Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report & Accounts

2010-11

Incorporating the Quality Report 2010/11

Excellence as standard

Sheffield Teaching Hospitals NHS Foundation Trust Annual Report and Accounts 2010-11 incorporating the Annual Quality Report 2010-11

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

Contents

Welcome

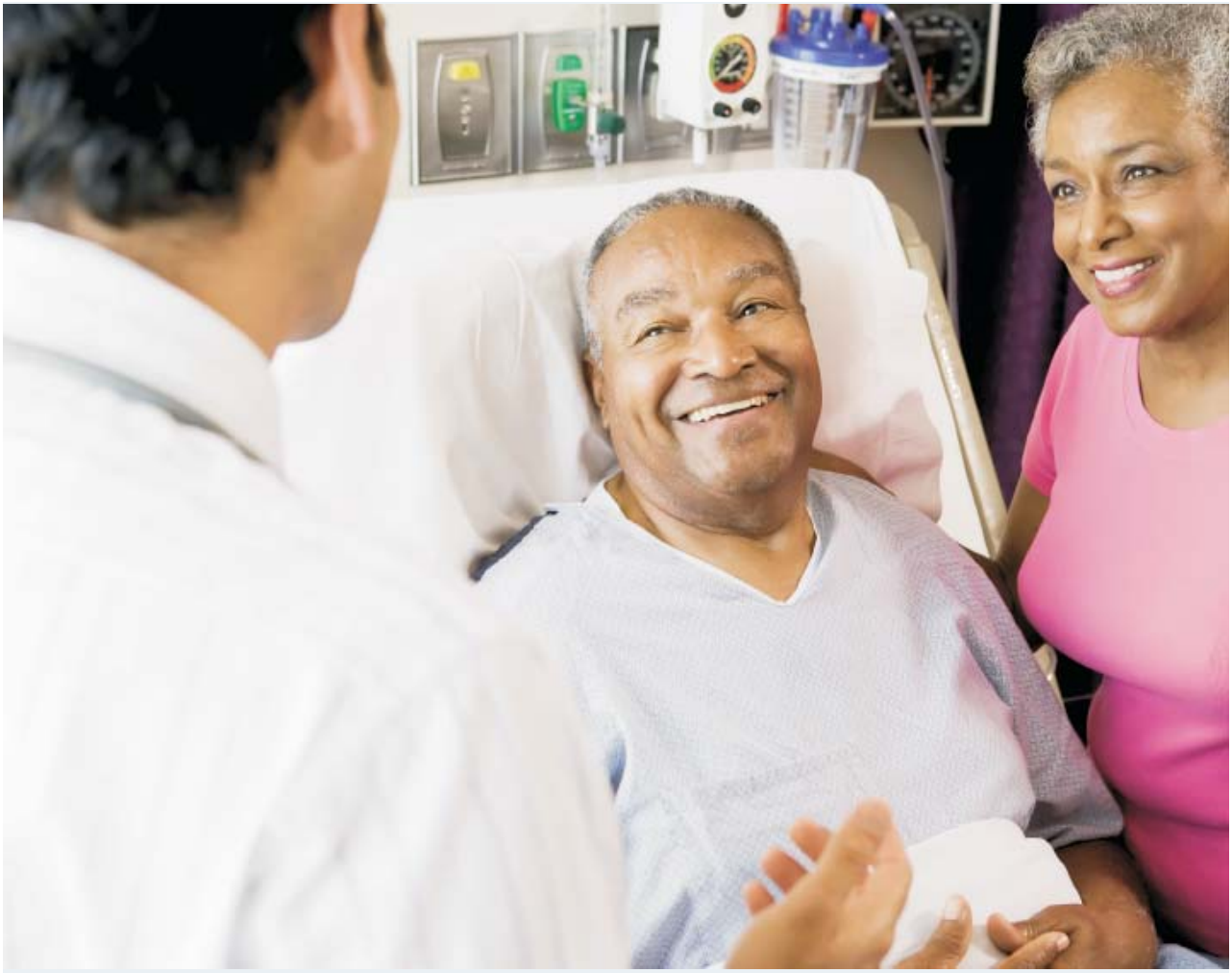
High quality care for all

As one of the largest and most consistently high performing NHS foundation trusts in the country, Sheffield Teaching Hospitals continues to offer some of the best care available in today's NHS providing high quality, value for money services at all of its five hospitals:

- Northern General
- Royal Hallamshire
- Weston Park
- Jessop Wing
- Charles Clifford Dental Hospital

Among the largest employers in the region, Sheffield Teaching Hospitals employs around 14,200 talented and dedicated people who continually strive to enhance the patient experience and improve clinical outcomes to meet the needs of the local, regional and national population that we serve.

During this year the Trust has carried out 281,898 inpatient episodes and day cases and 978,668 outpatient appointments totalling over 1.2 million patient episodes. Each year we build on our vision and priorities to ensure we provide high quality health services to our patients and create an environment where staff are empowered to explore new, creative ways of working for the benefit of patients.



Introduction

Once again it has been a successful year which culminated in services being further improved in the areas which really matter to patients. This includes safety, quality of care, waiting times, cleanliness of our hospitals and how responsive we are to our patients' differing needs. The results of the 2010/11 national NHS Inpatient Survey placed Sheffield Teaching Hospitals in the top 20% of NHS Trusts for patient satisfaction. This was achieved, not least, through the dedication and determination of all our staff to improve patient care, whilst at the same time working hard to ensure that the services offered represent value for money.

During the year we have driven down waiting times to an all time low albeit the national target of 18 weeks from referral to treatment has been challenging. In 2010/11 we have gone a step further and a high proportion of our patients were treated within 6-8 weeks.

Despite sustained pressure particularly around the rising number of emergency admissions, the Trust has continued to produce an impressive array of developments and achievements within an environment of testing financial demands.

Infection prevention and control continued to be one of our highest priorities during the year, which is reflected in a continued excellent performance in this area. We are one of the most successful teaching trusts in the country in preventing healthcare associated infections like MRSA.

In 2010-11 we completed a major reorganisation of clinical services in the Trust to ensure that we provided the 'right care, in the right place, at the right time' which would ensure we provided the best service to patients in the most efficient way possible. As a result, some services have moved across the city: for example, stroke services are now centralised at the Royal Hallamshire Hospital providing a gold standard service, whilst certain types of surgery are now based at the Northern General Hospital. This was a large and complex undertaking which was designed to ensure that we are able to put in place the organisational linkages that have to exist between different specialties to ensure a safe and effective service. We also introduced Hospital at Night at the Royal Hallamshire Hospital and many services including therapy services began to operate a more comprehensive 7 day service to further improve efficiency and meet patients' expectations.

The Year to View chapter on the following pages gives a snapshot of how patients are benefiting from these new developments and other improvements in healthcare services.

THE NHS CONSTITUTION
the NHS belongs to us all

Financial constraints will affect all areas of public service in 2011-12 and the NHS and Sheffield Teaching Hospitals are no exception. However we have an excellent financial track record and we are fortunate to employ some of

the best healthcare professionals in the NHS who continually innovate and look for ways to improve the way we deliver services.

The 'Right care, right time, right place' plan has been developed over the last year to carefully manage the financial challenge ahead. The principle is that if we can provide the right care, in the right place (primary care, hospital or in the community) at the right time and without delays, then this will help us to be as efficient as possible and provide a good standard of care and positive experience for our patients.

2011/12 will also be a significant year for another reason. As part of the national Transforming Community Services programme, Adult Community Services, that were part of NHS Sheffield, will become part of Sheffield Teaching Hospitals NHS Foundation Trust from 1st April 2011.

The integration of community services with acute hospital services is a unique and exciting opportunity for us to come together and harness the skills and expertise of both acute and community staff to begin to develop new ways of delivering services for the patients we serve. We have an opportunity to really tailor services to the needs of our patients and create a seamless journey without some of the delays and bureaucracy which can occur between organisations currently.

By working alongside GPs and community teams, we also have the opportunity to prevent some of the admissions to hospital which are not always clinically necessary by developing appropriate primary care or community support closer to their own home. We will also continue developing integrated care pathways to improve the management of long term conditions and developing new and formal partnerships in academia, research and commercial enterprise. The latter will ensure that Sheffield Teaching Hospitals stays well and truly on the map when it comes to research, education and innovation.

Finally we are very proud of all our staff and volunteers for their tremendous achievements, which are the basis for this organisation's success and for the excellent quality of care provided to patients. All our staff work above and beyond the call of duty to ensure that the needs of our patients are at the core of everything we do.

We are also very fortunate to be supported by some exceptional charities for which we are very grateful and we would like to take this opportunity to thank each and every one of them for their continued support.

Our foundation status enabled us to work even closer with our local community throughout the year through our membership and Governors' Council. We have increasing numbers of people attracted to foundation trust membership and the work of the Governors is making a positive impact on services with representation on many of our committees and boards.

The Trust considers the NHS Constitution as a guiding light in its relationship with staff and patients. It provides the foundation for both the letter and the spirit of the relationship with both staff and patients. Much of the work undertaken on staff engagement and improving the patient experience in 2010/11 has been designed to support the delivery of the NHS Constitution.

We continue to go from strength to strength as an organisation. However our ultimate goal is to ensure that without exception our patients receive excellent clinical outcomes, that their experience of our services is as convenient and personal as possible, and that our staff feel committed and can give of their best.

We will do this by focusing on 'quality outcomes' and by undertaking top quality teaching and research.

David Stone CBE
Chairman

Sir Andrew Cash OBE
Chief Executive

Year in View 2010 - 2011

We have had an exciting year during 2010/11 which has seen some amazing developments in the care and facilities we can offer to our patients. The following pages are a small snapshot of the improvements and initiatives which have taken place at Sheffield Teaching Hospitals over the past 12 months.

April 2010

Unique brain injury service

Harry Coleshill has recovered from a near fatal head injury thanks to a new specialist brain injury service.

Harry, 69, suffered a severe bang to his head after falling outside his home in Sheffield. He was taken to the Northern General Hospital for treatment where medical staff originally feared his injuries were so bad that they would prove fatal. However, thanks to the expertise of the hospital's new specialist brain injury team, Harry made an excellent recovery and is back at home enjoying his retirement. The brain injury team is a unique service in the UK. The team uses the different skills of specialists to provide a high standard of treatment to patients suffering head injuries. Consultant Rajiv Singh who leads the Brain Injury Team explains how Harry's treatment and diagnosis was a perfect example of how the new service helps people. He said:

"Head injuries are one of the most common causes of A&E attendance. This new unified team approach really does ensure that patients are getting the best possible service."

Brain injury patient Harry Coleshill and his family

May 2010

World class Cystic Fibrosis unit opens

A world class treatment centre designed especially for young people suffering from Cystic Fibrosis opened at the Northern General Hospital.

The state-of-the-art Centre was made possible thanks to £1million raised by the Sheffield Hospitals Charitable Trust's Cystic Fibrosis Appeal and a donation from The Cystic Fibrosis Trust.

Dr Frank Edenborough, Consultant Physician explains why the centre is so important:

"Rigorous infection control measures are particularly important for people with Cystic Fibrosis as they suffer from chest infections which can be very contagious to other people with the disease. Patients must therefore be isolated from one another in hospital which can create boredom. The new facility has been designed to cater to these specific needs in a 'home from home' environment and includes new 'bedrooms' with en-suite facilities. The rooms include a computer, TV, Wii and XBox to enable patients to continue their education or work, keep in touch with friends and alleviate boredom during hospital stays. The new Unit is the only one of its kind in the area and treats patients from as far afield as Grimsby and Buxton."

Management commentary

June 2010

Royal treatment for heart attack patient

Trisha Evans, who suffered a heart attack while cleaning her home, praised the Cardiothoracic Centre for treating her 'like a princess.'

Trisha, 60, was taken to the Centre at the Northern General Hospital where she received the new gold standard Primary Angioplasty Service. The service provides a faster and more effective way for patients to receive the treatment they need when they have suffered a heart attack. A catheter is inserted to inject dye to outline the coronary arteries under X-ray conditions. The blocked artery is then opened up by passing a small balloon inside the catheter and opening the blockage so blood flow can be restored. Trisha said she was amazed with the speed of her treatment and appealed for people in the region to continue to support the good work of the Hospital's Cardiothoracic Centre by raising funds for the South Yorkshire Heart Appeal which was launched by Deputy Prime Minister Nick Clegg. The appeal raises funds to help reduce the odds of death from heart disease and ensure the people of South Yorkshire and beyond continue to receive the very best in specialist medical care.

