exciting year. We recommend that you read both documents to get a flavour of our achievemnents.

Every year provides a new set of challenges and 2008/09 was no different. Our second year as a foundation trust was marked by some notable landmarks, including the opening of the King's Treatment Centre (KTC) in June 2008 and the completion of the first of our 'Towers'.

The opening of the KTC coincided with the culmination of our History Project. Lead by our former chairman Brian Meakin, the project researched the history of the King's Mill site and the numerous buildings and services that have been provided from this small part of Sutton-in-Ashfield. The unveiling of the displays in the KTC and the many memories that were re-kindled on the 4th July 2008 when the project was officially opened was a moving and notable event in the history of our hospital.

Providing The Best Care

On behalf of the board of directors, we are proud to report that during the year we achieved almost all of our core clinical performance & access targets, with the Healthcare Commission rating us as 'good' for our standards of clinical services and 'excellent' for use of resources.

We have continued to deliver year on year improvements whilst also ensuring that patients receive their care, diagnosis and treatment more quickly than ever before.

Moving into our new facilities will give us a tremendous opportunity to maintain improvements and ensure that you, our patients, receive the best care available.

Managing Our Finances

Financially, our revenues were up almost 14% to over £218m and we successfully delivered a healthy £8.4m financial surplus – vital in assisting us to meet the future costs of our new hospital and in maintaining our record of delivering year on year improvements in our financial performance.

We are delighted to report that we completed the year to 31 March 2008 having achieved a financial risk rating of 5 from Monitor, the independent regulator of foundation trusts, the highest level available.

Despite our good performance, we are not complacent. We will continue to focus relentlessly on improving our services and on providing healthcare of the very highest standards - meeting the expectations of our local community.

Engaging Our Community

During 2008/09 we continued to shape our vision for the future and made sure that we listened to the views of members, staff and patients.

As a result we have now got a clearer picture of the things we need to do to remain the hospitals of choice for our local community.

The culmination of this work will be reflected in our Best Care, Best People, Best Place vision, that will be launched in the coming year. The 2009/10 annual plan will focus on meeting a number of pledges for staff and patients alike and will reflect the issues that were highlighted during 2008/09.

As well as listening to the views of our local community, our governance arrangements are there to ensure engagement, transparency and openness in all that we do. By the end of March 2009, we had successfully recruited over 16,000 public members, placing us in the top foundation trusts nationally – an achievement we are particularly proud of.

We are grateful for the hard work and enthusiasm of our board of governors during the year in supporting our work and in working with us to influence and shape our services for the future.

Improving Our Hospitals

As we have already indicated, work on our new £367m 'super-hospital' on our King's Mill site progressed well. June 2008 saw the successful opening of the Kings Treatment Centre, and in April 2009, we started to move inpatient accommodation into the first two of our three 'towers'.

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

The completion of the two 'towers' has also meant that the planned reconfiguration of services at Mansfield Community Hospital has started, with the result that all of the trust's inpatient accommodation is now housed on two sites – King's Mill Hospital and Newark Hospital.

Over the past 12 months we have also invested over £900,000 in developing and improving services at Newark Hospital. In November 2008, we opened our new genito-urinary medicine service in Newark – a service that we have been planning for a number of years.

Reducing Our Impact On The Environment

During 2008/09 we joined with our construction partners in installing a new geothermal heat transfer scheme to provide environmentally effective heating and cooling for our new hospital.

This project is the largest in Europe and will ensure that our new hospital remains at the leading edge of innovative environmental design.

We have also recently commissioned a local specialist company to explore the feasibility of using coal mine methane reserves held under King's Mill campus as an additional energy conservation measure.

Both measures are designed to help us reduce our carbon footprint and reduce our energy use.

Leading Our Staff

There were a small number of personnel changes on the board of directors during the year. We welcomed Karen Fisher as executive director of human resources and Stuart Grasar as independent non-executive director. Peter Harris a long standing non-executive director left his post in January 2009, to take up an asspociate position with NHS Nottinghamshire County.

Challenges For The Year Ahead

Much has been achieved in the last 12 months and much more remains to be done.

Continuing to design more streamlined, effective patient services will be essential if we are to continue to transform the effectiveness and quality of care for patients. During 2008/09 we continued to re-design our divisional management and clinical leadership structures in order to prepare for the challenges ahead.

Our new divisional structure has enabled us to improve our focus on the core areas of our work and to ensure that clinical staff – doctors nurses and other health professionals – have a more direct impact on how our services are provided both now and in the future.

It is imperative the we continue to deliver solid, sustainable financial perfomance upon which we can build for the future. To do this we will continue to set stretching financial targets and to renew our focus on increasing our efficiency and effectiveness and on controlling our costs.

We believe that as a trust we are uniquely placed to seize the opportunities that these challenges bring. We should be ambitious by focusing relentlessly on improving our services and on really providing the 'Best Care, by the Best People in the Best Place'.

A Bright Future

We are proud that people often talk about the sense of 'friendliness and caring' at our trust and this praise is down to the dedication and commitment of our staff and volunteers. They make this a very special place to work.

On behalf of the board of governors and board of directors, we would like to extend our personal thanks and recognition to those at the heart of this excellent performance – our staff and volunteers, whose talents, enthusiasm and commitment to providing the very best standards of customer and patient care are greatly appreciated.

Our future as a foundation trust is bright indeed – we look forward to the coming year with confidence.

Tracy Doucét
Chairman **Date: 5th June 2009**

Jeffrey Worrall
Chief Executive **Date: 5th June 2009**
On behalf of the board of directors

2. Director's report

The trust was authorised to operate as an NHS foundation trust on the 1 February 2007.

Board of directors

During the year the following people acted as either executive directors or non-executive directors of the trust:

Tracy Doucét – chairman
Stuart Grasar – independent non-executive director (from 10 November 2008)
Peter Harris – independent non-executive director, vice chairman and senior independent director (to 26 January 2009)
David Heathcote – independent non-executive director and senior independent director from January 2009
Bonnie Jones – independent non-executive director and vice-chairman from January 2009
David Leah – independent non-executive director
Stephen Pearson – independent non-executive director

Jeffrey Worrall – chief executive
Lee Bond – executive director of finance
Karen Fisher – executive director of human resources (from 18 April 2009)
Mike Mowbray – executive medical director
Jane Warder – executive director of strategy and improvement
Carolyn White – executive nurse director
Denise Weremczuk – Acting executive nurse director (on 31 July 2008)

Details of the directors who were members of the board of director's on the 31 March 2009 are provided in section 6 of the annual report.

Principal activities of the trust in 2008/09

During 2008/09 the trust continued to provide comprehensive district general hospital (DGH) services and services for elderly people throughout central Nottinghamshire at three hospital sites - King's Mill Hospital (561 beds), Newark Hospital (102 beds), and Mansfield Community Hospital (112 acute beds).

We continued to serve a population of around 350,000 people, drawn mainly from the local District Councils of Ashfield, Mansfield and Newark & Sherwood, together with areas of the North East Derbyshire, Amber Valley, and Bolsover District Councils, and other surrounding District Council Areas in Nottinghamshire and Lincolnshire.

We also continued to put our values into practice for the benefit of people who rely on our clinical services – our patients - and the people who work with us to maintain our high service standards - our staff.

Business review of the trust in 2008/09

The trust enjoyed a further successful year. At the end of the financial year, we recorded a financial surplus over and above that planned; we achieved the majority of our access and workload targets; we achieved our activity plans; and we continued to recruit and retain staff. We received a number of positive endorsements from external independent agencies and continued to act in partnership with other agencies in the local health community.

The membership of the trust continued to grow, and to become increasingly representative.

The operating and financial review (OFR) in section 4, provides further details of our achievements as well as the levels of performance that we achieved in financial, access and quality terms.

The board of directors was regularly updated on the risks facing the trust during the year through its monthly executive performance report (EPR) and its quarterly review of the assurance framework, where the principal risks facing the trust are listed.

The board of directors was informed of aspects of the trust's performance that did not entirely meet its expectations and these included the less than expected reduction in the number of MRSA bacteraemias recorded by the trust during the year and its thrombolysis performance.

The board of directors considered action plans for reducing MRSA bacteraemias and this and other areas of risk and will continue to monitor performance and drive improvements in 2009/10.

The trust has had a successful year meeting its activity plans and the challenge of significant growth year on year in external referrals for both the King's Mill and Newark Hospitals of 12% and 15% respectively. This offered the board of directors assurance that strong demand for the trust's services continued to be seen.

The trust's longer term financial plan includes a number of activity assumptions that were developed and agreed as the basis of the business case for the modernising acute services (MAS) development and associated PFI agreement. These are being reviewed in light of the current economic climate, however, the increase in referrals received in 2008/09 gives the board of directors confidence that demand for our services is being maintained.

A strategy to develop partnership working through increased relationship management saw an extension to the existing partnerships with NHS Nottinghamshire County - the local primary care trust (PCT), Central Nottinghamshire Hospitals plc and its sub-contractors, volunteers and voluntary groups including the League of Friends, Daffodils, Newark Hospital Volunteers, Practice Based Commissioners, Nottingham Community Health (APO), Central Nottinghamshire Clinical Services (the local Out of Hours service) and Nottingham University Hospitals.

The trust is conscious of the need to protect the local environment and amongst other actions, installed a state of the art heat transfer scheme at King's Mill Hospital in partnership with CNH plc during the year and also commissioned a specialist company to undertake preliminary work to extract coalmine methane from below the King's Mill site, as an additional energy resource. Details of these schemes are provided within the OFR and provide excellent examples of the trust's commitment to sustainability.

The board of directors and the board of governors focused on a number of employment issues during the year and policies and procedures designed to ensure that the working lives of staff were as constructive and enjoyable as possible were introduced. The board of directors considered an annual report from its diversity and inclusivity working group in July 2008, and this provided assurance to directors that the trust continued to promote equality of access for the users of its services and equality of employment for staff. Further examples of actions being taken to protect and support staff are provided in the OFR.

The board of directors routinely considers key aspects of the trust's performance at its monthly meetings, using a range of performance indicators. These include financial indicators, access and workload indicators, workforce indicators and clinical quality and governance indicators. Further details of the performance indicators used during the year are provided in the OFR.

So far as the board of directors is aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps that they ought to have

taken as directors, in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Highlights of 2008/09

- Building our new hospital at King's Mill - the continuing modernisation of our hospital to become one of the most up to date hospitals in the country, and developing new ways of working in preparation, were the most notable events of the year. While the principal focus of development in 2008/09 was the commissioning of the King's Treatment Centre (KTC), significant progress was also made with the building of the first two 'towers' that will provide inpatient accommodation in 2009, with the third tower being operational in 2010/11.

- Providing new services - we introduced a number of new clinical services at King's Mill Hospital during the year, including percutaneous coronary intervention (PCI) or coronary angioplasty. Following approval by the British Cardiac Intervention Society in 2008, the trust recruited new consultant medical staff and launched the new service that enables patients to receive treatment under local anaesthetic and to return home the day after.

- Meeting targets:
    - Improving safety and clinical outcomes for patients.
    - achieving the majority of our waiting time and access targets;
    - achieving a financial surplus at the end of 2008/09 and ensuring continued financial stability for the trust;

- Achieving further MRSA reductions – While we were unable to meet the agreed reduction target, we did reduce the number of MRSA bacteraemias recorded at our hospitals in the year when compared to 2007/08.The board of directors also recognised that reducing the incidence of MRSA bacteraemia and other infections was one of its highest priorities and a significant amount of work was undertaken during the year to improve our performance.

- Developing more services at Newark Hospital – during the year we opened a new genitourinary medical service at the hospital and continued to develop further services including a sleep study service.

- Attracting excellent new clinical staff to work at our hospitals - people who see the prospect of helping us develop our new facilities and of being around when the new hospital starts operating as good reasons for choosing us as their employer. The success of our new buildings and services will rely on securing sufficient staff with the right skills and experience at the right time.

- Increasing our membership and increasing the level of engagement – At the end of March 2009 we had 16,713 public members as well as over 4000 staff members and around 660 'affiliate' members. During 2008/09 we arranged a number of successful member events and held our first constituency meetings where our governors were able to meet members first hand and find out their views of the trust and how they wish to see our services develop. The board of directors was then able to consider these views in developing its annual plan for 2009/10.

- Collecting the views of patients – the trust continued to use patient experience trackers (PETs) to find out in 'real time' how people using our services regarded the care and treatment they received. Hospital volunteers supported the trust in seeking views from patients using the PETs, thus ensuring that a true and accurate view of services was obtained. Wards and departments were informed of the outcome of their PETs ratings and were able to quickly address any concerns raised.

- Embedding new management arrangements across the trust - following the principles of service line reporting, and ensuring that more clinical staff are involved in the management of the trust and its future development.

- Being at the leading edge of a number of local and national initiatives, especially in the field of information technology (IMT) – the continuing successful implementation of Choose and Book, the extended use of the VOCERA communication system and the implementation of a range of other innovative and imaginative IMT solutions designed to improve the work of staff across the trust, were excellent examples of our continuing success.

- Ensuring that the quality of our services remains high and that these attract independent endorsement. In 2008/09 we again achieved 'excellent' and 'good' ratings from the Healthcare Commission.