Peter Lunn, 70, who suffered for years from increasing shortness of breath and tiredness, was another patient who benefited from the Centre. Peter can now breathe easily, thanks to the team at the Cardiac Rhythm Management Service. Peter is just one of many patients who gave the service, which investigates irregular heart rhythms and offers treatment, the thumbs up in a patient satisfaction survey.

Left: Deputy Prime Minister Nick Clegg meets patients at the Cardiac Centre.

July 2010

Check up shows Hospitals are in 'good' shape

Once again, the Trust scored highly in the annual inspection of food, cleanliness, infection control and patient environment. The Patient Environment Action Team, which assesses standards of cleanliness and food in every NHS healthcare site in England, rated the Trust 'Good' for Environment, 'Good' for Food and 'Good' for Privacy and Dignity.

A range of new initiatives was implemented in 2010 to help to improve the Hospital environment even further. For example artwork is now displayed throughout the hospitals to create a more welcoming setting.

The Trust is also working to improve patients' privacy and dignity by improving theatre wear and virtually eliminating mixed sex accommodation. Hilary Chapman, Chief Nurse/Chief Operating Officer, explains: *"Respecting our patients' privacy and dignity is one of our top priorities. I am delighted we are in a position to be able to reassure our patients that that they will be treated in areas where there are only patients of the same sex, unless there are exceptional circumstances. Patients can also expect to have access to toilets and bathrooms which are close to their bed and designated male or female."*

Year in View 2010 - 2011

August 2010

We care about customer care

A new customer care guide, which has been developed in partnership with patients and staff, was launched as part of an ongoing commitment to ensure patients and visitors get the very best service.

The Commitment to Customer Care guide sets out 10 core standards to ensure the same level of service is delivered to every patient, relative, visitor and colleague that reception staff encounter. The guide shows the Trust's ongoing commitment to making sure visitors to its hospitals get the best possible service from the moment they walk in.

Paula Rickwood, Reception Supervisor, explained the importance of giving the right impression. She said: "I firmly believe customer service is just as important when visiting a hospital as it is when visiting a five star hotel, everyone likes to feel special wherever they are. Receptions are often where patients will have their first personal contact with the hospital, and this first impression can play a key role in how they feel during the rest of their visit or indeed treatment. Many people often visit the hospital at a time when they are worried or anxious and so we have a duty to make sure they are welcomed and feel at ease right from the start.

September 2010

New stroke service praised for quality of care

A detailed review by the Care Quality Commission of stroke services across the UK highlighted Sheffield as being above the national average for supporting patients in coping with life after stroke.

Amanda Jones, Nurse Consultant for stroke care said: "We want to ensure patients who have suffered a stroke receive the highest standard of care from the moment they call the ambulance, during their treatment in Hospital and right through to their rehabilitation in the community." As part of this care, patients who suffer a stroke are now treated at a new centre of excellence at the Royal Hallamshire Hospital. Research has found that people in stroke units have a 25% higher survival rate than those treated in general wards, so the facility is potentially life-saving for people in Sheffield and the surrounding areas.

The new service has also improved the management of 'mini strokes' - Transient Ischaemic Attacks (stroke symptoms which disappear usually within minutes or hours), as many of these patients go on to suffer a full blown stroke. Patients are investigated and assessed by the specialists and started on the appropriate medications within 24 hours. Stroke patients have also praised the Trust's Complex Spasticity Clinic. The Clinic offers specialist treatment physiotherapy to allow patients to regain movement and independence after suffering a stroke.

Management commentary

October 2010

HIV Patient showed support for new home sampling scheme

Mugwagwa, a HIV patient from Sheffield's African community, encouraged others to take part in an innovative pilot HIV testing scheme after receiving excellent care from the Trust's Communicable Diseases department.

The free and confidential scheme was one of a number of initiatives to encourage people in the city to get tested for HIV.

Mugwagwa said: *"I decided to have a HIV test in 2002 after I came across an article that had information offering testing at the Royal Hallamshire Hospital's Genito-Urinary Medicine clinic. I had no symptoms, but had been married twice and was single again. A positive result did not shock me. I did not feel bad or miserable because I knew I was in the best place."*

Dr Christine Bowman, adds *"Throughout the city we are involved in a variety of approaches to HIV testing for many different communities. Diagnosing HIV in the early stages can really help people to enjoy long and relatively healthy lives."*

Communicable Diseases also took part in the city wide Sexual Health Week to raise awareness of Sexually Transmitted Infections, offered testing for Hepatitis in a city centre road show and embarked on a marketing campaign to promote the department's Travel Clinic - which offers advice and vaccinations to those travelling abroad.

Ray Poll, Nurse Consultant with Patient at Hepatitis Road show

Students from Tapton School
visit the Hand Centre with local artist Joe Scarborough

November 2010

£7m developments in surgery services ensure patients get the best care

Hot on the heels of changes which saw the creation of new stroke and heart attack services for the City, a series of new developments costing around £7 million opened as part of the second phase of changes happening at the Trust.

They included a new assessment unit for emergency surgical patients and a new hand unit and a state-of-the art burns unit all at the Northern General Hospital where most general surgical emergencies and major operating takes place. The new Surgical Assessment Unit opened very close to the A&E department to allow emergency patients who may need admission for surgical reasons to be assessed by specialists in the new unit rather than automatically being admitted to a ward. The new hand unit provides purpose designed facilities for those needing surgery on the hand and lower arm and the follow up care after the operation. The burns unit has been completely re-designed for adults with a burn injury and offers state-of-the-art accommodation for those needing this specialist care.

Mike Richmond, Medical Director, said: *"These new developments are part of our ongoing commitment to provide the best possible care for our patients."*

Year in View 2010 - 2011

December 2010

Meningitis victim gives gift of life

Four families were able to spend Christmas with a loved one they would have lost thanks to Jenna Higgins' ultimate gift.

The 25-year-old from America, was studying in Sheffield when she sadly died after contracting Meningitis. Jenna's parents were told the heart-breaking news at home in America and rushed to get the next available plane to see their only child. Her Mum, Betty Higgins, said: "*When I spoke to the doctor and he told us Jenna was brain dead, we immediately told him we wanted Jenna to be a donor. It wasn't just the fact that Jenna was on the organ donation register, it was also due to her kind and generous nature that made my husband and I know organ donation was what she would have wanted too.*"

As well as three other people, Jenna was able to save the life of a 13 year old boy by donating her liver. If he hadn't received the transplant, he would have died within the next 24 - 48 hours. Sally Snowden, Specialist Nurse, Organ Donation, said: "*Jenna's amazing gift to help others after her death has saved the lives of 4 people".* During 2010/11 a new poster campaign was launched by the Trust to encourage more people to sign up to the donor register.

January 2011

10 years of miracles at Jessop Wing

Kelly Derbyshire celebrated the New Year with her baby boy after a ground-breaking operation at the Jessop Wing Women's hospital that saved his life.

Kelly, 32, is just one of thousands of mums who understand why the Care Quality Commission's comprehensive review of NHS maternity services found that Jessop Wing delivered excellent care.

Kelly was over the moon to hold her baby, Junior, because just months earlier an ultrasound scan had revealed problems so severe that doctors feared he would not survive birth without pioneering surgery. Mr Saurabh Gandhi, Obstetric Consultant performed EXIT (Ex-utero Intrapartus Treatment), a form of foetal surgery, which had only been performed once before in Sheffield. Proud mum Kelly said: *"We were given fantastic care from the run up to the birth, during the operation and right through baby Junior's time on the intensive care unit. I feel so lucky to have Junior after knowing the odds were against him surviving."*

Management commentary

February 2011

Innovative service good for patients and NHS

John Hemingway, 20, is just one of hundreds of patients who have benefited from the innovative Outpatient and Home Parenteral Antibiotic Therapy (OHPAT) service.

The service, which is the biggest of its kind in the UK, allows patients to self-administer the intravenous drugs they need to combat infection in their own homes rather than spending weeks in hospital. In 2010 alone, it saved 3700 bed days which were able to be used by other patients.

Not only has the service received excellent feedback from patients, it has also reduced hospital acquired infections and saved the NHS thousands of pounds which can be spent on additional healthcare services. John, who recently underwent a bone marrow transplant, needed intravenous antibiotics for an infection in the six weeks before his treatment. He was therefore delighted to be able to spend time with his family, friends and girlfriend before his intensive treatment started. He said: *"If it wasn't for the service, I would have had to spend those six weeks in hospital which can be quite depressing and frustrating when you feel relatively well. It was particularly good as it allowed me to go on a special trip to London with my girlfriend."* The service regularly welcomes visiting staff from other hospitals all around the country to share the good practice which has been developed.

March 2011

Better than average outcomes for colorectal surgery patients

Patients undergoing colorectal surgery at Sheffield Teaching Hospitals have better than average outcomes according to a report by the National Cancer Intelligence Network (NCIN).

Mr Shwan Amin, Lead for Colorectal Cancer and Consultant Surgeon, said:

"The Sheffield Colorectal Unit deals with approximately 400 colon and rectal cancers in a year. The 30 day Mortality rate following surgery for colorectal cancer in Sheffield is 5.6% which is the lowest in the region and well below the national average.

This is in spite of the large volume of patients many with complex problems referred from other centres."

This is testament to the skilled health professionals who are constantly working to further improve the quality of care in our hospitals."

Survival rates for many other surgical procedures performed at Sheffield Teaching Hospitals are also rated as being better than the national average. The mortality rate for Sheffield Teaching Hospitals is 92.3 compared to the national average of 100.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Our commitment to high quality healthcare

Quality Report 2010-11

Foreword

This Quality Report describes the service quality improvement initiatives that we plan to achieve in 2011-12, and reports on those undertaken in 2010-11. It also reviews the quality of the services provided by the Trust, and includes comments from our main commissioning Primary Care Trust (NHS Sheffield), the Sheffield Local Involvement Network (LINk) and the Sheffield Health and Community Care Scrutiny Committee of Sheffield City Council.

Although this is a Trust report that is intended for patients and the public, some parts have to be written in the way required by Monitor, (the Independent Regulator of Foundation Trusts), and the Department of Health. We have tried to make the report as user friendly as we can, but we are required to report some sections in a particular way. Inevitably a report that describes specialist health services will have to use some words, phrases and abbreviations that are not familiar to the general reader. We have therefore included a Glossary to explain the specialist terminology at the back of this Annual Report.

We hope that this Quality Report tells you what you want to know about the services provided by Sheffield Teaching Hospitals NHS Foundation Trust.

If you have any comments on the content of the Quality Report, or how it is written, please contact Mrs. Sandi Carman, Head of Patient and Healthcare Governance, on 0114 2266486.

Introduction from the Board

We are pleased to introduce the Sheffield Teaching Hospitals NHS Foundation Trust Quality Report for 2010-11, which describes progress with the service quality improvements undertaken in 2010-11, and outlines further improvements to be undertaken in the year 2011-12.

We will build on the significant progress we have made with quality improvements in the past year and continue to use the discussions, decisions and actions that lead to the production of our Quality Reports to influence our service quality improvement programme in the coming year.

We are confident that the quality improvement priorities we have chosen for the next year will not only strengthen the excellent clinical care we deliver but will also improve the wider experience for patients and carers, and ensure that the Trust remains one of the best Teaching Hospitals in the UK.

Financial constraints will affect all areas of public service in 2011-12 and the NHS and Sheffield Teaching Hospitals are no exception but we will not allow that to interfere with the quality improvement programme that is outlined in this Report.

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the Commissioners dated 5 May 2011
  - Feedback from Governors dated 20 May 2011
  - Feedback from LINks dated 6 May 2011
  - Feedback from the Overview and Scrutiny Committee dated 27 March 2011
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29 November 2010
  - The 2010 national patient survey dated April 2011
  - The 2010 national staff survey dated March 2011
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2011
  - CQC quality and risk profiles dated March 2011
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

David Stone CBE
Chairman

Sir Andrew Cash OBE
Chief Executive

Introduction from the Medical Director

The Quality Report has to be useful and informative for patients and the public, and is therefore based on consultation and discussion. In order to compile this Report, we have consulted widely on which quality improvement priorities we should adopt for 2011-12, and what changes need to be made to the Report to make it more informative and useful to the reader. Some of the priorities that were identified for improvement last year are to be continued in 2011-12.

The process of agreeing on the Trust's Quality Improvement Programme and the production of this Report began in Summer 2010, with an initial meeting of the Trust staff who were to be involved. Preliminary consultation meetings followed, with representatives of NHS Sheffield, the Local Involvement Network, Sheffield Health and Community Care Scrutiny Committee and Trust Governors. The Quality Report Project Team was established in September 2010, under my chairmanship. The Team comprises the Trust staff who put the Report together, Trust managers and clinicians who can provide information and advice about the services being described, and representatives from the Trust Governors.

The remit of the Project Team is to decide on the content of the Quality Report and to ensure that the Trust quality improvement programme described in the Report is practical and achievable, and addresses matters relating to patient safety, the effectiveness of clinical treatment and patient experience. The Team also has to make sure that the Report meets the standards in the Department of Health Quality Report Toolkit 2010-11, formal Monitor reporting requirements, and External Auditor's recommendations, as well as taking account of the comments and opinions from external and internal parties.

The content of this year's Quality Report and the priorities for improvement in 2011-12 were agreed at the Project Team meeting on the 8th October 2010. Governors, clinicians and staff were invited to suggest areas for improvement for the next year. Each of the suggested areas were discussed in terms of benefits to patient safety, clinical effectiveness and patient experience and how they might complement national and local quality initiatives. After a lively discussion, the priorities were agreed. The Team has also ensured that the quality improvement and performance information in Part 3 of the Report matches national and local standards that have been set, (for example, by the Care Quality Commission or the NHS Operating Framework) and are agreed with NHS Sheffield, who are our main Commissioners. The 2009-10 Quality Report was reviewed by the External Auditors, who made a number of helpful recommendations about its content and structure. We have taken account of those recommendations, and held further consultations with outside partner organisations in early 2011, to finalise the content of this Report, which will also be reviewed by the External Auditors.

The priorities proposed for 2011-12 were agreed by the Trust Board of Directors. The final draft of the Quality Report was sent to external partner organisations for final agreement on the 1 April 2011, in readiness for the publishing deadline of 8th June 2011.

Professor Mike Richmond
Medical Director

Agreed priorities for improvement in 2011-12

This section describes the quality improvement priorities that have been adopted for 2011-12. These have been agreed by the Quality Report Project Team after discussion with patients, clinicians, governors and commissioners, and were approved by the Trust Board of Directors on 16 March 2011.

Progress on these priorities will be reported to the Trust Executive Group (TEG) at least four times per year.

Some of these are a continuation of priorities that were identified in the 2009-10 Quality Report, for improvement in 2010-11, as the work to deliver them is still underway. Where this is the case, a report on 2010-11 progress is combined with commentary on the objectives for 2011-12. The priorities cover 3 domains of quality: patient safety, the effectiveness of treatment and patient experience.

The Trust considers Equality, Diversity and Human Rights in every aspect of what it does and regards Equality, Diversity and Human Rights as essential when considering the delivery of high quality services. In 2011-12 one of the key areas the Trust will focus on is improving care for older people. This will incorporate taking account of older people's needs in accessing some services, ensuring respect and dignity, and ensuring older people benefit from good nutrition. Older people come from a range of communities and the Trust will take this into account when taking forward this work. The Trust publishes an Equality and Human Rights report each year and also describes its work in these areas in the Annual Report.

The quality improvement priorities for the year 2011-12 are:-

1. Improving the care received by older people using our services

2. Improving the diagnosis and treatment of venous thromboembolism

3. Reducing hospital acquired infection

4. Continued improvement in stroke care services

5. Reducing the number of operations cancelled for non-clinical reasons

Priority 1

Improving the care received by older people using our services

What we plan to do: We plan to improve the care received by older people using our services. We will pay particular attention to nutritional assessment, the prevention and treatment of hospital acquired pressure ulcers and the care of people with dementia.

Why: there is a rapidly expanding population of older people. Evidence in national reports and feedback from patients, interest groups, charities and professional bodies, indicates that we need to check that our care of older people is of the highest standard. We will identify areas where we can to further improve, and make the changes necessary to deliver continued improvements.

Nutritional Assessment

How to improve the service: as a first step in improving the quality of nutrition for older people using our services, we will increase the number of people who are screened or assessed for nutritional requirements within 48 hours of admission, and increase the number who are re-assessed and have an appropriate care plan, after having been identified by the screening or assessment process as being at risk.

How to measure progress: by using existing practice as a baseline. Internal surveys in the Trust show that currently 65% of patients who are aged 65 or over receive a Malnutrition Universal Screening Tool (MUST) screening on admission, and of those who were identified as being at risk, 51% went on to receive an appropriate care plan. We will continue to review progress throughout the year with the use of the MUST tool, through the Nutritional Steering Group. We will also conduct surveys throughout the year to measure the number of screenings, assessments and re-assessments and appropriate care plans, and compare them to the baseline. If there has been no improvement, we will take action to address the areas of concern through the Nutritional Steering Group.

In addition, a research team is testing two methods to improve the quality of inpatients nutritional care. Working with the ward teams they have produced action plans and will share good practice across the Trust. The research team is part of the Collaborative Leadership in Applied Health Research and Care (CLAHRC) in South Yorkshire.

Outcome: we have set a target of 70% for screening and 60% for assessment in 2011-12

Pressure Ulcers

Pressure ulcers are caused by many factors such as unrelieved pressure, friction, or temperature. Although often prevented and treatable if found early, they can be very difficult to prevent in frail elderly patients, wheelchair users (especially where spinal injury is involved) and terminally ill patients.

How to improve the service: by reducing the number of patients who develop pressure ulcers whilst in hospital

How to measure progress: by using the current situation as a baseline. From July to September 2010 there were 89 cases of pressure ulcers above Grade 2 severity. We have already agreed with NHS Sheffield a 10% reduction as a target for the period January - March of 2010-11 - i.e. 80 cases only. We will monitor this throughout the year to measure the number of

cases of hospital acquired pressure ulcers at Grade 2 or above. If there has been no improvement, we will alert the Tissue Viability team and the managers of the wards concerned so that they can take remedial actions.

Outcome: We have set a target of a 10% reduction for 2011-12.

Dementia Care Pathway

How to improve the service: We will design and implement a new multi-professional Care Pathway for patients with Dementia. This will take into account the needs of the patient and their carers, and where appropriate, will include working with other appropriate care providers, for example social care and voluntary sector organisations. The Dementia care pathway will be supported by a dedicated training programme for staff. We aim to roll out this new care pathway by September 2011

How to measure progress: As part of the development of the Care Pathway, we will define suitable standards for the care of patients with dementia, and establish an audit programme to measure our achievement of those standards.

Outcome: We expect to see our services meeting or exceeding the standards set.

Who:
Executive Director Lead:
Nutrition and Pressure Ulcers:
Professor Hilary Chapman, Chief Nurse and Chief Operating Officer

Dementia Care:
Professor Mike Richmond, Medical Director

Programme Leads:
Nutritional Assessment:
Dr Sam Debbage and Ms Becky McGeehan, Professional and Practice Development Leads

Pressure Ulcers:
Mr Chris Morley, Deputy Chief Nurse

Dementia Care:
Dr Chris Austin, Consultant Physician

Priority 2

Improving the diagnosis and treatment of venous thromboembolism

A venous thrombosis is a blood clot that forms in a vein. If a piece of a blood clot formed in a vein breaks off it can be transported to the heart, and from there into the lungs. A piece of a clot that is transported in this way is an embolism and can cause death. The process of forming a clot that becomes embolic is called a thromboembolism.

What we plan to do: reduce the risk of patients developing a venous thromboembolism (VTE), and increase the number of patients who are subsequently given appropriate preventative treatment if they have been identified as being at a high risk of developing a VTE relating to an episode of hospital care or treatment which potentially could be prevented.

From a low baseline we have seen significant improvements in the number of relevant patients who have received a VTE risk assessment, in the last quarter of the year this increased to 89.5%

Why: Despite improvements in diagnosis and treatment, a number of patients still die each year as a result of VTE.

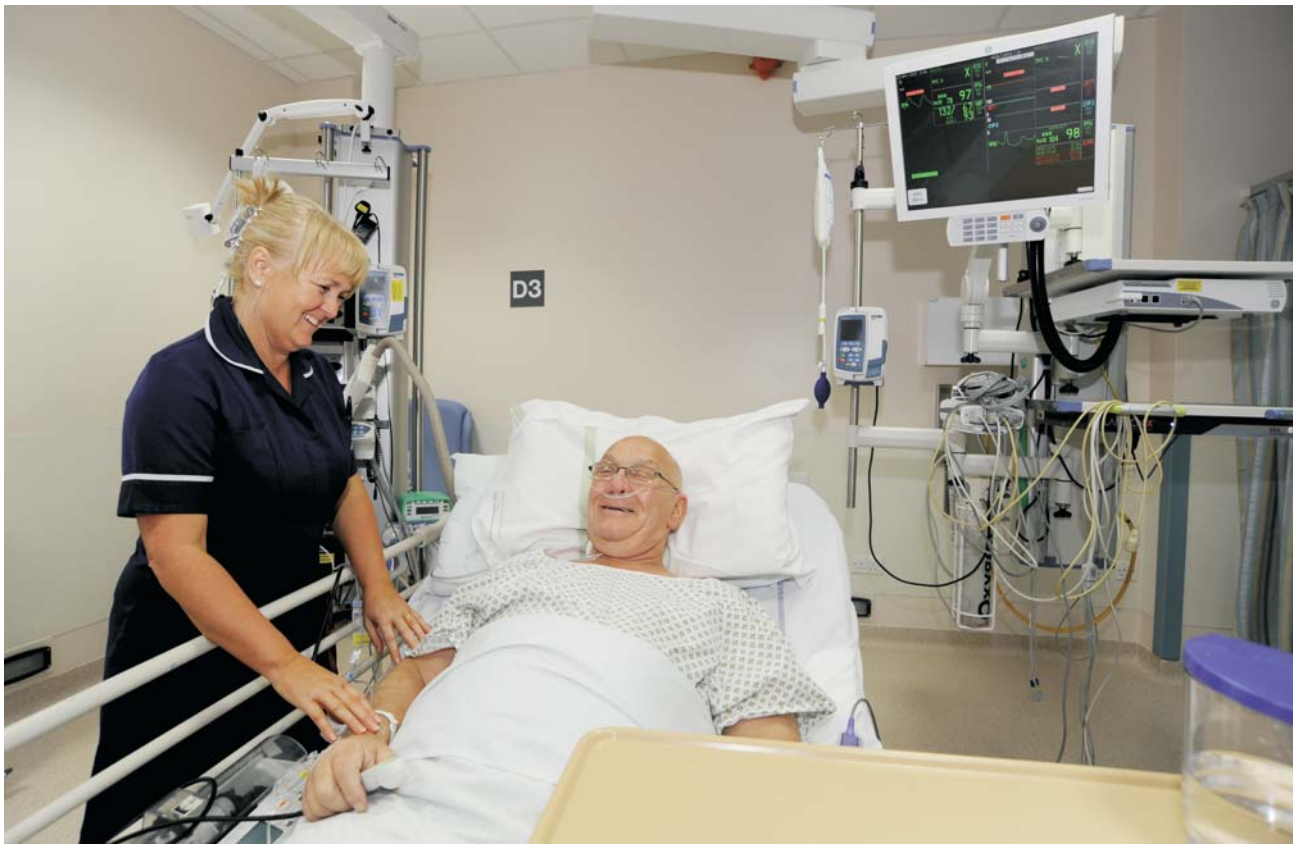
How: The establishment of improved risk assessment and screening procedures, and follow up actions, such as medication or pressure stockings.

Outcome: Our target is that at least 95% of patients who have been identified as requiring treatment to prevent thromboembolism receive preventative treatment.

Who:

Executive Director Lead:
Professor Mike Richmond, Medical Director,

Programme Lead:
Dr Rhona Maclean, Consultant Haematologist



Priority 3

Reducing hospital acquired infection

Reducing the incidence of hospital acquired Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections, and Clostridium Difficile (C Diff), has been carried over as Quality Report priorities from 2010-11 into 2011-12.

In addition, we are now for the first time required by the Department of Health to monitor the number of cases of Meticillin Sensitive Staphylococcus Aureus (MSSA).

MSSA is a common bacteria which is carried by approximately one third of the population. It is a common cause of infections in the community and in hospital and can cause boils, skin infections and blood stream infections.