Looking Towards the Future

While 2008/09 has been a largely successful year for the trust, the directors acknowledge that we must continue to review our performance and develop to remain successful – being a foundation trust and our new buildings give us a once in a lifetime opportunity to make a significant contribution to the health of our population and to increase the level of community involvement.

We are looking forward with enthusiasm to the challenges that 2008/09 will bring and we remain committed to:

- Continuing the development of models of care and treatment that will need to be in place in the medium and long-term future as part of the development of our new hospital especially relating to the inpatient wards;

- Maximising the benefits from the new management structure that we introduced during the previous year;

- Working with our key stakeholders – local people, staff and other partnership agencies to develop to meet their needs and aspirations.

3. *Background Information*

Sherwood Forest Hospitals NHS foundation trust was founded in February 2007, under the Health and Social Care (Community Health Standards) Act 2003.

Before being authorised as an NHS foundation trust, the trust was known as the Sherwood Forest Hospitals NHS trust, which was founded in April 2001.

Overall Vision

During the year, the board of directors continued to consult with its members, patients and staff on the strategic objectives for the trust.

The board of directors confirmed its aim to provide the Best Care, by the Best People and in the Best Place by 2013.

A number of strategic objectives were developed and these will be progressed in 2009/10 and subsequent years, to ensure that people continue to choose us for their care and that the trust will be one of the best in the East Midlands.

Formation

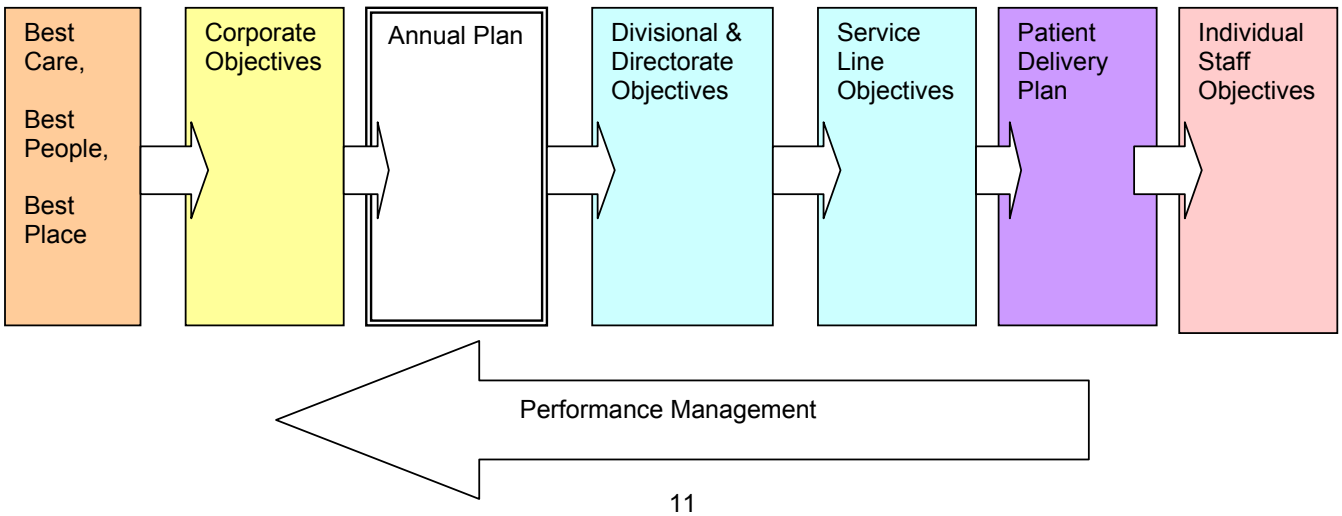
The aim has been to develop a trust strategy that translates into clearly understood annual delivery plans that have ownership and understanding from the board of directors to service lines to individual staff members.

The starting point was the existing trust Vision as outlined in the Service Development Strategy, with the four objectives:

- To be the healthcare provider of choice for our local communities
- To develop services which identify and meet the specific health needs and aspirations of our local population
- Extend the range and integration of services provided locally for the local population
- To achieve a financially viable and sustainable trust with a modern workforce and organisation

In developing an updated trust vision of *Best Care, Best People, Best Place* the emphasis has shifted, focusing on the quality of services and patient experience both of which are underpinned by operational efficiency.

Therefore it is envisaged that the delivery of the trust Vision will inform in the following way:



To develop the vision of *Best Care, Best People, Best Place* staff sessions and members (and governors) sessions were held to understand the perceptions of staff and members. This culminated in a summit in November 2008 where staff and members considered what we should promise patients and staff, co-producing the patient and staff pledges.

The format applied in these sessions was one of a positive question methodology. The aim was to be clearer about what our 'best' is, to enable an understanding of how we can do this more consistently.

The result of this work is seen in the development of the pledges and the strategic objectives for 2009-2013.

Strategic Objectives 2009-2013

Best Care, Best Place, Best People,

Best Care – Strategic Objectives – 2009 - 2013

- To exceed customer expectations
- Achieve excellent ratings in annual reviews
- Achieve top quartile in national patient survey
- To engage patients, public and staff in planning
- To improve the quality and safety of services year on year, and achieve CNST level 3
- To provide the best patient information
- To improve our productivity (benchmarking position for an agreed set of metrics)
- Reduce our referral to treatment times
- Implement an organisation - wide approach to continuous improvement

Best People – Strategic Objectives 2009 - 2013

- Achieve a more flexible approach to motivating and rewarding staff
- To ensure our staff feel more engaged and involved
- To ensure staff are clear about what is expected of them
- To invest time in our staff
  - training and education
  - coaching

Best Place – Strategic Objectives 2009 - 2013

- Care will be provided in clean and tidy settings
- Maintain the hospital's physical environment to the highest standards
- To improve our contribution to environmentally friendly ways of working

Pledges

In addition to the strategic objectives a set of pledges were also co-produced by members, governors and staff.

Patient Pledges:

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

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

- **We will show you 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**

Staff Pledges:

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

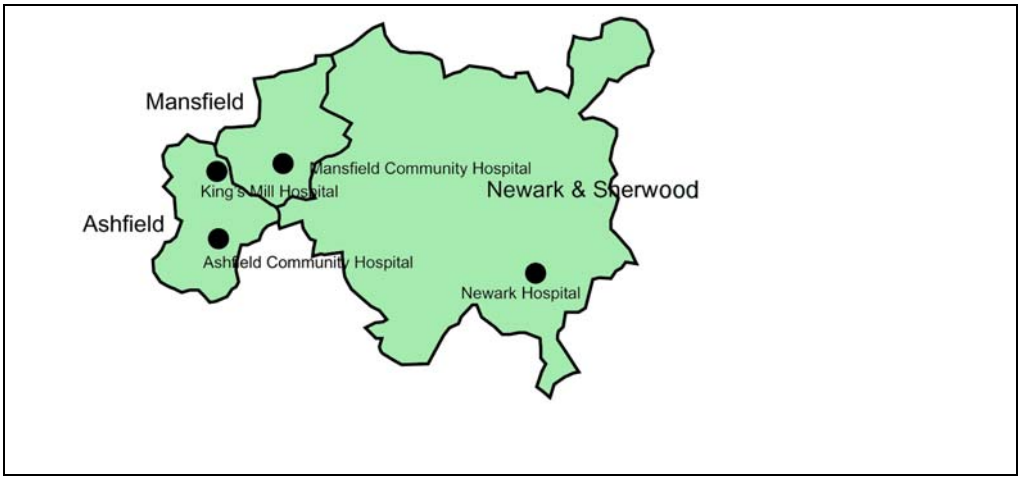
- **We will listen to you**
  (ask your views, working and communicating with you effectively)

- **We will support you to do the best in your job**

- **We will provide a safe environment**

The trust will develop a plan to achieve these pledges and develop the measures to demonstrate progress commencing with a staff workshop on 3 April 2009

Our Local Communities



Although the majority of our patients live within Central Nottinghamshire, approximately 14% of patients come from other areas, particularly North East Derbyshire and the Amber Valley within Southern Derbyshire, and increasingly Lincolnshire.

The area varies considerably in terms of urbanisation, deprivation and population concentration, with the main hubs of population in the west, focused around the towns of Mansfield and Sutton in Ashfield and to the east the main centre of population is Newark.

Much of the area is rural, particularly towards Newark, and the higher levels of urbanisation seen in and around Sutton in Ashfield and Mansfield are matched by increased levels of deprivation and health need.

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

The areas served by our trust have comparatively low indices of socio-economic measurement, with high levels of respiratory problems and other causes of chronic illness and long term disability, mainly resulting from the industrial past, especially the coal mining industry. The local area also has high levels of obesity, smoking, falls, and teenage pregnancy.

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

With regard to our workforce, the majority of our non-medical staff is drawn from the Central Nottinghamshire area, and so the local labour market is a very significant factor in our workforce development plans.

It is recognised that parts of the communities of Mansfield and Ashfield have low levels of educational attainment, and given the fact that most of the organisation's workforce is drawn locally, this could represent a risk to our future workforce development requirements.

The importance of this issue is reflected in our strategic objectives and we are taking a number of steps to manage this risk, working in partnership with local education providers.

Our Services

We provide comprehensive district general hospital (DGH) services and services for elderly people throughout Central Nottinghamshire at three hospital sites - King's Mill Hospital (561 beds), Newark Hospital (102 beds), and Mansfield Community Hospital (112 acute beds).

Services from Mansfield Community Hospital started to transfer to King's Mill Hospital in April 2009.

At the end of 2008/09, we had an income of around £192m and employed over 4,000 staff. We also received support for our volunteers, who currently number around 650.

Modernising Acute Services (MAS)

The Modernisation of Acute Services (MAS) project is a £367m private finance initiative (PFI) that we are leading in partnership with NHS Nottinghamshire County. The scheme is centred on the redevelopment of King's Mill and Mansfield Community Hospitals, and with a programme of service modernisation that will realise a number of benefits for the local community including:

- Shorter waiting times for hospital treatment
- Improved access to healthcare and fewer visits to hospital
- Reduced lengths of stay in hospital and care delivered closer to home
- Improved quality of care, based upon the latest national guidance
- More pleasant and welcoming hospital environments
- A major boost to the regeneration of local economies
- Assistance in the prevention of ill health
- Reduced levels of pollution

The scheme involves the provision and enhancement of a wide range of clinical and non-clinical services including, but not restricted to, all Women's and Children's services, Emergency Care, Diagnostic Imaging, Outpatients, Theatres and Adult Inpatients, taking the opportunity to group some of these within three new clinical care centres:

- The King's Treatment Centre - Diagnosis and Treatment Centre (open in 2008)
- Emergency Care Assessment Centre
- Women and Children's Centre

In addition, the positioning of the new accommodation will enable the creation of a single group of buildings to replace the fragmented layout of the existing estate creating a single unified hospital.

We achieved financial close on the scheme at the end of October 2005 and the completion date of the project remains as 2011/12. The capacity within the scheme, and the configuration of facilities and services provided, have all been developed within the context outlined above and are fully incorporated into our delivery plan.

The PFI is of 32 years duration and details of the financial aspects of the scheme are included in the trust's accounts.

Our PFI construction partner Skanska is recognised as a leader within the construction industry in sustainable development and is committed to improving the environmental, social and economic benefits of all of its projects.

A sustainability plan for the MAS project has been developed by CNH plc and this highlights the approach being taken against the following key aspects of the project.

- Design
- Energy
- Water management
- Transport
- Construction
- Waste management
- Pollution

During 2007/08 and in collaboration with our PFI Partner, we installed state of the art heat transfer technology at King's Mill Hospital. This uses the geothermal properties of the adjacent King's Mill reservoir to achieve reductions in the energy use at the hospital and to assist us in meeting our carbon dioxide emission reduction targets.

In 2008/09 we commissioned a specialist company to commence exploratory work to assess the feasibility of using coalmine methane reserves held below king's Mill Hospital as an alternative energy source.

These are excellent examples of the trust working in partnership with experts in the field to increase energy efficiency and protect the local environment.

King's Mill Hospital

King's Mill Hospital provides Medical, Surgical, Paediatric, Obstetric and Gynaecological services from a range of settings including general wards, an Accident and Emergency department, a Critical Care Unit, a Day Case Unit, and a Neonatal Intensive Care Unit. We have a state of the art Ophthalmology unit with its own dedicated operating theatre, and an Angiography Laboratory.

We also have Oncology and Endoscopy day care beds, and a full range of diagnostic and support services on the site.

The hospital is undergoing major refurbishment as part of the £367m MAS Project and following successful completion of the KTC in 2008, 2 new towers will provide inpatient accommodation in 2009/10. The final tower(the third) will be complete in 2010/2011.

Newark Hospital

Newark Hospital provides services from modernised accommodation, with two operating theatres and 101 beds in four wards. There is a wide range of general hospital services including General Medicine and Care of the Elderly, General Surgery including Trauma and Orthopaedics, Gynaecology, Urology, Ophthalmics, and a small accident and emergency unit. A Women's Assessment and Treatment Centre – the Sherwood Unit - was opened in early 2006, a Minor Operations Suite was opened in late 2006, and diagnostic and support services are provided, including a new CT Suite.

During the year we introduced a new genito-urinary medical service and a sleep study service.