We therefore plan to achieve a further reduction in the incidence of hospital acquired MRSA and C Diff, and to monitor the number of cases of MSSA in order to understand its incidence and the steps we may take to reduce it.

Why: reducing the number of infections acquired when in hospital continues to be a high priority for our patients, their carers and our staff.

What have we done: during 2010-11 the Trust undertook a wide range of activities which have contributed to the continued reduction in healthcare associated infection generally and the rate of MRSA bacteraemia and the number of cases of C.diff infection in particular. In addition to the expected activity, the Trust diagnosed and cared for a large number of patients with influenza and diarrhoea and vomiting caused by Norovirus (see explanatory note). This activity reflected that in the community and was similar to that seen across the UK.

In addition to continuing with our established infection prevention and control activities, the following initiatives were introduced:

- We have continued to update the Trust Infection Control Accreditation scheme. This is an annual check that wards and departments are achieving high standards of infection prevention and control practice and cleanliness. We have added new standards for drug preparation areas, storage areas and mattresses. In addition, the system for recording and feeding back audit results has been streamlined.

- We have used new testing technology to optimise cleaning schedules and protocols. This allows the operator to detect otherwise invisible deposits on an item, which could indicate that optimal cleaning has not taken place.
- We have introduced a new pathway to rapidly identify patients with possible norovirus infection helping to minimise spread to other patients
- We have developed and rolled out a computer based Infection Prevention and Control learning programme for all staff
- We have extended our data collection to include blood stream infection caused by Staphylococcus Aureus and E.coli
- We have introduced a different method for preparing the skin prior to the insertion of intravenous cannulae and the taking of blood cultures.
- We have developed posters displaying ward based infection prevention and control information to be placed at ward entrances
- We have worked with colleagues in the primary care sector to optimise the care of patients with MRSA and Clostridium difficile in the community

How: overall, rigorous infection prevention and control measures are essential to reduce the number of infections and keep it as low as possible.

MSSA

What - Monitor the number of Trust attributable (see explanatory note) cases of MSSA bloodstream infections. The first data collection started in January 2011 with 9 Trust attributable cases in that month.

How - we will collect information on cases of Trust attributable MSSA bloodstream infection, examine the information collected and devise methods of reducing the number of cases.

How to measure progress - We will review the data each month and look for trends. Once national data is available we will compare ourselves with other similar Trusts

Outcome - this work will contribute to a formal reduction target to be set for April 2012

MRSA

What - Maintain or reduce the number of MRSA Trust attributable blood stream infections when compared to 2010-11 figures.

How to measure progress - by comparison with 2010-11 figures

Outcome - In 2010-11 there were 9 cases attributed to Sheffield Teaching Hospitals. We plan to maintain this low level of cases and not exceed 10 cases for 2011-12.

Clostridium Difficile

What - Achieve a year on year reduction in the number of cases of Trust attributable Clostridium difficile.

How to measure progress - By comparison with 2010-11 figures

Outcome - In 2010-11 there were 184 cases attributed to Sheffield Teaching Hospitals. We plan to reduce this to 134 cases for 2011-12.

Explanatory note on the classification "Trust attributable."

Episodes of Hospital Acquired Infection are designated as "Trust attributable" by using the Department of Health definitions for each type of infection. For the episode to be classified as Trust attributable, the sample containing the organism has to be taken more than 48 hours after admission for MSSA and MRSA blood stream infections, and more than 72 hours after admission for Clostridium difficile infections.

Explanatory note on Norovirus (The winter vomiting bug)

In the comments from external organisations in the 2009-10 Quality Account, we were asked why Norovirus was not included in the hospital acquired infections that we aimed to reduce.

Norovirus is problematic to the Trust and disrupts the normal running of our services. It is easily transmitted in hospital. However, it is very different from other hospital acquired infections in that it is also easily spread in other institutions where there is a high concentration of people; for example, schools, nursing and residential homes, colleges, cruise ships. The amount of Norovirus that we see in the Trust will reflect the amount that is circulating in the community. This means that if there is a high incidence of Norovirus in the wider community, there will also be a high incidence in hospitals. We are awaiting further guidance on the management of Norovirus from the Department of Health, but it is recognised that this is very difficult to control in a hospital , as we cannot close the facility. It is therefore not practical to include it in our priorities as an infection that we can control and reduce by internal procedures, in the way that we can for other infections such as MRSA and C.Difficile.

Who:

Executive Director Lead:
Professor Hilary Chapman,
Chief Nurse/Chief Operating Officer

Programme Lead:
Dr Christine Bates, Consultant Microbiologist and Clinical Lead for Infection Control

Priority 4

Continued improvement in stroke care services

What are we planning to do: ensure that 95% of patients admitted with a stroke spend at least 90% of their inpatient stay on the specialist stroke unit. This priority is carried over from 2010-11. (The current Department of Health target for stroke patients' stay is that 80% of patients admitted with a diagnosis of stroke should spend at least 90% of their inpatient stay on a specialist stroke unit)

What have we done: during 2010-11 the Trust completed a major reorganisation of Stroke Services, which resulted in all stroke services being centralised in a dedicated Stroke Unit in the Royal Hallamshire Hospital, run by specialised nursing, medical and therapy staff. This has resulted in a significantly improved treatment pathway for stroke patients. The Unit has 79 dedicated stroke beds, with an hyper-acute stroke unit, acute stroke unit and specialist rehabilitation unit. The service has also initiated high risk TIA ("mini-stroke") clinics for patients to be seen within 24 hours. From July to October 2010, 94.8% of stroke patients spent 90% of their inpatient stay on the Stroke Unit, which is a dramatic improvement since the centralisation of the service to the Royal Hallamshire Hospital site.

Why: although stroke care services were a priority for improvement in last year's quality account, the Trust and the Quality Report Project Team felt it was important to ensure the improvement was maintained and the service should continue as a priority for improvement in 2011-12.

How: the service has already been reorganised. This was described in the 2009-10 Quality Account and is summarised above in "What we have done". In addition, a new procedure has been developed with local Ambulance services, that will bring stroke patients directly to the RHH, where they will immediately be triaged by stroke nurse specialists.

How to measure progress: by collecting the Department of Health Vital Signs Quality Standards that apply to stroke services, and the Accelerating Stroke improvement measures, developed by the National Stroke Team.

Outcome: we expect the stroke service at least to achieve the Vital Signs Quality Standard of ensuring that over 80% of patients spend at least 90% of their time on a stroke unit, and that high risk TIAs are assessed and investigated within 24 hours.

Who:

Executive Director Lead:
Professor Mike Richmond, Medical Director

Programme Lead: Ms Amanda Jones, Stroke Nurse Consultant and Clinical Lead for Stroke Services

Priority 5

To improve the patient experience by reducing the number of operations cancelled for non clinical reasons

What we are we planning to do: achieve a year on year reduction in the number of operations cancelled on the day of surgery for non-clinical reasons.

Why: cancelled operations were raised as a significant concern during the Quality Report consultation exercise. The Trust recognises that altering a planned surgery date is inconvenient, is often very upsetting for the patient and can impact on a patient's experience. This was set by NHS Sheffield as a Commissioning for Quality and Innovation (CQUINS) target in 2010-2011.

How: we will monitor the cancellation rates and the reasons given on a continuous basis. This will enable us to investigate specific situations and wider areas of concern with the departments concerned, to ensure that the reasons for the cancellations are resolved, or prevented from happening again.

Baseline:
768 cancellations in 2010-11

Outcome:
Overall in year reduction.

Who:
Executive Director Lead:
Professor Hilary Chapman, Chief Nurse/ Chief Operating Officer

Programme Lead:
Mr Richard Parker, Deputy Chief Operating Officer

Part 3: Review of Services in 2010-11

This part of the Quality Report reviews the Trust's quality performance in the year 2010-11. There are three sections:

1. A brief report on the quality improvement priorities that were listed in the 2009-10 Quality Account for achievement in 2010-11, that have not already been reported on.

2. A table of quality performance information that gives an overall view of the quality performance of the Trust in 2010-11.

3. A response to comments that were made by our external partner organisations in our discussions about the 2009-10 Quality Report, that have not already been addressed in the preceding sections.

3.1 Quality Improvements in the 2009-10 Quality Account

The following priorities were identified in 2009-10 Quality Account for achievement in 2010-11:

Final rollout of the Primary Percutaneous Coronary Intervention (PPCI) service for heart attack patients.

During 2009-10 the PPCI (see glossary) Service was extended to cover the populations of Rotherham, Barnsley, Doncaster and North Nottinghamshire. The final stage of the service rollout to North Derbyshire took place in April 2010. From April 2010 to the end of March 2011, 646 patients came to Sheffield Teaching Hospitals for consideration of PPCI. Of these 627 had PPCI completed.

The national standard for "door to balloon" time for PPCI is that 75% of patients should be treated in less than 90mins: our current percentage of patients meeting the standard is 84.1%.

The national standard for "call to balloon" time for PPCI is that 75% of patients should be treated in less than 150mins: our current percentage of patients meeting the standard is 72.8%.

Improving notification to patients of waiting times in Outpatients.

In the 2009-10 Quality Account, we reported that the Trust scored below the national average in respect of outpatients waiting for longer that they were told, or not being told how long their wait would be. The main improvement initiative identified for achievement in 2010-11 was the development of a new set of guidelines and standards for customer care in Outpatient Departments.

The Trust's new "Commitment to Customer Care Guide" is now complete and will be available on the Trust website. It has been developed by staff, patients, carers, and Governors in collaboration with the Institute of Customer Service. The guide will be officially launched in April 2011 and sets out core and supporting standards which will be implemented across all receptions from May 2011. The standards include notifying and keeping patients informed of current waiting times.

The guide is supported by a programme of customer service training workshops which will be provided for all reception staff during 2011 and a customer care toolkit which will be made available to all areas across the Trust.

Prior to the development of the standards a "mystery shopping" exercise of reception areas was carried out, which indicated that in some instances, only 10% of patients were informed of waiting times. The exercise will be repeated during November and December 2011, following implementation of the standards, so that changes and improvements can be monitored.

Following implementation of the standards in reception areas, they will be adapted and rolled out to other staff groups.

To keep our patients safe by making sure we reduce any potential risks of serious incidents occurring, for example wrong site surgery or medication errors.

In the 2009-10 Quality Account, we reported that the Patient Safety Board would continue to develop and manage a number of patient safety initiatives in 2010-11. These have been identified through learning from experiences in the Trust, and from other health organisations, as follows:-

- **Reducing infections in Intensive Care Units:** standards shown to improve care have been introduced in the intensive care units in the Trust. Newly introduced care bundle compliance in July 2010 - 90%.

- **Introducing and monitoring the use of the Safer Surgery checklist:** the Safer Surgery Checklist is a World Health Organisation initiative to improve the safety of patients undergoing operations. We introduced this procedure in 2010-11. The checklist is applied by the theatre staff before an operation begins. Monitoring the application of the checklist has shown that its use has led to a marked decrease in untoward theatre incidents. Average number of incidents per month reduced from 4.5 in 2009/10 to 2.5 in 2010/11

- **Safety for diabetic patients:** this work relates to procedures concerned with the administration of insulin. It was recently shortlisted for a national patient safety award after the Sheffield Teaching Hospital's team reduced the number of insulin medication incidents. Number of harm events in 2010/11 reduced by 63%. The Diabetes Inpatient team was awarded the BMJ 2011 Group award for Best Improvement in Quality and Safety for this work.

- **Preventing blood clots:** risk assessment documentation has been introduced and must be completed for all inpatients by medical staff. This is part of the overall objective to improve the management of VTEs in the Trust that is described in the section of this Report about our quality improvement objectives for 2011-12.

- **Procedures for patients taking anti-coagulant medication:** we are developing procedures for patients being discharged who have to take anti-coagulant medication. These are designed to improve communications with GPs and introduce a medication checklist for the patient and staff to complete before discharge. This initiative is still being developed.

- **Procedures for patients who become seriously unwell:** we have introduced new operational procedures for clinical staff to follow when a patient becomes seriously unwell. The new procedures have been tested in selected locations prior to application in all appropriate areas throughout the Trust. Medical attendance within 30 minutes to an unwell patient has improved from 60 to 90% on the pilot wards.

- **Procedures for patients with a reduced immune system:** this work, for cancer patients with infections, has reduced the time between assessment and receipt of antibiotics. 70% of acutely ill patients are prescribed and administered IV antibiotics within one hour (previously 45%).