Newark Clinical Development Strategy

We have continued to review and develop services at Newark Hospital in conjunction with NHS Nottinghamshire County. The trust remains committed to developing Newark Hospital as a high quality health service facility that meets the health needs of local residents.

Mansfield Community Hospital

Mansfield Community Hospital is managed by NHS Nottinghamshire County and during 2008/09, we provided health care of the elderly services from four wards with 96 beds. These services are supported by a small x-ray unit, pharmacy and therapy services.

The hospital is also undergoing major refurbishment as part of the £320m MAS project and we transferred inpatient services to King's Mill Hospital in April/May 2009 in line with the agreed reconfiguration of services.

The NHS locally

There are a number of factors and trends that, combined with the new health policy agenda, will have implications for us and our role in providing acute healthcare within the Central Nottinghamshire health community.

We recognise the changing external environment that we are operating within. Through the development and implementation of healthcare policy such as *Transforming Community Care* and *Equitable Access to Primary Medical Services* there is a shift in the emphasis of the delivery of health services, a response to the visions created following the Darzi review.

As a result we are aware of the changing expectation of our patients in terms of the healthcare need and that we have to be responsive to those changes. The development opportunities presented through World Class Commissioning offer new and different health care providers. A key issue for the trust in developing our business strategies is being clear where cooperation offers better rewards for patients and staff than competition. We also recognise the need to develop services following the pace of change created through the Next Stage Review, ensuring that we are a stakeholder in influencing and informing the strategies being applied.

The trust is monitoring the potential business opportunities through the procurement processes introduced last year. We recognise the need to have a robust assessment

framework to ensure opportunities pursued have a strategic fit and that capabilities are developed within service teams to respond to tender specifications.

Our lead commissioners, NHS Nottinghamshire County has established a commissioning strategy for the next ten years, stating their priorities. We are keen to be able to respond in terms of the services directly provided but also as part of the wider healthcare community. The impact of economic pressures on public spending plans require us to look to manage the implications of reduced investment in the medium term whilst taking forward delivery of our services with operational efficiency and meeting our quality agenda.

The development of Practice Based Commissioners (PBCs) and their ambitions for autonomy will offer more challenges in the coming year, with our two main clusters also setting priorities around the local service changes that they want to see happen. We will continue to work with PBCs in jointly reviewing these services.

The trust has also been working with the newly created East Midlands Specialised Commissioning Group. The management of 38 different specialised services offers us a new commissioner to work with alongside our lead commissioner, and an opportunity to change technologies and therapies to add to our service portfolio where services can be delivered locally.

A challenge for the coming year is the planned reconfiguration of acute beds. We will be moving acute beds off the Mansfield Community Hospital site and moving wards and departments into the new accommodation in to Towers 1 and 2 at King's Mill Hospital.

As a consequence of this move, we will be dependant upon Nottingham Community Health (NCH) - the local Arms-length Provider Organisation - implementing the necessary changes to ensure they have the capacity to receive referrals as agreed and supported by commissioners. In addition NCH now have space in their facilities that are no longer utilised. NHS Nottinghamshire County has supported a business case to develop services on the MCH site with plans to move in primary care services that may include a walk-in centre. We have already developed a strategic liaison forum with NCH and intend to continue to monitor and influence these developments.

Another local challenge is the establishment of a project to determine a strategy for Newark that relates to the health and public needs of the Newark and its surrounding population. This is a long term strategy that is reflecting on both the growth in and changes to the population demographics of the Newark area. Our representation on the project board and in associated work streams will ensure that the trust is well placed to advise, inform and influence this development, managing the potential implications for services delivered from Newark Hospital.

Clinical networks and the local sustainability of smaller specialties

We continue to participate in formal clinical networks and also in more informal partnerships with other providers, in order to ensure that the range and scope of services provided by smaller specialties is sustainable in the future. These include the Mid Trent Cancer Network, the East Midlands wide Cardiac Network, and the Nottinghamshire Pathology Network.

In addition, we have strengthened joint services with the Nottingham tertiary providers including Haematology, Dermatology, ENT, Histopathology and a Joint Breast Service.

We have also developed partnership arrangements for on-call provision in a number of specialties in order to maintain local service provision and effectively manage the reductions in working hours required.

As a foundation trust we have strengthened our involvement in local Clinical Networks, and during the year we have been able to review our inter-trust agreements (ITAs) covering those services that we provide and receive from other trusts.

4. Operating & Financial Review

Our Performance in 2008/09

The board of directors routinely considers key aspects of the trust's performance at its monthly meetings.

The key monitoring documents are;

- Monthly executive performance reports (EPR) - which provide both cumulative and monthly descriptions of performance, with a focus on finance, access, clinical quality and workforce. A summary of our performance is published each month;

- The clinical quality and patient experience sections of the EPR - which provide both cumulative and monthly descriptions of performance, with a focus on quality, including complaints handling, patient advice and liaison service and patient and public involvement, infection rates and patient safety. A summary of our performance is published each month;

- Quarterly assurance framework update reports - which detail the key risks to the achievement of the annual plan objectives and the controls and assurances in place to manage these risks.

- Other regular reports on key aspects of the trust's operation – for example, quarterly connecting for health reports, and monthly reports on infection control.

Together, these reports provide the board of directors with a comprehensive overview of our performance.

Governors are updated on our performance through our monthly 'News from the Board' publication, together with regular reports on performance at general meetings of the board of governors.

The monthly EPRs contain a number of key performance indicators (KPIs) against which our performance is monitored by the board of directors. During 2008/09, we reviewed the content of our performance management process to ensure that the directors continued to receive relevant and timely information with which to monitor performance.

A brief description of the main KPIs and our performance against these is provided below.

i) Meeting targets

Performance Target	***Threshold***	***Achievement at 31/03/09***
Clostridium difficile year on year reduction (to fit the trajectory for the year as agreed with PCT – assumed a 15% reduction if no level agreed in a contract)	292 cases by 31/03/09	177
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (assumed target is 50% of 2003/04 if no level agreed in a contract)	24 cases by 31/03/09	31
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancers	National threshold to be set in Summer 2009	Quarter 4 not included as target thresholds unconfirmed from 01/01/09
Maximum waiting time of 62 days from all referrals to treatment for all cancers	National threshold to be set in Summer 2009	Quarter 4 not included as target thresholds unconfirmed from 01/01/09
18-week maximum wait (by 2008). Admitted patients: maximum time of 18 weeks from point of referral to treatment	90.00%	95.2%
18-week maximum wait (by 2008). Non-admitted patients: maximum time of 18 weeks from point of referral to treatment	95.00%	98.7%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.00%	98.2%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	97.50%	Quarter 4 not included as target thresholds unconfirmed from 01/01/09
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	68.00%	60%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	98.00%	99.8%
All patients with operations cancelled for non-clinical reasons to be offered another binding date within 28 days	95.00%	99.7%
Maximum waiting time of 2 weeks for rapid access pain clinics	98.00%	99.3%
Minimising delayed transfers of care by 2008	3.50%	0%
GUM – 48 hour access	100.00%	100%
Booking of hospital appointments	100.00%	100%

ii) Treating patients

Category of Service	*2008/09 Target*	*Actual at 31/03/09*	*Percentage variation*	*2007/08 Actual*
Elective inpatients & Day Cases	34,900	36,920	+ 5.78%	34,021
Non-elective inpatients	36,732	37,555	+ 2.24%	36,933
New Outpatients (excluding GUM)	66,749	71,815	+ 7.58%	69,167
Accident and Emergency	106,442	101,719	- 4.4%	104,049

iii) Managing our Finances

The following information is an overview of the trust's financial performance in 2008/09. Summary financial statements included within section 7 of this annual report provide further detail for the year ending 31 March 2009.

In its second full year as a foundation trust, we have maintained our excellent track record of financial performance. The trust has met and in most cases exceeded its financial and performance plans for 2008/09.

The trust generated a surplus of £8.4m in year. This is in line with its long term financial plans which require the trust to generate sustainable surpluses in the period to 2011/12 when the full cost of the PFI funded redevelopment of the King's Mill Hospital becomes apparent.

This excellent result is due to a combination of factors including the delivery of the trust's productivity targets and good financial discipline and control.

Building on the successful delivery in 2007/08 of an ambitious productivity improvement programme, the organisation has once again delivered significant improvements in terms of productivity and efficiency in 2008/09. Against a backdrop of organisational change and growing demand for services the organisation managed to deliver £5.3m of productivity gains in year which contributed towards the achievement of the financial plans. The underpinning rationale behind the productivity programme has been to reduce costs and overheads in order to create a margin on clinical activity which can be reinvested into the trust's long term strategy, notably the MAS development.

These productivity gains have arisen from initiatives which have increased income with less, or no, increase in cost; and those which reduce costs with less, or no, reduction in income. Most notably through clinical service redesign, non pay procurement and workforce modernisation.

Key within this process has been the continued development of clinical service teams within the organisation and their role in delivering services whilst also being responsible for the fiscal challenges associated with running these services on a daily basis. This process is one which the organisation is committed to, and one which will develop progressively as we move into 2009/10.

The trust has continued to maintain a strong cash position and balance sheet. At 31 March 2009 the trust held cash deposits of £36.6m. Throughout the year the trust held a Prudential Borrowing Limit of £59.5m consisting of a long term borrowing limit of £44.5m and a working capital facility of up to £15m. As the trust has maintained a healthy cash flow throughout the year it has not needed to use any long term borrowing or its working

capital facility. As such, the working capital facility was not renewed in February 2009. Forward plans also show that use of such facilities will not be required.

The trust continues to maintain strong and productive relationships with its key PCTs from whom the trust receives the majority of its patient care income.

The board of directors remains confident that demand for services remains strong, and the contract for 2009/10 is already in place with our main purchasers.

With regard to capital, while the trust was unable to fully invest the planned level of capital during 2008/09, we did invest over £11m in a range of schemes and purchases. These included:

Scheme	***Level of Investment***
General Medical Equipment including KTC and Towers	
Pharmacy automated dispense KMH	£ 483,000
ENT workstations	£ 68,000
Bone power tools	£ 74,000
Microscopes	£ 80,000
Endoscopy washing equipment KMH	£ 98,000
Histology/ pathology equipment KMH	£ 106,000
Replacement beds KMH & NWK	£ 79,000
PUVA booths	£ 56,000
Ocular coherence tomogram	£ 60,000
Cardiology Equipment KMH	£ 221,000
Theatre equipment	£ 447,000
Replacement Theatre Cameras KMH & NWK	£ 374,000
Defibrillators KMH	£ 50,000
Scopes	£ 175,000
X-ray	£ 1,216,000
Total Medical Equipment	£ 3,587,000
Newark Hospital building schemes (including associated equipment)	£ 942,000
King's Mill Hospital building schemes	£ 1,172,000
Trust wide – Information, Management Technology (IM&T)	£ 1,135,000
Geothermal scheme KMH	£ 1,245,000
PFI related residual interest	£ 2,710,000

Our accounting policies for pensions and other retirement benefits are set out in note 1.18 (page 9) to the accounts and details of senior employees' remuneration can be found in page 79 of the remuneration report.

iv) Valuing our staff

During 2008/9 the trust implemented a number of change programmes in order to deliver continual improvement of the services we provide to our patients. A new nursing leadership structure was implemented, enhancing the nursing and midwifery contribution to the delivery of care. Much of the year focused on the move to the new hospital facilities, with the move to the Kings Treatment Centre in the summer and during the later part of 2008/9, the expansion and development of the workforce in preparation for the move to the new in-patient wards.

Our new operational management arrangements, involving clinicians in service management are helping us to deliver improvements required to deliver long term sustainability. The development of Service Line management has continued to be a feature of activities during the year with the provision of clarity around decision making

rights and the further development of service line managers. The trust has established a programme of events for the trust leadership team to support them in the delivery of their roles.

In recognising the value of our workforce, the trust continues to provide initiatives designed to improve the working lives of our staff. Staff continue to benefit from the provision of high quality occupational health and staff counselling services and the trust employs a manual handling co-ordinator and a health & safety manager to promote good practice. These services foster employee well-being and improved patient experiences. The trust has introduced a staff discount scheme which provides discounts from local businesses and is seeking to introduce lease car and cycle to work schemes for staff, these will be provided via new salary sacrifice schemes which help to reduce the cost to staff.

The trust completes an annual staff survey to identify how our staff feel about working within the trust. The trust is proud of the 2008 survey results which show that 92% of staff surveyed feel that their role makes a difference to patients, 56% of staff surveyed would recommend the trust as a place to work and 95% of staff surveyed believe the trust provides equal opportunities for career progression or promotion. The trust is committed to the ongoing development of its staff and will ensure staff are appraised and have personal development plans during 2009/10.

The trust has continued to provide an extensive programme of training and development opportunities during 2008/09. We continue to provide twice-monthly compulsory orientation days for all new starters, with Junior Doctors on rotation receiving their own tailored programmes in August and February.

We continue to hold Investors in People status and the 2008 staff survey results showed that we were in the top 20% of acute trusts with regard to staff feeling that there are good opportunities to develop their potential at work; staff receiving job-relevant training, learning or development in the last 12 months and staff receiving support from immediate managers.

During 2008/09, the board of directors received reports from the Diversity and Inclusivity Committee which highlighted the trust's approach to Equality Impact Assessment and the equality agenda. The trust has introduced a new pre-employability programme supporting the long term unemployed back into work and has also introduced workplace experience opportunities for individuals with a disability

The trust continues to seek improvements to sickness absence rates with a number of initiatives being introduced during the year. These include the audit of return to work interviews, revisions to the sickness absence policy, and the active review of staff with significant short term sickness and direct support to managers regarding managing sickness absence. The trust's sickness absence rate for 2008/9 remains relatively high at 4.9% and work will continue into 2009/10.

The board of directors recognises that engaged and involved staff contribute effectively to discussions regarding service development, the trust has a well developed partnership working framework and engages with staff governors who are elected to represent their members' views. The trust works in partnership with staff side colleagues to develop the changes necessary for sustained improvement.

The trust has many communication channels to ensure that staff are aware of matters that are important to them including the economic and financial factors affecting the trust. Monthly team briefings are provided, articles are published in the staff magazine Oakleaves, and regular staff bulletins are issued highlighting matters of interest.

Once again, the board of directors was able to say a big 'Thank You' to many staff at our annual staff excellence awards' ceremony, which was held in September 2008. While the ceremony provides the opportunity to celebrate our successes and share good practice, we recognise that we would not be able to meet the increasing demands placed upon our services without the loyalty, dedication, commitment and hard work of all staff at the trust. In recognition of staff who have supported the trust for a number of years, we now present 'Milestone Awards' marking 5, 10, 15, 20 and 25 years of service with the trust.

iv) Quality Report 2008/09 - Best care, Best People, Best Place

Quality is, and will always be, our first priority. Providing the best quality care for patients is what motivates our staff, and influences everything we do. During 2008/09 we defined our ambition as 'Best Care, Best People, Best Place.

Our first quality report, which is included as an appendix to our annual report 2008/09, provides greater details of what we have achieved so far, and focuses on our three key quality objectives of:

- Patient Safety;
- Clinical effectiveness and
- Patient experience.

Clinical Governance 2008/09

Good Clinical Governance - making sure our clinical services meet high standards - continued to be one of our key focuses during the year.

In practice good clinical governance means:

- maintaining a focus on continuous, demonstrable improvement in the quality of the patient experience and improvement in health care outcomes
- ensuring that clinical governance principles of quality and patient safety together with their processes and systems are embedded throughout the organisation
- ensuring the implementation of the national quality imperatives such as National Patient Safety Agency (NPSA) reporting, National Institute for Clinical Excellence (NICE) guidance, and other national best practice guidance
- operating effective risk management processes and accounting for clinical governance.

The trust monitors its performance on clinical governance through the national Standards for Better Health. The Standards are grouped under the following areas:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus
- Accessible and Responsive Care
- Care Environment and Amenities
- Public Health.

The following sections provide an overview of this work and how we work to achieve national standards of clinical governance.

Safety

- The trust has accreditation with the NHS Litigation Authority risk management scheme at Level 1. Our policies meet national standards for a wide range of patient safety related work such as incident reporting and learning, staff induction and

training, resuscitation and blood transfusion best practice. A Patient Safety Manager has been appointed to make further progress on our patient safety work.

- Reductions in our MRSA and Clostridium difficile infection rates continue. The new national Care Quality Commission (CQC) recently assessed the trust as compliant on these key patient safety measures. To carry out the assessment, the CQC asked that trusts declare whether they were compliant with the regulations and cross-checked this with other performance information, including patient and staff surveys, findings from the Healthcare Commission's hygiene inspections, trusts' declarations against core standards for infection control, and rates of MRSA and Clostridium difficile infection.

Clinical and Cost Effectiveness

- ***Specialist stroke surgery***
  Carotid artery surgery has been introduced to our developing vascular services. The procedure restores adequate blood flow to the brain by clearing arteries in the neck that have been narrowed, or almost blocked, by fat or cholesterol. It has been shown to be more effective at preventing strokes than blood-thinning drugs alone. Previously patients were treated at Nottingham or Leicester, so launching it at King's Mill is really good news for local people.

- ***Laparoscopic surgery for urological conditions***
  Advanced laparoscopic – also known as – keyhole surgery has been introduced for kidney cancer and non-malignant conditions. It involves performing operations through keyhole incisions using cameras and monitors. The technique generally results in a shorter hospital stay, a quicker full recovery time, less blood loss and better cosmetic result from the surgical scars. King's Mill is one of only a few hospitals in the region to offer this advanced surgery, which is good news for our patients, and cements our reputation for providing first class patient care.

- ***Professional Updating for clinical staff*** – We recognise the importance of ensuring that clinical staff are up to date in their clinical practice and provided a wide range of opportunities for professional updating and development. We have an active in-house training department that offers a wide range of training courses and professional development opportunities, including annual mandatory professional update days for clinical staff and professional development days focussing on single clinical issues.

- ***Improving standards of clinical care*** – We rely on a number of data collection systems to provide evidence of improvements. Data on readmission rates and lengths of stay showed that our performance is in-line with national averages. Clinical staff also participated in clinical audits to measure performance against recommended standards of care in cancer, stroke and trauma. During 2008/09, we have strengthened our reporting processes to ensure that we record the changes identified in audit work, that lead to improved outcomes for patients.

Governance

- ***Risk Management*** – We continued to develop our systematic approach to risk management, with Divisions holding risk registers that inform our register of high risks. The Clinical Governance Committee has reviewed these risks and monitored action plans to reduce risk levels.

- ***Research Governance*** – We continue to be Research active, and have contributed to the development of local research networks that will offer greater opportunities for local patients to become involved in research projects. In addition, we maintained our Research Governance arrangements according to

the Research Governance Framework for Health and Social Care, which sets out standards, responsibilities and monitoring arrangements for all research.

Patient Focus

We have continued with our efforts to provide patients with high levels of privacy and dignity. A number of small changes were implemented in year and patients reported improved satisfaction in national patient surveys. Significant increases in patients' ratings of their privacy and dignity were found in the national survey for patients in both the Emergency Department and on our wards, when scores were compared to the previous year.

In addition, patients' ratings were also improved in a number of key areas that really matter to patients, for example:

- Cleanliness of rooms and wards
- Involvement in decisions regarding care or treatment
- Receiving information before and after a procedure or operation.

Accessible and Responsive Care

The length of time that a patient waits for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of our services. This year, we continued to achieve a number of key national waiting time targets, for example,

- All patients with a suspected cancer, referred to hospital by their GP, were seen by a hospital specialist within 14 days of the GP referral.

- More than 95% of patients with a diagnosed cancer were treated within 62 days of their GP referral.

The trust continues to be a top performer at using the Choose and Book system. This system allows patients to choose a hospital or clinic and book an appointment with a specialist. More than 90% of outpatient appointments were booked directly on Choose and Book for our trust, and we have received national recognition for our hard work from NHS Connecting for Health, the Government agency that brings in new computer services and services.

Care Environment and Amenities

The trust's facilities are undergoing major transformation as part of the MAS scheme. During 2008/09 the King's Treatment Centre was officially opened. The Centre offers a friendly and comfortable place for patients, visitors and staff, organised around the needs of the patient. As well as generally improving our customer services we are employing state of the art technology including electronic reception facilities, electronic requesting of x-rays and blood tests and digital x-ray rooms which allows staff to look at images immediately.

Public Health

We continued to work closely with health and social care partners in Central Nottinghamshire. A clear planning and service modernisation structure has been developed over recent years to support joint planning, service improvement and delivery and to ensure that operational issues which arise between organisations are effectively addressed.

Working within this structure, we have developed a wide range of integrated services including:

- Joint working with the local PCTs and Social Services on the Jonah project to safely reduce patient length of stay.
- Children and young people's services including dietetics, drug and alcohol liaison, psychology services and sexual health.
- Mental Health liaison within A&E.

v) Making Experiences Count - learning from complaints

In our annual report for 2007/08, we were able to highlight the continuous improvements that we had achieved in our complaints handling performance. Last year our record of improvement was maintained.

The trust received 499 formal complaints in 2008/09, compared with 395 in 2007/08. We hope to continue to improve our response times, thus illustrating the successful partnership that has been established between our Operational Divisions and our Complaints' Handling Team.

The main performance targets for receiving and responding to complaints are, providing an acknowledgement of a formal complaint within two working days and a substantive response from the Chief Executive within 25 working days.

During 2008/09, 99% of complaints received by the trust were acknowledged within two working days and 83% of complaints received a substantive response from the Chief Executive within 25 working days. This is a level of performance that we are keen to maintain.

The reasons for complaints being answered outside the national target included the unavailability of key staff, and the complexity of the complaint. When we were not able to respond within the target, we consulted with the complainant and agreed an extension of time with them.

The vast majority of complaints were resolved by the trust locally, with only 8% requiring a second substantive response (compared with 8% in 2007/08). As in previous years we used a number of ways to deal with complaints at the Local Resolution stage, including meetings with complainants involving senior clinical and managerial staff, both at the trust and at complainants' homes and inviting complainants to meet and discuss their concerns with staff.

Having listened to complainants we were able to make improvements to our services, for example:

- The correct reporting process for faults with heating system/temperature on the ward was reiterated to all members of staff on the ward.

- The staff working in the Scanning Department at Newark Hospital reviewed the wording used when advising patients that their scan is of a suitable quality to use and does not need to be re-taken.

- The system in A&E for leaving case notes out for patients to be referred to ENT clinic was reviewed, in order to streamline the system.

- A Ward Leader reinforced with staff that patients should be appropriately dressed at all times before being transferred from the ward.

- The procedures for following up blood test results by A&E staff was reviewed to make the system more robust.

- Staff received updated training on the use of equipment and oiling of equipment on a regular basis, in order to ensure that patient safety is not compromised. In addition, it was arranged for the equipment to be inspected as part of a routine maintenance contract.

- The Emergency Department and ENT are working together in order to improve communication between the two departments and processes have been tightened.

The national Complaints Handling process enables complainants who remain unhappy with their response to seek an independent review. Since July 2004, the Healthcare Commission has taken responsibility for the Independent Review stage of the national Complaints Procedure. The role of the Healthcare Commission in reviewing complaints ended on 31 March 2009 and was replaced by the Parliamentary and Health Service Ombudsman.

During 2008/09, we were informed of seven requests for independent review that were received by the Healthcare Commission relating to complaints handled by the trust.

The Healthcare Commission has since considered all of these seven cases, four of which were not upheld, as the Healthcare Commission considered that the trust had taken appropriate action to resolve the complaint. We have acted on the recommendations made by the Healthcare Commission on the other three cases.

During 2008/09, the Parliamentary and Health Service Ombudsman received two cases for review and both cases are under investigation.

A new national revised complaints procedure came into effect on 1 April 2009 and we shall continue to view complaints positively.

Patient Advice and Liaison Service (PALS)

This year was a busy year for the PALS service. During the year, PALS received a total of 4439 enquiries, an increase of 63% compared to 2007/08 and this equated to 365 enquiries per month.

Of these enquiries:

- 43% related to issues with communication
- 14% related to issues with appointment queries
- 9% related to environmental issues
- 9% related to issues with waiting times
- 8% related to procedural issues
- 6% related to praise for care and treatment received
- 11% related to other categories of enquiries including clinical issues, health and safety issues and control of infection.

Of the 1920 communication issues, 61% were requests for information and 23% were concerns with information received by patients and visitors.

The PALS team continue to promote their service across the trust to ensure that we continue to capture the patient experience in our hospitals. The Pals team work with all staff groups to continually strive to improve hospital services. Below are examples of improvements that have been made as a result of PALS enquiries:

- the main reception desk at King's Mill hospital was altered to enable better access for patients and visitors to communicate with the reception team;

- baby changing facilities available on the King's Mill site were increased;

- patient appointment letters were changed;

- replacement hearing aid batteries were made available from the main reception desk at King's Mill hospital.

During 2008/09, the PALS team continued to co-ordinate a team of volunteers to capture our patients' experiences using the patient experience trackers (PETS). The information gathered has assisted with a number of immediate service improvements

5. Putting Our Values into Practice

For the first time this year we have published a separate annual review of 2008/09 that provides a greater insight into the operation of the trust and the many exciting events that have taken place during n eventful and memorable year.

The annual review is available on request from Mike Tasker, company secretary at King's Mill Hospital.

6. Board of Governors

Our board of governors was formally established in February 2007 following our authorisation as an NHS foundation trust. We held our first elections in March 2006 and a by-election was held in July 2006.

Since this time, any vacancies that have arisen amongst elected governors have been filled in accordance with the provisions of the constitution and no further elections have been necessary. All governors were appointed for three years from authorisation.

The first meeting of the board of governors post-authorisation was held on 1st March 2007, and during 2008/09 we held a further 6 meetings including our annual members' meeting on the 9 September 2008.

All meetings of the board of governors are public meetings. In 2008/09 four were held in the Mansfield constituency, one in the Ashfield constituency (annual members' meeting) where King's Mill Hospital is based and one in the Newark and Sherwood constituency (October 2008).

The governors continue to represent the interests of their members in the development of the foundation trust and during 2008/09 we ensured that governors were able to become involved in our annual planning process. A joint development session with the board of directors and the board of governors was held in January 2009 when governors had the opportunity to comment on proposed developments for the coming year and to highlight their priorities.

As well as representing the views of members on the annual plan, governors have also raised questions on the performance of the trust and have ensured that the board of directors continues to meet the terms of the authorisation.