- **Preventing falls:** we have identified a number of reasons for patients' falls and have introduced procedures to reduce them. Care bundle introduced in May 2010 for patients at risk of falls on pilot wards. Care bundle compliance has risen from 65% to 90%.

Part 3: Review of Services in 2010-11

3. 2. Table of quality performance information

Measure of quality performance "M" indicates a Monitor standard	2008-09	2009-10	2010-11
Never Events: STHFT occurrence (Patient Safety Indicator) 'Never Events' are serious, largely preventable patient safety incidents that should not occur if available preventative measures have been implemented. An example is wrong site surgery. The Trust has reported two never events in 2010-11, both of which relate to retained swabs which were subsequently located and removed. The relevant policies have been revised and changes to practice made to avoid a recurrence. The data source for this indicator is the National Patient Safety Agency	0	0	2
Hospital Standard Mortality Ratio (HSMR) (Patient Safety Indicator) **Sheffield Teaching Hospitals performance** **National Benchmark** Mortality, or death rates, are calculated using the number of deaths at a hospital trust compared with the number of patients who would be expected to die, taking into account age, complexity of illness, deprivation and sex. The baseline for England is set at 100. An HSMR figure lower than 100 indicates that fewer patients died than expected; a figure higher than 100 means that more patients died than expected. Sheffield Teaching Hospitals death rate is significantly below the national average. The data source for this indicator is: Hospital Episode Statistics (HES) **Note that because of the national decline in death rates, Dr Foster and the Department of Health reset the average each year. The confirmed reset value for STHFT in 2009/10 is 92.3, which has been rated in the Dr Foster Good Hospital Guide 2010 as "significantly low". STHFT was one of only 26 hospitals in England who retained a significantly low HSMR.**	90.8% 100.0%	92.3% 100.0%	91.0% 100.0%
Percentage of patients who were readmitted to hospital (Effectiveness Indicator) **Sheffield Teaching Hospitals performance**	6.5%	6.5%	6.8%
Percentage of hip replacements we do in the trust that are revisions (Effectiveness Indicator) **Sheffield Teaching Hospitals performance**	24.5%	24.6%	22.1%

Measure of quality performance "M" indicates a Monitor standard	2008-09	2009-10	2010-11
Percentage of patients that would recommend our hospitals to a relative or friend (Patient Experience Indicator):			
Sheffield Hospitals: yes definitely	**71%**	**69.6%**	**74.5%**
yes probably	**23.8%**	**22.6%**	**16.6%**
Total	**94.8%**	**92.2%**	**91.1%**
National Average: yes definitely			**67.2**
yes probably			**24.9**
total			**91.8%**
The data source is the CQC In Patient Survey			
Staff Survey (Quality Indicator)			
Sheffield Teaching Hospitals Performance	**-**	**3.63**	**3.55**
National Benchmark	**-**	**3.64**	**3.62**
The staff engagement score is an overall measure from our staff survey, which is particularly important given that the main area of our complaints relate to poor care or attitude by staff and poor communication. It was only developed in 2009 and thus data for previous years is not available. It is a summary score with 1 being poorly engaged staff and 5 being highly engaged staff.			
The data source for this indicator is the CQC staff survey.			
Percentage of patients who spent less than 4 hours waiting in A&E. (M)			
Sheffield Hospitals performance	**97.8%**	**98.3%**	**97.6%**
National Standard	**98.0%**	**98.0%**	**95.0%**
The data source for this indicator is a local data collection system that feeds the national Quarterly Monitoring Accident and Emergency return.			
Clostridium difficile year on year reduction (M)			
Trust attributable cases in Sheffield Teaching Hospitals	**267**	**202**	**184**
Sheffield Teaching Hospitals target	**446**	**375**	**304**

Measure of quality performance "M" indicates a Monitor standard	2008-09	2009-10	2010-11
Reducing the number of MRSA blood stream infections (Patient Safety Indicator) (M)			
Trust attributable cases in Sheffield Teaching Hospitals	**24**	**16**	**9**
Sheffield Teaching Hospitals Targets	**36**	**32**	**13**
All of the figures are entered onto MESS (Mandatory Electronic Surveillance System) and reported via the HCAI Data Capture System, Administered by the Health Protection Agency (HPA).			
Screening for all elective inpatients from MRSA (Patient Safety Indicator)			
Sheffield Teaching Hospitals Performance	**-**	**-**	**100%**
National Benchmark	**-**	**-**	**100%**
The Trust has a comprehensive policy which details all aspects of MRSA screening, decolonisation, treatment and management and this is updated regularly to reflect changes to national screening policies. The trust technically exceeded the target and therefore overachieved the 100%.			
This is a new standard in 2010/11			
Percentage of patients needing to be admitted to hospital who waited less than 18 weeks from referral to hospital to treatment (Patient Experience Indicator) (M)			
Sheffield Teaching Hospitals achievement	**91.1%**	**90.0%**	**93.0%**
National Standard	**90.0%**	**90.0%**	**90.0%**
The data source for this indicator is the national returns we fill out from our local systems.			
Percentage of patients who do not need to be admitted to hospital who waited less than 18 weeks from GP referral to hospital treatment (Patient Experience Indicator) (M)			
Sheffield Teaching Hospitals achievement	**96.8%**	**97.0%**	**98.0%**
National Standard	**95.0%**	**95.0%**	**95.0%**
The data source for this indicator is the national returns we fill out from our local systems			
Percentage of patients who waited less than 31 days from diagnosis to receiving their treatment for cancer (Patient Experience Indicator) (M)			
Sheffield Teaching Hospitals achievement	**100%**	**98%**	**97%**
National Standard	**98%**	**96%**	**96%**
The data source for this indicator is the Exeter national cancer waiting times database. Going Further on Cancer waiting times guidance was nationally reviewed and resulted in revised thresholds which necessitated a redefining of the national standard (this also relates to the 62 day target)			

Measure of quality performance "M" indicates a Monitor standard	2008-09	2009-10	2010-11
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer. (Patient Experience Indicator) (M)			
Sheffield Teaching Hospitals achievement	95.0%	87.0%	86.0%
National Standard	95.0%	85.0%	85.0%
The data source for this indicator is the Exeter national cancer waiting times database.			
Percentage of patients who received thrombolysis treatment within the recommended time of 60 minutes. (Effectiveness Indicator) (M)	No cases referred	No cases referred	No cases referred
Note that this measure has now been replaced by the percentage of patients who received Primary Percutaneous Coronary Intervention within 150 minutes of calling for help.			
Sheffield Teaching Hospitals achievement	N/A	N/A	72.8%
National Standard	N/A	N/A	75.0%
The data source for this information is the MINAP audit.			
Percentage of patients who waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis. (Patient Experience Indicator) (M)			
Sheffield Teaching Hospitals achievement	100%	93.0%	93.0%
National Standard	100%	93.0%	93.0%
The data source for this indicator is the Exeter national cancer waiting times database.			

3. 3. Explanatory responses to the comments made by external organisations in the 2009-10 Quality Account.

The LINk, NHS Sheffield and the Sheffield City Council Health Scrutiny Committee commented in the 2009-10 Quality Account on the following issues:

- Pharmacy Services for outpatients and patients being discharged
- Single Sex Accommodation

Pharmacy services

There was concern that patients were waiting too long to get their prescriptions once they had been told they were being discharged, and that the re-location of Outpatient Pharmacy to C Floor of the tower block at the Hallamshire was inconvenient for patients attending the Outpatient building.

The time taken to receive medications to take home, once discharge has been agreed, is an area identified for improvement in the national in-patient survey of 2009, with 69% of patients whose discharge was delayed stating that waiting for medicines was the reason for the delay. This issue has been examined by the Pharmacy management and Trust Discharge Teams.

Although patients waiting for their discharge medication often assume that the pharmacy is the source of any delay, there are many factors that contribute to difficulties in obtaining discharge medication, and the Trust is examining the whole process. We are currently testing

a computer system that includes patient discharge planning information, so that more discharge prescriptions can be prepared in advance. The Trust has also invested in electronic prescription tracking systems in the two main dispensaries at the Northern General and Royal Hallamshire Hospitals to assist the pharmacy in managing the dispensing workload, and these have the added advantage of allowing ward nursing staff to see when their patients' prescriptions are ready.

Discharge prescription turnaround times at both hospitals have already fallen by more than 10% since 2009-10. Further improvements to IT systems are underway so that within the next 12 months the use of electronic discharge summaries will help all our medical, nursing and pharmacy staff to speed up the process of medication supply.

We acknowledge that the relocation of the Outpatients Department pharmacy has impacted on the out-patient experience, but it was necessary to allow a much-needed expansion of the Eye Department outpatient services and reduce the congestion in a very busy clinic. At the same time, the Trust invested in a new prescription tracking system and an automated dispensing system for the main pharmacy to help the pharmacy improve efficiency.

We recognise that waiting time is an issue for our outpatients. Many outpatient prescriptions are complex, requiring specialist medication and additional clinical checks, but the pharmacy is currently dispensing outpatient prescriptions in an average of 22 minutes per prescription item, and 98% of prescriptions are completed in under an hour. We are working hard to reduce waiting times even further by investigating the possibility of reducing hospital waiting time to zero for some patients, by arranging home delivery for selected specialist medications, or by referring non-urgent, non-specialist treatment back to GPs.

Single Sex Accommodation.

The Trust recognises the importance of protecting patients' privacy and dignity by providing care in single sex accommodation. We declared compliance with the guidance on eliminating mixed sex accommodation in March 2010 and have recently confirmed compliance against the updated guidance provided in the Department of Health letter, 'Eliminating Mixed Sex Accommodation'.

As part of the process to assess compliance with the updated guidance, a self assessment was undertaken leading to the production of an action plan. compliance with eliminating mixed sex accommodation was discussed by the Trust Board of Directors on 16 March 2011. Breaches of the guidance are formally captured and reported to NHS Sheffield monthly. Patients' perceptions of compliance with delivering same sex accommodation are surveyed and reported to the Patient Experience Committee each month. The areas identified in the report are visited to check the arrangements in place to support patents' privacy and dignity.

In some circumstances it is necessary to place patients in mixed sex accomodation to enable them to receive highly specialised care. As a tertiary centre, Sheffield Teaching Hospitals provides a number of such specialised services: for example, Neurosciences, Cardiac Services, Spinal Injuries and dialysis. As such, it may be that more patients experience care in a mixed sex environment than they would do in smaller, less specialised Trusts.

In summary, Sheffield Teaching Hospitals is committed to providing care to patients that protects their privacy and dignity by using single sex accommodation, except where the need for highly specialised care takes precedence.

Formal statements on Sheffield Teaching Hospitals NHS Foundation Trust services

This section contains formal statements on the following services and standards in Sheffield Teaching Hospitals NHS Foundation Trust. These are required by Monitor and the Department of Health.

- Services provided
- Clinical Audit
- Research
- Care Quality Commission Registration
- Commissioning for Quality and Innovation Indicators (CQUINS)
- Data Quality standards

The wording of these statements, and the information items required, are set by Monitor and the Department of Health. Every Foundation Trust has to include these statements in its Quality Report and has to use the same wording. Each Trust completes the statements with its own information. Using the same words and the same information items in all Quality Reports enables a reader to make a direct comparison between different Trusts for these particular services and standards .

Services provided

During 2010-11 Sheffield Teaching Hospitals NHS Foundation Trust provided or subcontracted general hospital services locally, tertiary services regionally and certain specialist services nationally. The Board of Directors has reviewed all the data available to them on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2010-11 represents 100% of the total income generated (£654.4m) from the provision of NHS services by Sheffield Teaching Hospitals for 2010-11.

Clinical Audit

During 2010-11, 43 national clinical audits and 2 national Confidential Enquiries covered NHS Services that Sheffield Teaching Hospitals provides.

During that period, Sheffield Teaching Hospitals participated in 98% national Clinical Audits and 100% national Confidential Enquiries of the national clinical audits and national Confidential Enquiries, which it was eligible to participate in.