The board of governors has also been involved in the process for assessing evidence for the trust's compliance with the Healthcare Commission's Standards for Better Health, focusing in detail on three of the core standards.

We have provided many opportunities during 2008/09 for members of the trust to meet their governors first hand. A number of member events were held focusing on issues that our members had indicated were their priority areas of interest. We have arranged events on physiotherapy and occupational therapy, heart and lungs, Information technology, Newark Hospital developments, the new hospital build and diabetes.

Members attending these events have been encouraged to meet their governors and to share views on the services we provide.

We also held staff and public constituency meetings in the year and will be using the experiences of these for further meetings in 2009/10.

The board of governors' appointments committee, chaired by the trust's chairman appointed one new non-executive director in October 2008.

During the year, the board of governors reviewed its committee structure and made a number of changes. The following committees were established:

- A performance and strategy committee – designed to assist the board of governors with its performance monitoring and consultation responsibilities;
- A membership and engagement committee – designed to assist with the recruitment and engagement of members;
- A patient quality and experience committee – designed to assist the board of governors assess and make suggestions regarding the quality of patient services.

During the year, the board of governors continued to review the reporting arrangements for the King's Mill Hospital and Newark Hospital patient reference groups (PRGs) and new arrangements for securing patients views were agreed.

A register of governors' interests is maintained by the trust and information regarding this can be obtained by contacting Mike Tasker, company secretary, at the trust's headquarters.

At 31st March 2009, the composition of our board of governors was as follows:

Governor	Constituency	Elected or Appointed	Attendance at meetings Total – 6 meetings
Eve Booker	Ashfield	E	6
Mary Wilde	Ashfield	E	6
Beryl Perrin	Ashfield	E	6
Ann Lee	Ashfield	E	5
Jennifer Doohan	Ashfield	E	2
Richard Webster	Ashfield	E	4
Yvette Price-Mear	Mansfield	E	5
Christine Bacon	Mansfield	E	6
Davina Fordom	Mansfield	E	4
Geoff Stafford	Mansfield	E	6
John Marsh	Mansfield	E	5
Deryck Brown (to January 2008)	Mansfield	E	3
Hilda Tagg	Newark & Sherwood	E	3
Margaret Ralls	Newark & Sherwood	E	4
Geoff Seymour	Newark & Sherwood	E	4
Enid Clarke	Newark & Sherwood	E	5
Adrian Hartley	Newark & Sherwood	E	6
Graham Tomlinson	Newark & Sherwood	E	3
Dorothy Platts	Derbyshire	E	4
Walter Satterthwaite	Derbyshire	E	5
Nigel Mellors	Staff – King's Mill Hospital	E	5
Janice Matthews	Staff – King's Mill Hospital	E	5
Kay Orgill	Staff – King's Mill Hospital	E	6
Clive Gie	Staff – King's Mill Hospital	E	6
John Wood	Staff - King's Mill Hospital	E	5
Bucky Oladeinde	Staff – Newark Hospital	E	5
Larry Khongwir	Staff – Newark Hospital	E	6
Mel Chiverton (until June 2008)	Staff – Mansfield Community Hospital	E	1
Peter Gradwell	Staff – Volunteers	E	6
Elaine Wilson	Staff – Volunteers	E	6
Barry Answer	Mansfield District Council	A	3
Mark Avis (from November 2008)	Nottingham University	A	1
John Knight (until April 2008) Mick Parker (from June 2008)	Ashfield District Council	A	5
David Payne	Newark & Sherwood District Council	A	6
Barbara Brady (until June 2008) Amanda Sullivan (from July 2008)	NHS Nottinghamshire County	A	4
Barbara Dempster (until July 2008)	NHS Nottinghamshire County	A	2
Patricia Harman	West Notts. College	A	6
Vickie Minion	Nottinghamshire County Council	A	2
Chris Kerrigan (until July 2008)	NHS Nottinghamshire County	A	1

7. Board of Directors

In accordance with the 2006 Act, the directors of the former Sherwood Forest Hospitals NHS trust were appointed as the initial directors of the NHS foundation trust. Since authorisation, we have experienced a number of changes on the board of directors. In April 2008, Tracy Doucet was appointed as chairman and Karen Fisher was appointed executive director of human resources. Stuart Grasar was appointed as independent non-executive director in November 2008. Peter Harris left his post as independent non-executive director in January 2009.

All of our non-executive directors were determined as being independent. Post authorisation as a foundation trust, the non-executive directors' term of office is initially 3 years.

During 2008/09 the board of directors reviewed its governance and committee structure in order to ensure that executive directors focused on the operational management of the trust and that independent non-executive directors remained independent. As a result, the board of directors agreed to disestablished the quality assurance committee and the human resources committee and to refocus the role of the financial strategy and investments committee to investments. The terms of reference for the audit committee, remuneration committee and nominations committee were also reviewed.

The membership of these 4 committees at the 31 March 2009 was as follows:

Nominations committee

Tracy Doucét - Chairman
David Heathcote - Member
Jeffrey Worrall - Member
Karen Fisher - Member
Mike Tasker – Member

Remuneration committee

Tracy Doucét - Chairman
Bonnie Jones - Member
Stuart Grasar - Member

Investments Committee

Tracy Doucét - Chairman
David Heathcote - Member
Stephen Pearson - Member
Bonnie Jones - Member
Jeffrey Worrall - Member
Lee Bond - Member
Jane Warder - Member
Carolyn White - Member
James Zaman - Member
Mike Tasker - Member

Audit committee

David Leah - Chairman
David Heathcote - Member
Stephen Pearson – Member

The audit committee

The audit committee is a committee of the board of directors and supports the board of directors in ensuring that effective internal control arrangements are in place. The audit committee is also the governance committee for the trust.

The audit committee comprises of three independent non-executive directors and provides an independent check on the executive arm of the board of directors. The audit committee provides assurance to the board of directors on a wide spectrum of control issues, and in recent years has widened its scope to include other areas in addition to financial controls. The audit committee reviewed its terms of reference during the year to ensure that the systems of control for clinical governance and information governance in particular were robust. This followed the disestablishment of the quality assurance committee.

The audit committee receives reports on all systems of control including operational management issues and risks. It also considers the controls and assurances that underpin the statement of internal control (SIC) included in the annual report and accounts and the declaration of compliance with the Healthcare Commission's standards for better health.

It also reviews the adequacy of the trust's assurance framework.

The audit committee met on 3 occasions during 2008/09 and focused on specific items identified in its annual work plan. The non-executive directors met in private with the trust's auditors in December 2008.

An assessment of the audit committee's effectiveness in 2008/09 was carried out and a work plan to address any issues identified, was agreed.

As an NHS foundation trust, the board of governors is responsible for the appointment of the trust's external auditor, and a competitive procurement process was undertaken during 2007/08. This process resulted in the appointment of KPMG as the trust's external auditors in November 2007.

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

The audit committee acknowledged that the external auditor may be asked to carry out non-audit services and agreed that a policy would be developed to ensure that the objectivity and independence of the auditor was safeguarded should such a request be made.

The nominations committee

The nominations committee met 3 times in 2008/09. The principal focus of the nominations committee is the development and assessment of the board of directors.

During the year the nominations committee considered job roles and specifications for vacancies on the board of directors, including one non-executive director vacancy that arose during the year.

During 2008/09, the following meetings of the board of directors, the nominations committee, remuneration committee and audit committee, took place.

Directors in attendance are also noted:

Name of Director	Board of Directors Maximum 12 (including 1 extraordinary meeting)	Nominations Committee: Maximum 3	Remuneration Committee: Maximum 4	Audit Committee: Maximum 3	Investment Committee: Maximum 7	Board of governor meetings: Maximum 5
Tracy Doucét	12	3	4	N/A	6	5
Peter Harris (to 26 January 2009)	9 Max. 9	2 Max.2	N/A	2 (observer)	N/A	4
David Leah	12	N/A	N/A	3	5 Max. 5	4
Stephen Pearson	11	1 Max. 2	N/A	3	5	1
Bonnie Jones	12	N/A	4	N/A	1 Max. 1	4
David Heathcote	12	2 Max. 2	2 Max. 2	3	7	4
Stuart Grasar (from 10 November 2008)	5 Max. 5	N/A	2 Max. 2	1 (observer)	N/A	1 Max. 1
Jeffrey Worrall	12	3	N/A	N/A	4	4
Lee Bond	11	N/A	N/A	3	7	2
Carolyn White	10	N/A	N/A	N/A	3	1
Mike Mowbray	10	N/A	N/A	N/A	James Zaman (designated deputy 4	0
Jane Warder	10	N/A	N/A	N/A	5	4
Karen Fisher	11	3	N/A	N/A	N/A	2
Denise Weremczuk	1 Max. 1	N/A	N/A	N/A	N/A	N/A

The following section provides a brief profile of the directors who were members of the board of directors on the 31 March 2009.

Directors' Profiles

Tracy Doucét, chairman

Tracy was appointed chairman of the board of directors from the 2 April 2008.

Tracy joined the Sherwood Forest Hospitals NHS trust on 1 July 2006, in a designate capacity, before being appointed substantively to the foundation trust board of directors on 1 February 2007.

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 director of corporate development and HR with Greater Nottingham TEC.

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.

During 2008/09, Tracy also chaired the nominations committee, the remuneration committee and the investments committee.

Jeffrey Worrall, chief executive

Jeffrey was appointed as chief executive of Sherwood Forest Hospitals NHS trust on 7 February 2002, and subsequently appointed chief executive of the NHS foundation trust on the 1 February 2007.

Jeffrey began his working life in local government, before joining the NHS in 1984 with Rotherham Health Authority. He was subsequently appointed deputy chief executive of Derbyshire family health services authority (FHSA), and has been an NHS chief executive since 1997. His more recent posts include chief executive of both Southern Derbyshire Health Authority and North Nottinghamshire Health Authority.

He is chair of the local cardiac network and chair of the local pathology network.

Jane Warder, executive director of strategy and improvement

Jane joined the board of directors in June 2007.

Passionate about improving patient experience, Jane has worked in the NHS for over 20 years. Initially trained as a nurse, Jane has had numerous roles to support organisations in improvement, including working cross organisationally, nationally, with boards, clinical teams and individuals.

Her responsibilities now include improvement, performance, cancer, PALS, volunteers, marketing,

Lee Bond, executive director of finance

Lee joined the board of directors in August 2007. Lee was previously executive director of finance at Sheffield Children's Hospital NHS foundation trust and has worked in the NHS since 1993.

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

Carolyn White, executive nurse director

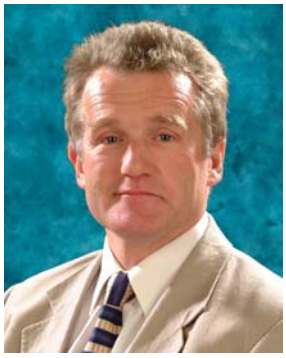
Carolyn joined the trust on 16 July 2001, having previously worked for 12 years at the Hull and East Yorkshire Hospitals NHS trust in a variety of senior nursing and management roles.

She trained as a registered children's nurse and state registered nurse in Liverpool and qualified in 1982.

Carolyn has worked for most of her clinical career in paediatric intensive care.

Since her appointment Carolyn has significantly raised the profile of nursing services within the trust. Her professional drive has improved recruitment, retention and training of nurses and other clinical staff. She has highly developed leadership skills and change management experience most recently demonstrated in her role as lead for the trust's emergency services collaborative. This resulted in the trust being recognised as one of the country's top performing hospitals for emergency care.

Carolyn was appointed executive nurse director of the foundation trust on 1 February 2007



Mike Mowbray, Executive Medical Director

Mike has been a consultant anaesthetist at King's Mill Hospital since July 1991 and was appointed executive medical director to the Sherwood Forest Hospitals NHS trust in June 2002.

He was subsequently appointed as executive medical director of the foundation trust on 1 February 2007.

Since 2000, Mike has been a college advisor for the royal college of anaesthetists with a PASK certificate from the association of anaesthetists.

While continuing to provide clinical care, the executive medical director's role is to provide dynamic leadership of the trust's medical profession, play a key part in developing policies and strategies, and offer a medical perspective on all matters to the board of directors.

Karen Fisher, executive director of human resources

Karen joined the board of directors as executive director of human resources on the 14 April 2008.
Karen was previously deputy HR director at Nottingham University Hospitals NHS Trust and has worked in the NHS for 28 years.

Karen, is the principal HR advisor to the trust's board of directors, and is a member of both the Chartered Institute of Personnel and Development and the Healthcare People Management Association and has a Masters degree in HR Management.

Stuart Grasar, independent non-executive director,
Stuart was appointed to the board of directors in November 2008.

Stuart is a Chartered Fellow of the Institute of Personnel and Development and until November 2006 was head of the Public Services Department of North Nottinghamshire College in Worksop.

Stuart has also held appointments on the board of the Ilkeston Consumer Co-operative Society, including acting as chairman for three years between 2003 and 2006.

Stuart formally joined the Board of Directors on 10 November 2008 and is a member of the remuneration committee.

Bonnie Jones, independent non-executive director,

Bonnie joined the board of directors on the 1 February 2008 and was appointed acting vice-chairman in January 2009.

Bonnie is a member of the remuneration committee, the investments committee and is the non-executive director representative on the trust's infection control committee.

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

Bonnie was subsequently appointed chair of Newark and Sherwood primary care trust in 2000, where she spent six years.

During this time the trust developed as a lead commissioning organisation in Trent, working closely with the trust.
Until September 2008, Bonnie was chair of a charity providing out of school care in Newark, an executive committee member of Newark and Sherwood community and voluntary services (CVS) and a member of Nottinghamshire probation board.

David Heathcote, independent non-executive director

David joined the board of directors on the 1 February 2008. David was appointed senior independent director in January 2009.

David is a member of the audit committee, the investments committee and the nominations committee.

David is a Chartered Certified Accountant and has held senior management roles with a number of Midlands based companies. He currently is a non-executive director of a Nottingham company operating within the financial services sector.

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

David Leah, independent non-executive director

David joined the Sherwood Forest Hospitals NHS trust on 1 November 2005, and was appointed to the foundation trust board of directors on 1 February 2007.

David is the chair of the audit committee.

David is a chartered certified accountant by profession and has worked for a wide range of companies.

Previously he was group finance director of one of the country's leading interior contracting groups, and his wide commercial knowledge has enabled him to contribute to the establishment of successful business strategies.

David is now a director of a business support consultancy.

Stephen Pearson, independent non-executive director

Stephen joined the Sherwood Forest Hospitals NHS trust on 1 January 2006, and was appointed to the foundation trust board of directors on 1 February 2007.

Stephen is a member of the audit committee, the nominations committee and the investments committee.

Stephen is a solicitor by profession and has substantial experience in public-private matters, acting on behalf of a range of public and not-for-profit bodies. He has worked as an in house lawyer in the public sector and commercial industry, and is currently a partner in a major Nottingham law firm. He holds a postgraduate diploma in local government law.

His experience includes a role as secretary to Nottingham Health Authority for 2 years, and he has lectured on PFI/PPP, the role of local improvement finance trusts in the NHS and, most recently concerning the effect of changes in EU procurement law and the obligations imposed by freedom of information legislation.

In accordance with good governance practice, the board of directors includes a balance of independent non-executive directors, with skills and expertise to complement those of the executive directors.

The board of directors is confident that its composition is appropriate to face the challenges of healthcare locally. During 2008/09, the nominations committee reviewed the composition of the board of directors, its collective skills and expertise and highlighted areas of development. This work will continue during 2009/10 to ensure that the changes to governance arrangements enacted in 2008/09 continue to support the trust meet its objectives.

The board of directors will continue to evaluate its performance and the performance of its committees in order to ensure that it continues to remain effective.

Assessment of the effectiveness of the board of directors, selected committees - particularly the audit committee - and individual directors, was undertaken during 2008/09. The assessment included individual evaluation of directors using established processes, and a self-assessment questionnaire that committee members completed.

The assessment process will be used again in 2009/10 and consideration will be given to extending this to further committees.

A register of directors' interests is maintained by Mike Tasker, company secretary, at the trust's headquarters.

8. Governance statement

During 2008/09, the trust's corporate governance framework was reviewed and a number of changes were agreed. The role of board of director's committees was reviewed in order to ensure that executive directors were able to fulfil their management responsibilities more effectively and that the independence of non-executive directors was protected.

In addition, the respective roles of the two boards as described in the constitution and the standing orders were maintained and we continued to develop these roles further and to ensure that the two boards work effectively together. The roles of the two boards are clearly described within the constitution: Section 8.17, confirms the role and responsibilities of governors, which include:

- The appointment of the chairman and non-executive directors and the setting of their terms and conditions of service;
- The appointment of the trust's auditor;
- To comment on the trust's forward plans;
- Consideration and provide comment on the annual accounts annual report;
- To provide views on the trust's strategic direction;
- The development of membership;
- To represent the interests of members;
- Holding the board of directors to account in relation to the authorisation.

Section 9.7 confirms the role and responsibilities of directors, which include:

- Exercising the powers of the trust;
- Establishing arrangements to allow the exercise of these powers through sub-committees and executive directors;
- The preparation of the trust's forward plans;
- The presentation to the board of governors of the annual accounts and annual report.

During the year, the constitution was amended to reflect changes to the meeting arrangements for the board of directors; a reduction in the number of PCT governors; and changes to the quorum of the board of governors. These amendments were approved by Monitor in September 2008.

The constitution will be amended further in 2009/10 to reflect the transfer of services from Mansfield Community Hospital and the abolition of this class of the staff constituency. A subsequent increase in the number of governors representing King's Mill Hospital will be made following the transfer of services.

The trust's standing orders, standing financial instructions and, in particular, the scheme of delegation, detail the types of decisions that have been delegated to the chief executive and other staff by the board of directors, as well as those powers that have been reserved. The chief executive remains the Accounting Officer for the foundation trust.

Foundation Trust – Code of Governance

In October 2006 Monitor, the independent regulator of NHS foundation trusts, published the NHS foundation trust code of governance ('the Code') which contains a number of disclosure requirements.

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

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

A. Directors

The trust has accepted the principles described within the Code in relation to its directors. It is confident that the trust is led by an effective board of directors, and that there is a clear division of responsibilities between the chairman and the chief executive as described within the trust's key governance documents. The board has a balance of executive and independent non-executive directors.

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

B. Governors

The trust has accepted the principles described within the Code in relation to its governors and has established a board of governors in accordance with the 2006 Act.

The board of governors has met frequently during 2008/09 and has adopted the trust's key governance documents. A code of conduct for governors has been issued to all governors. The board of governors has established a number of committees in order to meet its responsibilities and ensure that it focuses on issues of importance to members of the trust.

C. Appointments and Terms of Office

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

A nominations committee, chaired by the trust's chairman, has been established and has reviewed the structure, size and composition of the board of directors. The nominations committee is involved in reviewing the job specifications for all executive and non-executive director vacancies on the board of directors.

The trust has one nominations committee for both executive and non-executive director appointments, and has worked closely with the board of governor's appointments committee.

D. Information Development and Evaluation

During 2008/09, both the board of directors and the board of governors have received information in a timely manner, to enable them to discharge their respective duties.

Directors and governors joining the two boards receive induction and ongoing training.

Developmental sessions for directors and governors and a joint governors and directors session have been arranged during the year. Action plans to address any developmental needs identified form these sessions have been agreed.

The board of directors accepts the need to conduct a formal and rigorous evaluation of its own performance, and a process to enable this was developed during the year. The chairman conducted individual appraisals of non-executive directors, and the chief executive conducted appraisals for executive directors. An agreed process for the appraisal of the chairman was agreed with the board of governors, involving the senior independent director and the chair of the appointments committee. An appraisal of the chairman's performance for 2008/09 will be undertaken in early 2009/10.

E. Director Remuneration

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

The remuneration committee reviewed levels of executive directors' pay in 2008/09 and the board of governors considered the remuneration of the chair and non-executive directors in April 2008. The board of governor's appointments committee will review remuneration in early 2009/10.

F. Accountability and Audit

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

With regard to internal control, the board of directors is assured through the audit committee that the trust's systems are sound and safeguard public and private investment.

The trust appointed KPMG as its auditor in November 2007.

G. Dialogue with Stakeholders

The board of directors accepts the requirement to consult with and involve members, patients, clients and the local community, regarding its plans and recognises the complementary role played by governors in this responsibility.

A number of formal and informal opportunities for interaction between the two boards have been created, including a joint developmental session in January 2009 specifically designed to consider the annual plan for 2009/10 and the development of quality accounts and the quality report. In addition, directors have attended board of governor meetings, including meetings of its committees, and governors routinely attend meetings of the board of directors.

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

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

Section A.1.3 – A formal process for appraising the performance of the trust's chairman was agreed in 2008/09, and the outcome of this process will be agreed with the governors during 2009/10.

Section B.1.7 – The constitution and standing orders for the board of directors provide mechanisms for the board of governors to raise concerns as described within the Code however, a policy for raising concerns was not established over and above these mechanisms.

Section C.2.1 – The remuneration committee on behalf of the board of directors has considered the principle of the re-appointment of the chief executive and executive directors on a 5 yearly basis, but considered that the contracts offered to the chief executive and executive directors included sufficient powers to address any areas of concern regarding performance without the time limit suggested.

Section E 1.1 – The remuneration committee on behalf of the board of directors has concluded that performance related pay for executive directors was not appropriate.

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

9. Membership

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

Public constituencies

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

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

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

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

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

At the 31 March 2009, the trust had 16,713 public members and 661 affiliate members.

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

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

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

As at the 31 March 2009 the percentage of members living in our four constituencies was approximately:

Ashfield – 27.4%
Derbyshire – 11.9%
Mansfield – 33.0%
Newark & Sherwood – 27.7%

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

- 6.3% of our catchment population is aged 16-21, and 74% is aged 22 years plus. In our public membership, 2.69% are aged 16-21, and 89.9% are aged over 22.

- 49.1% of our catchment population are males and 50.9% females. In our membership, 40.15% are males and 59.77% are females. 0.08% of our members have not confirmed their gender.

The trust's membership manager has played a significant part driving forward membership by recruiting more members and enhancing the engagement programme. The profile of the membership has increased across the trust and the community. The board of governors has also been heavily involved in the recruitment and engagement of the members in 2008/09.

During 2008/09, the principal means of membership recruitment was through face to face contact at local events, community and voluntary groups and within the trust. We have targeted all areas in our catchment area with a particular focus on those groups who are under-represented.

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

Staff constituency

The staff constituency is divided into 4 Classes – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital, and Volunteers. During 2008/09, the Mansfield Community Hospital class of the staff constituency will be abolished following the transfer of services to King's Mill Hospital.

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

Engagement with members

Engagement with our members is extremely important and we are constantly improving and increasing the level of this. There is evidence that there is an increase in the number of members responding to surveys and attending member events. This is monitored regularly at the membership and engagement committee of the board of governors, where innovative methods of engagement are discussed.

During 2008/09 representatives from the trust, including governors, attended a number of meetings of local community groups to highlight the work of governors, and we held further staff and public constituency meetings.

The board of directors recognises the need to seek governors' views on developments at the trust and to gain an understanding of members' aspirations and concerns. As a result, the board of directors has taken the following steps to engage with governors:

- Directors, including non-executive directors, have been invited to all board of governor meetings and have attended these regularly;
- Directors, including non-executive directors, have attended governors' induction meetings and developmental sessions;
- A joint event to discuss the annual plan was held in January 2009. This enabled all directors and governors to meet and exchange views;
- Governors have been invited to and have attended board of directors meetings;
- Designated non-executive directors attend board of governor committee meetings in order to assist with the committees' work.

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

We have continued to arrange member events to include subjects that are of interest to members and to give members the opportunity to pass on their views to governors. Events during 2008/09 included physiotherapy and occupational therapy, heart and lungs, Information technology, Newark Hospital developments, the new hospital build

and diabetes. The member events have been very successful and well attended. These will continue in 2009/10.

Customer focus groups with public and staff members have taken place during 2008/09. Members have assisted the trust with developing and shaping the trust's vision for the future.

10. Summary Financial Statements

This section includes summary financial statements and a statement on internal control (SIC) for the accounting period:

1 April 2008 to 31 March 2009

A copy of the trust's Full Annual Accounting Statements are available on request and free of charge by telephoning 01623 672277 or email sue.newburn@sfh-tr.nhs.uk.

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

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust ('the Trust'), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

As described on page 49 the Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor. Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year ended 31 March 2009.

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

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

Basis of audit opinion

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

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

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

Opinion

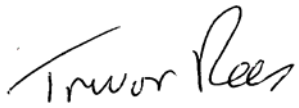
In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts in England, of the state of the Trust's affairs as at 31 March 2009 and of its income and expenditure for the year then ended; and

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements of the NHS Foundation Trust Financial Reporting Manual.

Certificate

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



Trevor Rees (Senior Statutory Auditor)
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
2 Cornwall Street
Birmingham

5 June 2009

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 Financial Reporting Manual and in particular to:

• observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

• make judgements and estimates on a reasonable basis;

• state whether applicable accounting standards as set out in the NHS foundation trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

• prepare the financial statements on a going concern basis.

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

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

Signed _____ **Date: 5th June 2009**
Jeffrey Worrall
Chief Executive

EXECUTIVE DIRECTOR OF FINANCE REPORT

OVERVIEW

Against a backdrop of improving patient services, notably through the provision of new facilities and increased access to services, it is very pleasing to report that the Trust has met its Financial targets in year delivering a surplus of £8.4m.

With regards Monitors' performance measures the full year financial results achieved an overall rating of 5 as detailed below:

Key Performance Indicators		Annual Plan		Actual Outturn	
Financial Metrics	**Weight**	**Value**	**Rating**	**Value**	**Rating**
EBITDA Margin %	25.0%	8.6%	3	8.4%	3
EBITDA % Achieved	10.0%	100.0%	5	100.1%	5
Return on Assets %	20.0%	9.4%	5	9.5%	5
I and E Surplus Margin %	20.0%	3.9%	5	3.9%	5
Liquid Ratio -Days	25.0%	58.1	5	45.5	5
Weighted Average			4.5		4.5

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 in line with Financial Reporting Standard 18. This assessment takes into consideration all information available about the future prospects of the Trust and also covers Financial, Governance and Mandatory Service risks.