The national Clinical Audits and national Confidential Enquiries that Sheffield Teaching Hospitals participated in during 2010-11 are also shown in Table 1 as follows:

Table 1

Audits & Confidential Enquiries	Participation	% Cases Submitted
Peri- and Neonatal		
Perinatal mortality confidential enquiry (CEMACE)	Yes	100% (81/81)
Neonatal intensive and special care (NNAP)	Yes	100% (784 /784)
Children		
British Thoracic Society:Paediatric pneumonia	N/A	N/A
British Thoracic Society: Paediatric asthma	N/A	N/A
College of Emergency Medicine: Paediatric fever	N/A	N/A
RCHP Childhood epilepsy	N/A	N/A
PICANet: Paediatric intensive care	N/A	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes (Adults)	100% (27 / 27)
RCPH: Diabetes	N/A	N/A

NB Some audits are listed as not applicable (N/A) as these services are not provided by Sheffield Teaching Hospitals

Audits & Confidential Enquiries	Participation	% Cases Submitted
Acute Care		
Emergency use of oxygen (British Thoracic Society)	Yes	100% (78/78)
Adult community acquired pneumonia (British Thoracic Society)	Yes	Ends 31.05.11
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Ends 31.05.11
Pleural procedures (British Thoracic Society)	Yes	100 % (45/40)
Cardiac arrest (National Cardiac Arrest Audit)	No	0
Vital signs in majors (College of Emergency Medicine)	Yes	100% (50/50)
Adult critical care (Case Mix Programme)	Yes	100% (1137/1137)
Potential donor audit (NHS Blood & Transplant)	Yes	Data not yet available
NCEPOD confidential enquiry	Yes	100% (176/176)*
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	99.9% (5420/5424)
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Started 02/02/11
Chronic pain (National Pain Audit)	Yes	Started 01.03.11
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	Ends 30.08.11
Parkinson's disease (National Parkinson's Audit)	Yes	23% (9/40)*
COPD (British Thoracic Society/European Audit)	Yes	116% (58/50)
Adult asthma (British Thoracic Society)	Yes	100% (63/63)
Bronchiectasis (British Thoracic Society)	Yes	100% (40/40)
Elective procedures		
Hip, knee & ankle replacements (National Joint Registry)	Yes	98% (1240/1264)
Elective Surgery (National PROMs Programme)	Yes	73% (3271/4456)*
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	Yes	100% (105/105)
NHSBT UK Registry: Liver Transplant	N/A	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	100% (1609/1609)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	47% (236/505)*
Carotid Interventions (Carotid Intervention Audit)	Yes	89% (77/87)
CABG and valvular surgery (Adult cardiac surgery audit)	Yes	100% (1057/1057)
Cardiovascular disease		
Familial hypercholesterolemia (National Clinical Audit of Mgt of FH)	Yes	100% (45/40)
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100% (1537/1537)*
Heart Failure (Heart Failure Audit)	Yes	50% (498/1005)
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	100% (503 /503)
Acute Stroke (SINAP)	Yes	100% (93/93)*
Stroke Care (National Sentinel Stoke Audit)	Yes	100% (93/93)

Audits & Confidential Enquiries	Participation	% Cases Submitted
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	100% (1403/1403)
Renal transplantation (NHSBT UK Transplant Registry)	Yes	100% (63/63)
Patient transport (National Kidney Care Audit)	Yes	100% (550/550)
Renal colic (College of Emergency Medicine)	Yes	100% (50/50)
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	94% (451/480)
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	97% (311/320)*
Head and neck cancer (DAHNO)	Yes	86% (105/122)*
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	69% (471/681)
Severe trauma (Trauma Audit & Research Network)	Yes	100% (52/52)*
Falls & non-hip fractures (National Falls & Bone Health Audit)	Yes	100% (60/60)
Psychological Conditions		
National Audit of Psychological Therapies; depression; anxiety	N/A	N/A
POMH: Prescribing in mental health services	N/A	N/A
NAS: National Audit of Schizophrenia	N/A	N/A
Blood transfusion		
O negative blood use (National Comparative Audit of Blood Transfusion)	Yes	71.3% (57 /80)
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	100% (40/40)

Please note the following:
Data for projects marked with an asterisk* require further validation. Where data is provided these are best estimates at the time of compilation, however, data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June and therefore final figures may change.

British Thoracic Society (BTS) Audits: where the BTS did not state the number of cases to be submitted, the Trust discussed expected sample sizes with BTS and submitted according to their advice.

Parkinsons UK Audit: data submitted for a six week period rather than the full four months. 21% of participating Trusts submitted less than 10 cases.

SINAP: the Trust commenced submission for patients discharged from 21/02/11 and this represents one month of data only.

TARN: the data does not reflect a full year as the Trust commenced participation in Autumn 2010.

The Trust did not participate in the National Cardiac Arrest Audit because the Trust Resuscitation Committee decided that it would not be of sufficient value.

The Trust was eligible to participate in the following additional national audits on the National Programme not elsewhere reported in the Quality Report 2010-11.

Table 1

Audits	Participation	% Cases Submitted
National Audit of Dementia (RCPCH)	Yes	100% (80/80)
Vascular access (National Kidney Care Audit)	Yes	100% (67/67)
Continence Audit (RCP)	Yes	100% (114/80)
Cardiac Rhythm Management	Yes	100% (995/995)

The national Clinical Audits and national Confidential Enquiries that Sheffield Teaching Hospitals participated in, and for which data collection was completed during 2010/11, are listed above in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 16 national clinical audits were reviewed by the Trust in 2010/11. Seven of these reports were reviewed by committees of the Board and nine were reviewed by senior teams in the clinical area. Sheffield Teaching Hospitals intends to take a number of actions to improve the quality of healthcare provided. Three examples of which are included below.

Heart Failure Audit 2010

Following the results of the Heart Failure Improvement Review in 2006 some of the STHFT Heart Failure Service pathways were redesigned and a new diagnostic pathway was introduced in January 2009. The latest results of the national Heart Failure Audit 2010 indicate that these changes have improved the Heart Failure Service. For example, prescribing of ß-blockers locally is 75% compared with a national level of 55%. This has improved from 34% in 2006.

BTS National Asthma 2010

Care of patients admitted with an acute asthma attack should reflect BTS guidelines to ensure best practice. This is the second BTS National Asthma Audit and STHFT has participated in both. Comparison of the STHFT 2010 data with the national 2010 data and a comparison with 2009 and 2010 results has identified improvements and has made the following recommendations;

- Improve monitoring during acute treatment phase - measure peak flow regardless of pre-or post bronchodilation
- Need to continue to improve prescribing and administering systemic corticosteroids promptly
- Improve the documentation of the checking of the inhaler technique with advice
- Ensure discharged on ICS inhaler & oral corticosteroids
- Use of Asthma Action Plan
- Arrange follow up with GP practice at 48 hours

NCEPOD - 'A Mixed Bag: Use of Total Parenteral Nutrition'.

NCEPOD's purpose is to assist in maintaining and improving standards of medical and surgical care by reviewing the management of patients, by undertaking confidential surveys, and by maintaining and improving the quality of patient care. They produce reports across a broad range of topics and provide their own recommendations for healthcare providers to consider. One such report was 'A Mixed Bag: Use of Total Parenteral Nutrition' (PN).

A number of recommendations were made, some of which are listed below with current position or action to be taken:

- PN should only be given when enteral nutrition has been considered, and excluded, as either inappropriate and/or impracticable. However situations may arise where both enteral and parenteral nutrition are necessary.
  The STH 'Nutrition Handbook' has information on nutrition screening and care pathway, enteral tube feeding and parenteral nutrition. All staff can access the information and protocols from the STH intranet website. All patients referred for PN are reviewed by a dietitian.
- Regular documented biochemical monitoring should be mandatory to ensure avoidable metabolic complications never occur. The Nutrition Support Team (NST) has to contact biochemistry and request magnesium, chloride and bicarbonate separately. NST is working on a 'PN profile' which would streamline the process.
- Where the possibility exists that a patient may require PN this should be recognised early. Subsequently, should PN become a clinical necessity, this should be rapidly actioned and PN started at the earliest opportunity. However, there is rarely, if ever, an indication to start adult PN out of normal working hours.

Sheffield Teaching Hospitals endorse the use of the 'MUST', screening tool. It is the responsibility of nursing staff to refer patients who are at risk of malnutrition with a MUST score of 2 or more, to the dietitians.

The reports of 124 local clinical audits were reviewed by the provider in 2010/11 and Sheffield Teaching Hospitals intends to or has taken actions to improve the quality of healthcare provided. Some examples are:

Audit Compliance of NICE Clinical Guideline 64

Prophylaxis Against Infective Endocarditis (IE) In Patients Receiving Upper And Lower Gastrointestinal Tract Endoscopy

The aim of NICE guidance is to provide evidence-based recommendations to guide healthcare professionals in the appropriate care of people considered to be at risk of IE who may require antimicrobial prophylaxis before an interventional procedure. The objective of this audit was to measure current practice in antimicrobial prophylaxis against IE in adults undergoing interventional procedures against the recommendations in the guidance.

Audit Standard	Compliance
Patients should not be given antibiotic prophylaxis against IE when undergoing procedure of the upper and lower gastrointestinal tract where there is no evidence of infection.	99.98%

Conclusions:

The frequency with which antibiotic prophylaxis is prescribed prior to gastroscopy has reduced markedly since the publication of NICE clinical guideline 64. Antibiotics were only administered to one patient undergoing a simple gastroscopy in the post-NICE period audited and this patient was at particularly high risk of infective endocarditis. Overall, therefore, adherence to NICE clinical guideline 64 within Sheffield Teaching Hospitals was excellent. Involvement of NICE in the production of other guidelines relevant to infection control and antibiotic stewardship should be encouraged.

Audit of NICE Clinical Guideline 88 Low Back Pain (LBP)

The aims of the audit were to ascertain whether patients seen with LBP symptoms at Sheffield Teaching Hospitals musculoskeletal physiotherapy departments, were being treated in accordance with NICE Guideline 88.The objectives were to identify where there was non-adherence to the guidelines, identify why and ensure practice is altered accordingly.

Recommendations and Action Plan

Recommendation	Action
Dissemination of results	Feedback to Outpatient Physiotherapy teams at STH Therapy Services study day
Ensure all patients are screened for potentially serious pathology (Red Flags)	Teaching sessions with Outpatient musculoskeletal physiotherapists. Change in notekeeping
Ensure all patients are screened for potential likelihood of developing chronic pain (yellow flags)	Teaching sessions with Outpatient musculoskeletal physiotherapists Change in notekeeping
Every patient with LBP/ chronic LBP encouraged to 'stay active'.	Teaching sessions with Outpatient musculoskeletal physiotherapists. Change in notekeeping
Re-Audit CG88	Review 100 patient notes with LBP
Ensure Diagnostic triage is carried out if patients are not improving after 6 weeks	Implementation of a standard that all patients with LBP will undergo a further diagnostic triage at 6 weeks if they are not improving
Notes of spinal patients need to be filed separately in order to enable swift access for reports/audit/research	Implementation of new filing and 'sticker' system to identify spinal notes

Conclusion

The audit of the NICE CG88 has shown that the specific patient characteristics outlined in the guideline are not routinely encountered at STH physiotherapy departments. The application of the guideline remit to all patients seen with LBP has illustrated specific training requirements.

Clinical Research

Sheffield Teaching Hospitals continuing extensive involvement in Clinical Research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

The number of patients receiving NHS Services provided or subcontracted by Sheffield Teaching Hospitals in 2010-11 that were recruited during that period to participate in Research approved by a Research Ethics Committee was 8865.

Sheffield Teaching Hospitals NHS Foundation Trust was involved in conducting 718 Clinical Research Studies. STHFT used national systems to manage studies as required. Of the 220 studies given permission to start, all 220 were given permission by an authorised person less than 30 days from receipt of a valid complete application.

97% of relevant studies were established and managed under national model agreements. 16% of the 718 eligible Research studies required a Research Passport.

In 2010/11 the National Institute for Health Research (NIHR) supported 359 of these studies through its Research Networks.

Care Quality Commission registration

Sheffield Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'fully compliant'. Sheffield Teaching Hospitals had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals during the period 1 April 2010 to 31 March 2011.

The Trust has participated in the following special reviews by the Care Quality Commission:

a) 'Meeting the physical health needs of people with learning disabilities' and 'meeting the physical health needs of people with mental illnesses'. The outcomes of this review are awaited.

b) The Sheffield health and social care community was the subject of a review of its arrangements for Safeguarding Children and Looked after Children. Ofsted conducted the review, although the health aspects of this review were undertaken by the CQC. STH fully participated in this review but were not recommended to make any changes as a result of the review.

c) The CQC undertook a review of the Trust's compliance with Outcome 17: Complaints of the CQC essential standards of quality and safety. The key findings of the review were:

   Sheffield Teaching Hospitals NHS Foundation Trust has policies, procedures and various supporting processes to effectively lead and manage complaints.