A detailed paper covering all these risks and the opinion drawn thereon was approved by the Audit Committee on the 21st April 2009, and is available separately on request. The review concluded that the Foundation Trust is a Going Concern, and has taken steps to ensure this remains the case for at least the next 12 months.

INCOME AND EXPENDITURE

Total income for the year was £218.9m (£190.7m in 2007/8) representing a growth of 14.78%. This growth results from a number of sources including additional funding for inflationary pressures and funding from the Department of Health for the dual running costs of the PFI scheme. The largest source of income growth however is attributable to significant growth in clinical activities as the Trust has driven waiting times down to meet the 18week referral to treatment targets. Growth in outpatient and daycare services in particular has been significant in year.

Continued effort has been applied throughout the period to reducing our costs and obtaining value for money. During 2008/9 the Trust developed an ambitious programme to deliver productivity improvements across the organisation which delivered significant financial benefits. Also during 2008/9 the Trust has continued to embed Service Line Management throughout the organisation. We plan to realise further benefits in 2009/10 from the continued development of both these programmes.

Details of our full year costs relating to directors remuneration are given in note 6 to the summary accounts.

BALANCE SHEET

During 2008/9 the Foundation Trust invested significantly in its fixed asset infrastructure (£11,772,000). The Foundation Trust invested over £4.0m on upgrading or acquiring new equipment essential for the day-to-day operation of the Trust. In addition a further £1.0m was invested in improvements in information systems and technology in conjunction with the North

Nottinghamshire Health Community, and additions of £2.7m were recognised within the Balance sheet to account for the Private Finance Initiative (PFI).

Since becoming a Foundation Trust the Trust has benefited from increased flexibility and the ability to carry larger cash balances forward into future years. The closing cash balance at 31 March 2009 was £36.6m. This has reduced slightly from £39.9m at 31 March 2008 due to increased capital expenditure and movements on working capital.

CHARITABLE FUNDS

During the financial year we received donations and legacies to our charitable funds of £357,000 (£481,000 in 2007/8), which included legacies of £105,000 (£161,000 in 2007/8).

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 £344,000 (£384,000 in 2007/8) to support the activities of the Trust and for the welfare of patients and staff.

OUTLOOK

Given the global economic outlook the next few years present a period of significant challenge for the Trust in terms of the facilities we have available to provide patient care and the regulatory regime under which we operate:

- The Trust reached financial close in November 2005, on the £367m redevelopment of Kings Mill Hospital and Mansfield Hospitals, together with significant refurbishment and upgrade works at Newark Hospital. This contract includes the future operation of the facilities services across the Trust (e.g. estates, cleaning, catering and portering) until 2043.

- The redevelopment is phased and the Trust has already benefited from the refurbishment of the Newark site, opening of the KTC and two of the three towers which are being brought into use with the first transfers occurring in March 2009. The remainder of the scheme is scheduled for completion by 2011.

- The redevelopment will enable the Trust to operate more efficiently and will bring many benefits to our patients. In particular:

    - Ward accommodation will be in line with the latest standards with increased bed spaces comprising 50% single rooms and 50% in 4 bed bays.
    - Rationalisation of service locations will bring to an end inefficiencies caused by services being scattered across sites.
    - Dedicated Kings Treatment Centre, bringing together outpatient, diagnostic and day case facilities together in an efficient patient focussed manner.
    - State of the art pathology laboratory, obtaining the efficiency benefits of technology.
    - Through the development of Mansfield Community Hospital, owned by Nottinghamshire County PCT, but part of the overall MAS redevelopment scheme, we now have the capacity to ensure that acutely ill patients can be cared for in dedicated acute care facilities with the Community Hospital specialising on the rehabilitation of patients during the post acute phase of their treatment.

- The plans we have developed to improve our productivity continue to be refined and this will ensure that we are able to benefit fully from the new hospital developments outlined above.

- The Trust continues to rollout the functional benefits of the integrated ESR Human Resources and Finance system to improve efficiency and co-ordinated working practices across the Trust in areas such as e-rostering and self sickness certification.

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

The Trusts future financial plans take account of known risk factors including forecast activity changes. They also take account of the wider economic downturn when considering cost and income inflation. The plans also identify the efficiency requirements faced by the Trust throughout the period. This detailed planning work has enabled the Trust to construct plans which mitigate against known risks as far as possible over the next 4 year period. The significant risks to the Trust include:

- A significant cost reduction strategy over the next four years recognising that the period of unprecedented growth in income enjoyed over recent years is unlikely to continue and pressures on the cost base, notably arising from the new hospital development, will require careful management.

- 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. In response to this the Trust is looking to explore opportunities in Primary Care as well as consolidating its position as the acute and secondary care provider of choice locally

- Detailed activity volumes have been agreed and contracted for in 2009/10. These reflect the organisation's drive to reduce its waiting time for treatment yet further. This reflects not only our business intention but also our commissioners' intentions.

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.

Lee Bond

Executive Director of Finance

5th June 2009

FTC SCHEDULES FOR THE SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST FOR THE PERIOD ENDED 31 MARCH 2009

Consolidation schedules numbered FTC01 to FTC28 are attached.

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 2008/09 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.

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

Lee Bond
Executive Director of Finance
5th June 2009

Chief Executive Certificate

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

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

Jeffrey Worrall
Chief Executive
5th June 2009

INCOME AND EXPENDITURE ACCOUNT

For Year Ended 31st March 2009	Year Ended 31st March 2009		Year Ended 31st March 2008	
	£000	£000	£000	£000
Income from activities:	**167,966**		149,587	
Other operating income	**50,933**		41,114	
TOTAL INCOME		**218,899**		190,701
Operating expenses:				
Staff costs	**130,454**		122,081	
Non-staff costs	**69,131**		53,576	
Depreciation, amortisation & impairments	**6,942**		8,104	
Audit fees	**48**		61	
Directors' remuneration	**1,001**		846	
		(207,576)		(184,668)
OPERATING SURPLUS		**11,323**		6,033
Profit / (Loss) on Disposal of Fixed Assets		**(414)**		(100)
SURPLUS BEFORE INTEREST		**10,909**		5,933
Finance income - Interest receivable		**1,329**		1,351
Finance costs - Interest Payable		**(7)**		(10)
Other finance costs - unwinding of discount		**0**		0
Other finance costs - change in discount rate on provisions		**0**		0
SURPLUS FOR THE FINANCIAL PERIOD		**12,231**		7,274
Public dividend capital dividends payable		**(3,790)**		(3,645)
RETAINED SURPLUS FOR THE FINANCIAL PERIOD		**8,441**		3,629

BALANCE SHEET

As at 31st March 2009	31st March 2009		31st March 2008	
	£000	£000	£000	£000
FIXED ASSETS				
Intangible Fixed Assets				
Software Licences	**3,203**		3,453	
Tangible fixed assets				
Land	**18,584**		18,584	
Buildings	**13,444**		32,503	
Assets under construction	**11,098**		6,962	
Equipment	**15,027**		13,831	
		61,356		75,333
CURRENT ASSETS				
Stocks	**2,318**		2,341	
Debtors	**63,539**		43,896	
Cash at bank and in hand	**36,580**		39,898	
	102,437		86,135	
CREDITORS: Amounts falling due within one year	**(27,179)**		(33,114)	
NET CURRENT ASSETS		**75,258**		53,021
TOTAL ASSETS LESS CURRENT LIABILITIES		**136,614**		128,354
CREDITORS: Amounts falling due after more than one year		**-**		-
PROVISIONS FOR LIABILITIES AND CHARGES		**(3,136)**		(3,031)
TOTAL ASSETS EMPLOYED		**133,478**		125,323
FINANCED BY:				
TAXPAYERS' EQUITY				
Public dividend capital	**84,303**		84,303	
Revaluation reserve	**16,110**		26,252	
Donated asset reserve	**2,109**		2,395	
Income and expenditure reserve	**30,956**		12,373	
TOTAL TAXPAYERS EQUITY		**133,478**		125,323

Jeffrey Worrall
Chief Executive
5th June 2009

CASH FLOW STATEMENT

For Year Ended 31st March 2009	**Year Ended 31st March 2009** £000	**£000**	Year Ended 31st March 2008 £000	£000
Operating Activities				
Total operating surplus	**11,323**		6,033	
Depreciation and amortisation charge	**6,942**		8,104	
Amortisation of government grant	**0**		0	
Other Movements	**842**		1,277	
Transfer from donated asset reserve	**(360)**		(361)	
(Increase)/decrease in stocks	**23**		(110)	
(Increase)/decrease in debtors	**(2,015)**		5	
Increase/(decrease) in creditors	**(8,194)**		13,561	
Increase/(decrease) in provisions	**105**		1,659	
Net cash inflow from operating activities		**8,666**		30,168
Returns on Investment and Servicing of Finance				
Interest received	**1,329**		1,351	
Interest element of finance leases	**(7)**		(10)	
Net cash inflow from returns on investments and servicing of finance		**1,322**		1341
Capital Expenditure				
Payments to acquire tangible fixed assets	**(8,835)**		(5,677)	
Payments to acquire intangible fixed assets	**(681)**		(629)	
Net cash outflow from capital expenditure		**(9,516)**		(6,306)
Dividends paid		**(3,790)**		(3,645)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**(3,318)**		21,558
Financing				
Public dividend capital received	**0**		2,500	
Public dividend capital repaid (not previously accrued)	**0**		(1,456)	
Other capital receipts	**0**		0	
Capital element of finance lease rental payments	**0**		(43)	
Net cash inflow from financing		**0**		1,001
INCREASE/(DECREASE) IN CASH		**(3,318)**		22,559

STATEMENT OF RECOGNISED GAINS AND LOSSES

For Year Ended 31st March 2009	**Year Ended 31st March 2009**	Year Ended 31st March 2008
	£000	£000
Surplus for the period before dividend payments	**12,231**	7,274
Unrealised surplus on fixed asset revaluations/indexation	**0**	5,009
Fixed asset impairment losses	**0**	0
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**103**	1,442
Reduction in the donated assets reserve due to depreciation, impairment, and / or disposal of donated assets	**(360)**	(361)
Total recognised gains and losses for the period	**11,974**	13,364
Prior period adjustment		
- Pre-95 early retirement	**0**	0
- Other	**0**	0
Total gains and losses recognised in the period	**11,974**	13,364

NOTES TO THE SUMMARY FINANCIAL STATEMEI					
1. Breakeven performance and five-year financial summary					
The trust's breakeven performance for 2008/9 and for the preceding four years is as follows:					
	2004/05	**2005/06**	**2006/07**	**2007/08**	**2007/08**
	£000	**£000**	**£000**	**£000**	**£000**
Total Income	146,149	164,237	180,971	190,701	218,899
Retained surplus for the year/period	8	1	2,878	3,629	8,441
Break-even cumulative position	101	102	2,980	6,609	15,050

2. Better Payment Practice Code - measure of compliance

	2008/09		**2007/08**	
	Number	**£000**	**Number**	**£000**
Trade Creditors				
Total bills paid in the year	**47,630**	**85,585**	43,707	51,733
Total bills paid within target	**43,994**	**79,801**	42,788	50,921
Percentage of bills paid within target	**92%**	**93%**	98%	98%
NHS Creditors				
Total bills paid in year	**1,562**	**13,820**	1,325	15,021
Total bills paid within target	**1,387**	**12,354**	1,283	14,994
Percentage of bills paid within target	**89%**	**90%**	97%	99%

The Better Payment Practice Code requires the trust to aim to pay all valid invoices by the due date or within the 30 days of receipt of goods or a valid invoice, whichever is later. Following audit review the calculation was amended for 2008/9, and the Trust has been working in year to attain the 95% targets. These were achieved in March 2009, and it is expected that these will be maintained in 2009/10.

3. Audit Services

The Audit fee charged to the Accounts in the period was £47,725.00. All of the work carried out by the External Auditors was in accordance with the Code of Practice.