   Evidence demonstrated effective complaints monitoring processes which also continually evaluate effectiveness of policy and procedure.

   The current processes have a clear focus on understanding the individual person's concerns and evidence showed lessons are learned and service improvement delivered as a result of comments, complaints and suggestions.

d) The Trust participated in the Dignity and Nutrition for Older People inspection programme. Following an unannounced visit on 23rd March 2011, the CQC requested the submission of additional documentation, and we now await the outcome of this review

Sheffield Teaching Hospitals has implemented a Compliance Framework designed to provide a mechanism to continuously monitor compliance with the 16 essential standards of quality and safety defined by CQC.

Central Alert System

The Central Alert System (CAS) provides feedback to the Department of Health (DH) to monitor progress of actions taken in healthcare organisations to comply with safety alerts.

There is a local CAS lead in each Clinical Group and Corporate Directorate who receive the alerts from CAS via the Trust lead and the STHFT in-house system. The in-house system has built-in time scales to ensure that DH deadlines are met.

A total of 188 alerts were received between January and December 2010. When benchmarked with other Trusts STHFT have a very good level of performance.

All 131 alerts which had a completion deadline in 2010 were completed and closed on time.

CQUIN Payment Framework

In 2010-11, 1.5% of our contract income, (approximately £9m) was conditional on achieving quality improvements and innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed quality improvement goals for 2010-11 and for the following 12 month period are available on request by emailing the Service Development Department at quality@sth.nhs.uk

Data Quality

Sheffield Teaching Hospitals submitted records during 2010-11 to the secondary uses service (SUS) for inclusion in the Hospital Episodes Statistics, which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

% for admitted patient care - 97.7%

% for outpatient care - 99.6 %

% for accident and emergency care - 97.4%

The percentage of records in the published data which included the patient's valid General Practitioner Registration code was:

% for admitted patient care 100%

% for outpatient care - 100%

% for accident and emergency care 100%

Sheffield Teaching Hospitals Information Governance Assessment Report overall score for 2010-11 was Level 2 and was graded green

Sheffield Teaching Hospitals will be taking the following actions to improve data quality:

1. A Data Quality Policy has been produced and went through the necessary ratification processes in January 2011.
2. A data quality group has been established. It includes representatives from each care group and will report to the Trust Information Governance Committee.
3. The group will

- Oversee the development and implementation of the Data Quality Policy
- Approve the data quality audit plan and receive the data quality audit reports
- Participate in the development of training to ensure high levels of data quality
- Agree the data quality improvement plan
- Ensure that all documentation for local systems is regularly reviewed and updated and monitor the effectiveness of these arrangements
- Ensure that data quality reports from external sources are reviewed with any necessary corrections being made.

Sheffield Teaching Hospitals was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (Clinical Coding) were:

Primary diagnosis incorrect - 23%

Secondary diagnosis incorrect - 28%

Primary procedures incorrect - 7%

Secondary procedures incorrect - 10%

- The results should not be extrapolated further than the actual sample audited
- Gastro-enterology, Chest Medicine, General Surgery and Care of the Elderly services were reviewed within the sample.

Comments on the 2010/11 Quality Report from the following external organisations:

- NHS Sheffield
- Local Involvement Network
- Sheffield Health and Community Care Scrutiny Committee
- Statement from Trust Governors

Statement From NHS Sheffield

We have reviewed the information provided by Sheffield Teaching Hospitals NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and gives a fair picture of the Trust's performance.

Our view is that Sheffield Teaching Hospitals NHS Foundation Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust achieves good results in national surveys of patient experience, its hospital standardised mortality ratio is low relative to national averages, and it has achieved significant reductions in MRSA and clostridium difficile.

Sheffield Teaching Hospitals provides a very wide range of general and specialised services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. Nonetheless, we believe that the specific priorities for 2011/12 which the Trust has highlighted in this report - care for older people, diagnosis and treatment of venous thromboembolism, reducing hospital acquired infection, improving stroke care and reducing the number of cancelled operations - are appropriate areas to target for continued improvement.

From our own knowledge of the Trust's services, we would highlight a number of further areas where there are specific challenges in 2011/12.

- Care in A&E. A new range of national indicators of clinical performance in A&E services have been introduced for 2011/12, and it will be important that the Trust gives priority to these. Complying with the 95% requirement for patients to be seen and treated within four hours remains a particular challenge.

- Waiting times in outpatient clinics. Elsewhere in this document, the Trust has reported on the action it has been taking during 2010/11 to improve communication with patients around waiting times in outpatient clinics. It will be very important that this action is seen through to a conclusion in 2011/12, with demonstrable improvements in patient experience.

- Communication with GPs. Under the CQUIN scheme for 2010/11, the Trust has improved the timeliness of outpatient clinic letters sent to GPs after a patient attends clinic. It will be a key priority for NHS Sheffield - and for GP commissioners in particular - that similar progress can be made during 2011/12 to improve both the timeliness and the content of letters sent by the Trust to GPs when a patient is discharged from inpatient care.

Sheffield Local Involvement Network Commentary

These comments refer to the Quality Report 2010-11

Sheffield LINk is pleased that one of the priorities for the year 2011/2012 is one we recommended last year "Improving the care received by older people using our services".

LINk undertook a recent enter and view visit to one of the Trust's sites specifically to observe the nutritional and personal care provided for older people while in hospital for surgical treatment. The recommendations LINk reported included specifics around nutrition, skin care and care plans that support staff to give the most appropriate person centred care these recommendations also fit with the priority above.

LINK recommend that in the next QA as part of the reporting on this priority the place that older people were discharged to (own home, intermediate care, permanent care residential/ nursing etc) is included, along with readmission data.

Very few trusts map quality to individual services provided and where they do, usually the quality of only one or a few services or specialties are reviewed this is true of this Trust. This is not surprising, given the wide range of services provided by the Trust, and the need to keep quality accounts to a readable length and format for a lay audience. However, this does highlight a key tension in quality accounts, between comprehensiveness of comment on the range of services provided on the one hand, and the length and complexity of the documents on the other. The key function of a Quality Account is to provide the lay person with understandable information by way of a dialogue.

We commend the Trust for their plan to produce an "easy read" version of the document and recommend that in

future years a draft of this is provided along with the draft QA in order that it can be read in conjunction with the "full" QA.

Data is not presented as performance over time and therefore it is difficult to be able to make comparison and evaluation of year on year performance. This is especially vital for choice to be made by the public as outlined in the legislation going through Parliament currently.

LINk recommend; The use of a separate column of a 'traffic-light', where performance is rated red (poor), amber (adequate or not particularly good) or green (good) this would be a way of providing a considerable amount of information with a clear indication of the level of performance. Traffic light indicators are widely used and could be easily incorporated into the Quality Account.

LINk also recommends; presenting the quality measures in context by telling a story and thus avoiding presenting a random assortment of indicators. It would be helpful to accompany all information with an explanation of whether it represents good or poor performance. Also to ensure that tables and graphs are constructed reliably and have clear titles and legends.
In order to present a balanced and representative picture of the quality of services, the Trust should highlight both positive and negative data.

Staff feedback, the views of staff are an important marker of an organisation's managerial competence, workforce well-being and hence its ability to deliver high-quality care. Staff views should be shown in the quality accounts. The CQC annual national surveys of NHS staff provide a readily available source of data on the views of NHS staff.

We would like to see information included on how many complaints there have been, how they were resolved and at what stage. This is very current in people's minds due to the recent Ombudsman report on services in hospital for the older patient.

In the dialogue that LINk engaged in prior to the compilation of this QA we specifically requested a summary of Patient Safety Alerts received during the year and the action taken on them. This information is not included in the draft we have seen.

Within "Agreed priorities for improvement in 2011/12" page 9 it states that "progress on these priorities will be reported to the Trust Executive Group at least four times per year". LINk requests that these reports are made publically available via your website. These can then contribute to the "ongoing dialogue" which is recommended within the guidance that the Trust undertakes with LINk and Scrutiny.

LINk agrees and supports the Trust in the other identified areas of priority.

Finally we state that Sheffield LINk accepts this QA as an honest account of the services provided by this Trust.

Mike Smith, Chair, Sheffield LINk
6th May 2011

Sheffield Health & Community Care Scrutiny Committee

Response to the Sheffield Teaching Hospitals Foundation Trust Quality Account April 2011

Sheffield's Health and Community Care Scrutiny Committee was pleased that the Trust, following feedback from last year, approached us early on in the Quality Accounts process, enabling us to be involved in the consultation on which quality priorities should be selected this year. We were glad that the Trust took on board our views in their final selection, particularly around cancelled operations, as this has been an issue the committee has had concerns over in the past. We were pleased that the Trust included responses to issues we raised in last year's Quality Account - on single sex accommodation and pharmacy services.

We would have found it useful if more comparative information had been included, particularly around priority 5 - reducing the number of cancelled operations. In future, we'd like to see patient, public and staff feedback incorporated in the Quality Account.

The key is ensuring that these priorities translate into improvements for patients, and we look forward to monitoring progress over the year. We hope that the Trust will make their quarterly progress reports to the Trust Executive Group available to us and members of the public to help us do this.

Statement from Trust Governors

Trust Governor representatives have been involved throughout the development of the 2010/11 Quality Report.

At the Trust Project Team meetings there were extensive discussions, feedback offered and accepted regarding the identification of priorities and changes in the presentation and formatting of the report, draft copies were also reviewed. Project Team meetings were held in October 2010, November 2010, December 2010, February 2011 and April 2011. Trust Governors were present at all of these meetings. Minutes are taken.

The quality indicator 'percentage of patients who are readmitted to hospital' was agreed for external assurance review by the Trust Governors' Council on 23 March 2011. The contents of the Quality Report 2010/11 are a fair reflection of the Trust's activity and service provision

Graham Thompson (Patient Governor)
20 May 2011

Independent Assurance Report to the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2010 to March 2011;
- Papers relating to Quality reported to the Board over the period April 2010 to March 2011;
- Feedback from NHS Sheffield dated 5 May 2011;
- Feedback from Governors dated 20 May 2011;
- Feedback from LINks dated 6 May 2011;
- The Trust's Healthcare Governance Committee Annual Complaints Report for 2009/10 dated 29 November 2010;
- The 2010 national patient survey;
- The 2010 national staff survey;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 26 May 2011; and
- Care Quality Commission quality and risk profiles dated March 2011.

I consider the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Governors' Council in reporting Sheffield Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Governors' Council to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Governors' Council as a body and Sheffield Teaching Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Damian Murray
Officer of the Audit Commission
3 Leeds City Office Park
Holbeck
Leeds LS11 5BD

27 May 2011

Improving our patients' experience

We are committed to delivering patient-focussed services that make a real difference to the care we provide. To help us achieve this, we take every opportunity to listen to what people say about current services and standards of care and to involve them in new developments.

Complaints and compliments also provide us with a valuable insight into the experience of patients at the Trust and enable us to make improvements to our services or to let staff know when they are providing an excellent service. Patients, their families and visitors are encouraged to share any concerns or suggestions they have with us so that their comments and suggestions can be investigated and responded to, and so that we can learn lessons from their experiences.

Committed to good customer Care

Our new 'Commitment to Customer Care' standards have recently been developed in partnership with patients, Governors, receptionists and the Institute for Customer Service. The standards, which are initially to be implemented across all reception desks, recognise the important role which receptions play in creating a positive first impression and putting patients and visitors at ease. Staff training workshops and a Customer Care Toolkit have been developed to help staff to put the new standards in place. A team of trained volunteers carried out a 'mystery shopping' exercise before the standards were implemented and the exercise will be repeated again later in the year to monitor the impact of the new standards. The standards have been welcomed by reception staff and, once implemented, they will be adapted for other staff groups and rolled out across the Trust.

Patient Experience Report

The Trust's new quarterly Patient Experience Report brings together all patient feedback including complaints, patient surveys, mystery shopping and website feedback. It presents different information in a variety of ways including graphs and charts, patient comments, and photographs. This enables us to see at a glance the things which patients most frequently comment on, where we are doing well and where we can make improvements. The report also provides information on new projects or actions we have taken to improve our services. In addition, one or two themes from each report are selected for more detailed analysis in the next report.