4. Management costs		
	2008/09	**2007/08**
	£000	**£0**
Management costs	**6,817**	**6,603**
Income (net of NMET Income)	**208,780**	**183,279**
Percentage	**3.27%**	**3.60%**

5. Salary and Pensions of Senior Managers

These are detailed on page 10. However for clarity an explanation of Cash Equivalent transfer values is included below.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005-06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute & Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

5. Salary and Pension entitlements of senior managers

Name and Title	Salary	Other Remuneration **	Real increase during the year in pension and lump sum at age 60	Total accrued pension (incl. lump sum) at age 60 at 31 March 2009	Value of Cash Equivalent Transfer Value as at 1st April 2008	Real increase value of Cash Equivalent Transfer Value during the year ended 31st March 2009	Real increase value of Cash Equivalent Transfer Value at the end of the reporting period - 31st March 2009	Benefits in kind *
	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £2,500)	(nearest £1,000)	(nearest £1,000)	(nearest £1,000)	(nearest £100)
2008/09	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£**
Executive Directors:								
Mr B.Meakin	**0**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
(Chair to 31st March 2008 inclusive)								
2007/08	*40-45*	*0*	*n/a*	*n/a*	*n/a*	*n/a*		*0*
Ms T. Doucet	**40 - 45**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
(Appointed Chair 1st April 2008)								
2007/08 (as non-executive director)	*10-15*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
Mr J.Worrall	**135-140**	**0**	**30 - 32.5**	**215 - 217.5**	**719**	**367**	**385**	**6700**
(Chief Executive)								
2007/08	*135-140*	*0*	*17.5 - 20*	*180-182.5*	*608*	*95*	*111*	*5600*
Mr W.Gregory	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
(Executive Director of Finance)								
2007/08	*10-15*	*0*	*2.5-5*	*n/a*	*220*	*10*	*63*	*6000*
(Left 31st May 2007)								
Dr M.Mowbray	**25-30**	**155-160**	**22.5 - 25**	**190 - 192.5**	**589**	**347**	**362**	**7400**
(Executive Medical Director)								
2007/08	*20 - 25*	*140-145*	*12.5-15*	*162.5 – 165*	*512*	*65*	*77*	*8000*
Mrs C.White	**85-90**	**0**	**0-2.5**	**110-112.5**	**376**	**107**	**116**	**5200**
(Executive Nursing Director)								
2007/08	*85-90*	*0*	*12.5 - 15*	*105 - 107.5*	*311*	*57*	*65*	*3200*
Mrs S. Rollett	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
(Executive Director of Human Resources)								
2007/08	*75 – 80*	*0*	*(10 - 12.5)*	*172.5 - 175*	*314*	*(315)*	*(314)*	*0*
(Appointed 1st February 2007, left 23rd March 2008)								
Mrs E. Konieczny	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
(Acting Executive Director of Finance - 1st June 2007 to 5th August 2007 inclusive)								
2007/08	*0-5*	*0*	*0 - 2.5*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
Ms J.Warder								
(Executive Director of Strategy and Improvement appointed 4th June 2007)	**85 - 90**	**0**	**20 -22.5**	**100 - 102.5**	**238**	**131**	**137**	**3000**
2007/08	*65 - 70*	*0*	*15 - 17.5*	*77.5 - 80*	*170*	*52*	*68*	*0*
Mr L.Bond	**100 - 105**	**0**	**2.5 -5**	**77.5 - 80**	**194**	**60**	**64**	**3800**
(Executive Director of Finance - appointed 6th August 2007)								
2007/08	*60-65*	*0*	*10 - 12.5*	*72.5 - 75*	*137*	*35*	*57*	*8*
Ms K.Fisher								
(Executive Director of Human Resources - appointed 14th April 2008)	**75 - 80**	**0**	**5-7.5**	**110 -112.5**	**328**	**110**	**122**	**0**
2007/08	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
Non-Executive Directors:								
Mrs D.George	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
2007/08	*5 – 10*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
(left 31st January 2008)								
Mr P.Harris	**10-15**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
(left 31st January 2009)								
2007/08	*10-15*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
Mrs S.Andrews	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
2007/08	*5 –10*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
(left 31st January 2008)								
Mr S.Pearson	**10-15**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
2007/08	*10 - 15*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
Mr D.J.Leah	**10-15**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
2007/08	*10 - 15*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
Mrs B. Y. Jones	**10-15**	*0*	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
2007/08	*0 - 5*	0	n/a	*n/a*	*n/a*	*n/a*	*n/a*	0
(appointed 1st February 2008)								
Mr D. B. Heathcote	**10-15**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
2007/08	*0 -5*	*0*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*0*
(appointed 1st February 2008)								
Mr S. Grasar	**0-5**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**0**
(appointed 10th November 2008)								
2007/08	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*

Notes

* The amounts shown for benefits in kind relate to the provision of lease cars.

** Other remuneration relates to remuneration for the Executive Medical Director for clinical work.

Jeffrey Worrall
Chief Executive Date: 5th June 2009

6. Related Party Transactions

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

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sherwood Forest Hospitals NHS Foundation Trust.

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 Department. These significant entities are listed below:

	Income £000	Expenditure £000
Bassetlaw Primary Care Trust	833	0
Department of Health	5,192	0
Derby City PCT	180	3
Derby County PCT	17,091	10
Derby Hospitals NHS Foundation Trust	307	45
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	0	72
East Midlands Ambulance Services NHS Trust	0	897
East Midlands Strategic Health Authority	10,324	2
Imperial College Trust	0	17
Kettering Foundation Trust	67	0
Leicester County and Rutland PCT	2,429	33
Leicester City PCT	167	0
Leicester PartnershipTrust	65	141
University Hospitals Leicester Trust	683	52
Lincolnshire Primary Care Trust	2,968	0
Moor field's Eye Hospital NHS Foundation Trust	0	25
NHS Blood and Transplant	0	1,006
NHS Business Services Authority	0	264
NHS Litigation Authority	0	2,371
Northampton Teaching PCT	194	0
Northampton Trust	160	0
Nottingham University Hospitals NHS Trust	2,819	1,399
Nottingham City PCT	3,605	137
Nottinghamshire County Primary Care Trust	156,252	2,442
Nottinghamshire Healthcare NHS Trust	1,209	266
NHS Purchasing and Supply Agency	3	4,088
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	0	154
Sheffield Children's NHS Foundation Trust	0	51
Sheffield Teaching Hospitals NHS Foundation Trust	0	25
United Lincolnshire Hospitals NHS Trust	187	1

In addition the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Department of Health for Education and Skills in respect of University Hospitals.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board. The Sherwood Forest Hospitals Charitable Fund purchased goods and services for the Trust during the financial year, and also provided purchases for patients and staff at the Sherwood Forest Hospitals. The administration of the Charity is carried out by the Trust, and during the financial year the Trust charged the Charity for this service.

The audited accounts/the Summary Financial Statements of the Funds Held on Trust are available separately.

STATEMENT ON INTERNAL CONTROL 2008/09

1. 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.

2. 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 31st March 2009 and up to the date of approval of the annual report and accounts.

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.

3. Capacity to handle risk

The trust's risk management policy was approved by the board of directors in September 2008, and sets out the responsibility and role of the chief executive in relation to risk management. Through chairing the trust's executive management board (EMB) and receiving regular reports from the key committees and groups that oversee the management of risk, including the risk management group (non-clinical) and the clinical governance committee, the chief executive provides leadership to the management of all risks faced by the trust.

The EMB reports to the board of directors through the monthly executive performance report (EPR) that includes details of the top rated risks and how these are being managed by the executive team.

The trust's audit committee and its investments committee deal specifically with internal control and investment risks faced by the trust and report directly to the board of directors. Internal control and financial risks are reflected in the overall consideration of risk at the board of directors through the monthly EPR.

The trust carries out regular risk assessments and has produced risk registers at various levels across the organisation including the strategic assurance framework. The assurance framework was reviewed each quarter in 2008/09 by the board of directors in order to ensure that the risks registered remained relevant and that progress had been made with any actions identified. This review included cross referencing the assurance framework to the domains set out by the Healthcare Commission's Standards for Better Health. The assurance framework enables risk management decision-making to occur as near as practicable to the risk source and for those risks that could not be dealt with locally to be passed upwards to the appropriate level.

Awareness training on risk management, risk assessment and incident reporting are included in the trust's core induction programme which must be attended by all staff on their first day of work. This highlights key trust policies and procedures. These policies include the risk management strategy, and policies for health and safety, infection control and complaints. The core training processes also include specific risk management training (Fire, Lifting and Handling, Health and Safety and mandatory updates). The trust also employs a system of root cause analysis (RCA) to review processes and incidents in order to identify ways of reducing risks and learning from experiences. RCA has been used extensively during 2008/09 with MRSA incidents so that lessons highlighted can be learned. The trust also links with partner organisations to provide appropriate education and training in this area.

More specific training is provided as required for directors and senior managers on their roles and responsibilities for managing all risks.

4. The risk and control framework

The risk management framework is set out in the risk management policy. The key elements of the policy include:

- The board of directors recognises that risk management is an integral part of good management practice and to be most effective should become part of the trust's culture and strategic direction. The board of directors is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

- The aim of the trust's risk management policy is to create robust structures, systems and processes that will minimise or eliminate risks to patients, staff, the organisation and to third parties by promoting consistency in practice in clinical and non-clinical services. The policy is aimed at creating a deep awareness and responsibility for the assessment and management of risk at all levels in the organisation, whether through individual practice or through management arrangements.

- Responsibility for the effectiveness of organisational systems of control and risk management rests unequivocally 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 policy.

- In addition, 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's risk management policy describes the risk management structure within the trust and the interrelationship between the principal trust committees involved in the risk management process. Their key responsibilities can be summarised as follows:

    - The EMB is responsible for the overall control of the risk management process on behalf of the board of directors, and for ensuring that all significant risks are reported to the board of directors on a regular basis, through the EPR.

    - The audit committee is responsible for reviewing the effectiveness of the trust's systems of internal control, overseeing the work of the trust's auditors and the implementation of its plan to manage the risk of fraud and corruption. The audit committee reports after every meeting to the board of directors;

- The investments committee deals specifically with investment risks faced by the trust. It receives reports from the executive director of finance and assists the board of directors in forming action plans to deal with the risks faced;

- The risk management group (non-clinical) advises the EMB on the framework and structure to effectively manage organisational and non-clinical risks;

- The clinical governance committee advises the EMB on the management of clinical risks

In addition to this committee structure, the trust also:

- Provides and maintains a comprehensive selection of policies and procedures, which are available to staff. Risk assessment processes are included within a wide range of these policies. Examples include accident and incident reporting, handling complaints and claims, managing health & safety and dealing with fraud and corruption.

- Maintains an ongoing risk management process to develop and keep up to date the trust's assurance framework, register of high risks and other risk registers. This process includes risk identification, evaluation, identification of control and development of action plans to mitigate risks where appropriate.

As referred to above, during 2008/09 the trust's assurance framework was considered on a quarterly basis by the board of directors. The 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 how the board of directors draws assurance that these risks are being managed effectively.

The assurance framework identified any gaps in assurance and control relating to the principal risks facing the trust. As well as listing the gaps, the assurance framework also lists the actions being taken to address the gaps and to manage the risk.

The gaps identified in 2008/09 related to a wide range of risks, including financial risks (for example the performance of some of the trust's productivity improvement programmes); clinical risks (for example, the failure to meet the MRSA reduction target); and efficiency risks (for example the failure to meet the reduced length of stay target).

Failure to meet the MRSA reduction target in 2008/09 was considered a significant gap in control and the trust worked closely with the department of health's infection control support team during the year, and has taken steps to improve performance. Quarters 3 and 4 demonstrated that improvement had been achieved.

The board of director's review of the assurance framework will continue in 2009/10 and will include ensuring that the objectives identified in the 2009/10 annual plan are specific, measurable, achievable, realistic and timely (SMART); that measures of control and assurance are appropriate; and that the assurance framework continues to be integrated into the governance process within the trust.

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 nominated by the board of governors, providing patient and public involvement;
- Summaries of the monthly EPR and the actions to address key objectives are published 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.

The principles of the trust's risk management policy apply to all risks, including those associated with information. In view of growing concerns nationally regarding the management of information by public authorities, especially personal data, the Department of Health established an information governance assurance programme (IGAP) in 2007/08 and asked all boards of directors within the NHS to undertake a review of their information governance arrangements. Boards of directors of NHS foundation trusts were also required to self-certify their levels of compliance to Monitor and chief executives were required to sign a statement of compliance in February 2008.

The trust reviewed its information governance arrangements in accordance with IGAP in 2007/08 as required by the Department of Health and by Monitor and the chief executive completed a declaration in February 2008. There were no serious untoward incidents involving breeches of confidentiality in 2008/09.

In 2008/09, the trust conducted an assessment of its information governance arrangements using the Department of Health's information governance toolkit (IGT). The results of this assessment confirmed that the trust had continued to improve its governance rating.

During the year, the trust continued to ensure that it complied with equality, diversity and human rights legislation. The board of directors received an annual report in September 2008, that provided assurance on this important aspect of its work.

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

The board of directors also reviews the economy, efficiency and the effectiveness of the use of resources through a number of monitoring processes. As well as the monthly EPRs, the executive team reviews the success of operational management through regular performance management meetings and there are regular reports to the board of directors on progress against cost, and latterly, productivity improvement programmes (PIPs).

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.

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, the EMB plans to address weaknesses and ensure continuous improvement of the system are in place.

I have also been advised by the following processes:

- Regular review by the board of directors of the assurance framework;
- 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;

- Consideration of board of directors agendas, papers and the quarterly assurance framework updates that provide me with evidence of the effectiveness of controls;
- Attendance and debate at the EMB and other committees of the board of directors;
- Attendance at performance management meetings where the performance of the operational divisions is regularly monitored;
- The outcome of visits, reports and assessments of external independent agencies including:

    - Retention of NHSLA standard 1 for acute services in February 2008 and for Maternity Services in October 2006;
    - Compliance with the Standards for Better Health in April 2009;
    - Maintenance of Improving Working Lives Practice + status;
    - 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;
    - A positive outcome from the work that was undertaken in 2008/09 with the department of health's infection control support team

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 director's 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 EMB in ensuring a comprehensive and coherent framework of risk management that integrates clinical, non clinical and corporate governance and provides a strategic direction for this important work;
- 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

There has been one significant internal control issue identified between 1 April 2008 and 31 March 2009, relating to the failure to meet the MRSA reduction target.

Signed…….. **Date: 5th June 2009**
Chief Executive
(on behalf of the Board)