Ward Posters

A new poster has been designed which will be displayed on each ward from July 2011. Posters will be individual to each ward and will provide key information in a way which is clear and easy to understand. Information includes details of ward staff, ward visiting times, infection rates, cleaning schedules, patient feedback and how to make a comment or complaint. The posters have been designed in consultation with staff and patients and will be placed in a highly visible place on each ward. Posters will be updated every 3 months to ensure that the information is up-to-date.

Enhancing the Healing Environment

In January 2010 the Trust was proud to be selected to take part in the prestigious 'Enhancing the Healing Environment' scheme, supported by the King's Fund and Department of Health. The scheme has a focus on improving the environment for people with dementia and will incorporate the entrance, reception area and ambulance wait area in the outpatient department on A floor at the Royal Hallamshire Hospital. Patients, visitors and staff have been involved in redesigning the

area using interviews, workshops and questionnaires. In addition to refurbishing and redecorating the area, other changes to the environment include:

1 Providing a concealed area for wheelchair storage to reduce clutter
2 Introducing new seating and additional seating to improve comfort
3 Installing a signage station and providing a reception/enquiry desk to make wayfinding easier

Whilst improvements will focus on helping people with dementia, the benefits will be felt by all patients, visitors and staff who use the area.

Arts in Health

New artwork schemes using a special material (Digiclad) have recently been introduced to areas where it was previously difficult to place artwork. The new material is only 5mm thick so does not create a hazard in busy or small areas, it is hardwearing and easily cleaned. Artwork using this material has been introduced to the Burns Unit, Renal Unit, Surgical Assessment Centre and Labour ward. The artwork displays photographic images of natural scenes and landscapes chosen by patients, visitors and staff. Examples of other recent art projects include a schedule of weekly music performances across the Trust covering areas including Spinal Injuries and outpatient waiting areas. Musical performances have received extremely positive feedback from patients and visitors, who enjoy relaxing and listening to the music.

Volunteering

The Trust is pleased to have around 700 volunteers who carry out a variety of roles helping to enhance the experience of patients and visitors. Our voluntary services team works closely with schools, colleges and community groups to recruit volunteers from age 16 years and up. Volunteer roles include Volunteer Welcomers who meet and greet patients and visitors and help them find their way. A new volunteer role, Mealtime Volunteers, has been a great success. A team of four volunteers received training to support patients at mealtimes and following a pilot on the Spinal Injuries Unit, a further 16 volunteers have now been trained and the scheme is being rolled out to other areas where there are high numbers of patients who need support with feeding. Volunteers also play a key role in gathering patient feedback through the Trust's programme of Frequent Feedback surveys. 46 trained volunteers have interviewed 6,383 patients about their experience of our services since June 2009.

Working in Partnership

A new database holding details of local patients and members of the public who want to be involved in helping us to improve services is now in use. To date 500 people have registered their interest following a survey which was sent to all Foundation Trust members. The database holds details of the particular interests of each person, which may be certain specialties such as cardiac care or orthopaedics, or certain topics such as cleanliness or patient information. The database will allow much larger numbers of people to be involved in giving us their views and helping us to improve our services. It will also ensure that, when we start a new project, we can easily contact all those people who are interested in that issue to invite them to be involved. Priority projects each year will be chosen based on patient feedback from surveys, complaints and other sources of patient feedback. In addition, as well as the more traditional ways of talking to people such as holding meetings, we also plan to use modern technology such as texting, email and web based discussions to ensure we make it easy for people to be involved.

Complaints and Compliments

Complaints and compliments continue to provide a valuable source of feedback about our services. The Trust's new system of risk assessing and scoring all new concerns ensures that serious issues receive attention quickly. Between April 2010 and March 2011 the Trust received 1297 concerns. 90% of complaints were responded to in 25 working days. The number of complaints received has fallen since 2009-10 and this is likely to be because many concerns are now being dealt with 'on the spot' wherever possible, ensuring that problems are

resolved quickly for patients and their families. Over the past year, there has been a focus on improving how information from complaints is reported. This has led to identifying particular areas or issues which have received higher numbers of complaints and taking actions to resolve the problem. One example is an increased number of complaints regarding problems contacting an outpatient department by telephone which led to actions being taken to resolve the problem. The situation was then monitored through mystery shopping and the problem has been resolved.

New guidance and a programme of training for staff has been developed in relation to responding to concerns and complaints. This includes a new fact sheet for all staff and training as part of the Trust induction for all new staff.

Actions taken as a result of complaints include:

- In orthopaedics, additional nursing staff are attending the Trust Bladder Management Course, so that a higher number of ward nursing staff are trained to perform catheterisations

- In general surgery, toast bags have been purchased for use by coeliac patients so that toasters can be used safely for patients suffering from allergies who have special dietary requirements

- In obstetrics, new postnatal notes for both mother and baby will ease the transition of care from hospital to community, facilitate improved care planning and contain key advice, information and contacts for parents.

- In anaesthetics, a protocol is currently being developed to support the self administration of Clexane. Part of this new protocol ensures that a referral is made to the patient's GP practice so that they are aware of the need for a full blood count to be taken from the patient.

All actions taken as a result of complaints are reported in the monthly concerns report, so that good practice can be shared across the Trust and wards and departments can adopt new approaches and ideas wherever appropriate.

In 2011, we will be carrying out a complainant survey to identify areas where we can make improvements to the complaints process.

'Tell us what you think...'

A new 'Tell us what you think' leaflet and comment card explains how patients and visitors can make a comment, compliment or complaint. Posters and comment boxes will be on every ward from July 2011 enabling patients and visitors to comment on our services. Comments received are reviewed and acted on, and are reported as part of the new quarterly Patient Experience Report.

NHS Sheffield Primary Care Patient Advice and Liaison Service (PALS) Team

In February 2011 responsibility for the primary care PALS transferred to the Trust. This means that patients and their families can now telephone, write, or email to a single point of contact for help or advice in relation to services at STH, GP and practices or in the community. New patient information leaflets have been produced to advertise this new, integrated service.

Frequent Feedback

The Frequent Feedback survey allows us to survey patients 'on the spot' regarding their experiences of the service. The total number of surveys completed since June 2009 is:

Inpatients - 5383
Accident and Emergency - 1000

A programme of surveys will continue throughout 2011 with around 300 patients each month being interviewed.

National Surveys

Three national surveys have been carried out during 2010-11 and the Trust has scored very well in each.

National Cancer Survey 2010

2693 eligible patients from this Trust were sent a survey and 1682 questionnaires were returned completed, representing a response rate of 68%. Out of 59 questions this Trust scored in the top 20% of Trusts in 19 questions, the middle 60% in 40 questions and the bottom 20% in 0 questions. We were one of only 12 Trusts nationally who did not score in the bottom 20% in any questions. High scoring questions include patients always being given enough privacy when being

examined or treated. Lower scoring questions include patients waiting longer than 30 minutes for their appointment to start.

National Maternity Survey 2010

From the 536 surveys sent to mothers, the Trust received 269 responses, a response rate of 50.2%. Compared to the 2007 survey results, the Trust performed significantly better on 8 questions and significantly worse on 2 questions. Areas of high performance include being treated with dignity and respect during labour and birth and seeing the same midwife every time at antenatal check ups. Areas of lower performance include antenatal classes not being held at a fully convenient place and mothers not having a health check up postnatally.

Inpatient Survey

Of the 850 patients who were sent a questionnaire, 416 responded, a response rate of 49%. Compared with the 2009 survey, the Trust scored significantly better on 3 questions. Areas of high performance include cleanliness of room, ward and toilets and having confidence and trust in doctors and did not score significantly worse on any of the questions. Areas of lower performance include patients not being asked to give their views on the quality of care and discharge being delayed.

Following all national surveys, action plans are agreed to address areas where improvements can be made.

The right information at the right time

Providing patients with good quality information is an important part of the care we provide. As a trust we provide access to thousands of different patient information leaflets including over 1500 which we have developed ourselves. Managing these resources is an ongoing task for staff, ensuring they remain up to date and continue to meet patients' needs. This task has been made easier over the last year with the help of a new patient information database. The new system helps staff keep track of the many resources available across the organisation including personalised electronic reports which show when their own leaflets need reviewing.

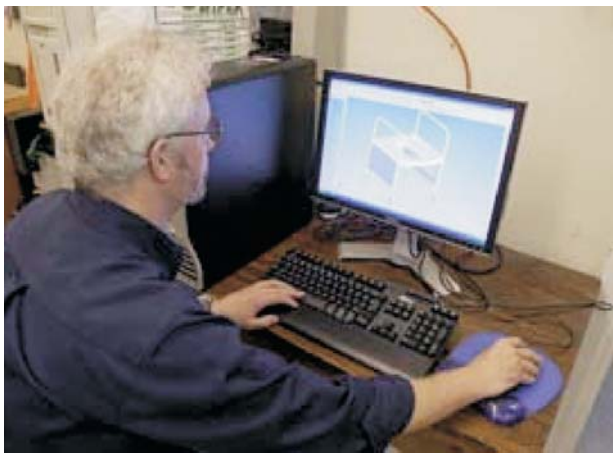
Helping patients access the right information has also stepped up a pace with the introduction of Information Prescriptions (IPs). IPs are a way of providing personalised access to a range of national and local information resources including welfare advice, support groups, social care as well as health. This exciting new development will usher in a new way of providing patients with information by allowing us to tailor information as well as send electronic information resources such as video clips.

Work has specifically begun in Diabetes and Cancer where we have been working with local partners and NHS Choices to begin assessing/identifying local information resources for inclusion in the IP. As a Trust we are particularly pleased to have been selected as one of 15 Beacon Sites to begin the intensive roll out of IPs. With the support of an IP Facilitator from the National Cancer Action Team we have now begun to provide training and support to staff in using the National IP System (www.nhs.uk/ips). As IPs develop we hope to extend their use to other areas of the trust in due course.

Providing accessible information also extends to those groups of patients who find it difficult to access standard format information. This includes the visually impaired and patients with a learning disability. Work has continued in both these areas over the last year for which we have received praise at a national and local level. A particular highlight however was winning for the second time a BMA Patient Information Award for our easy to read information.

Research and Innovation

We want to remain at the forefront of international leading-edge practice in healthcare so that patients have the benefit of the very latest new technologies and therapies. This means developing strong relationships between research, clinical practice and industry. The Trust has been responsible for pioneering advances in medical technology and treatments that are now regularly employed in hospitals around the country. Here is an update on some of the innovative work the Trust has been involved in over the last 12 months.



Devices for Dignity Healthcare Technology Cooperative

The Trust is one of only two in England to host a National Institute for Health Research (NIHR), Healthcare Technology Co-operative (HTC). The HTC is a national resource established to address areas of unmet clinical need.

Focusing on three themes (Assistive Technology, Renal Technology and Urinary Continence) it is delivering innovative medical devices to support patients with long term conditions, which preserve their dignity and independence.

Devices for Dignity (D4D) has just completed a third very successful year. The first product to market "The Dignity Commode" was achieved in November 2010 and D4D are currently running a Regional Innovation Fund project to demonstrate how D4D can help achieve national up-take of this innovation.

The programme of research and development activities has continued to grow with a current portfolio of 32 high impact projects. D4D is collaborating with Universities, Industry, Charities and NHS Trusts across the UK to deliver positive outcomes to patients.

D4D now has 2 National Expert Networks consisting of key opinion leaders in the fields of Assistive Technology and Urology providing strategic guidance, expert peer review and a route to dissemination for D4D innovations. To support this robust stream of Research & Development initiatives, D4D has attracted a total of over £6 million funding to date.

Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

This leadership collaboration funded by the National Institute for Health Research (NIHR) and hosted by Sheffield Teaching Hospitals has continued with its commitment to our partners and to the development of wider collaborations internationally, with industry, other NIHR infrastructure, and service user groups.

All of the ten NHS Trusts in South Yorkshire are now actively engaged in CLAHRC project work, with interest shown from other organisations wider afield in the NHS, local authorities and the third sector.

A key element to this success is that their work is closely aligned to the objectives and needs of the NHS: namely promoting self management of long term conditions, and the development of projects and services that focus on quality of care, addressing health inequalities, clinical and cost effectiveness. They undertake both applied research in these areas together with projects that translate the evidence we already have of effective care into everyday practice on the wards, in out-patient departments and within the wider hospital community.

CLAHRC SY has had 84 active projects this year, 38 of which were research projects and 46 evidence implementation and service development projects. They have also been very successful in gaining additional funding of £4.35m, £2.56m from new external grants, £1.61m for adopted projects working with CLAHRC-SY, and £0.19m of external funding for non-research projects.

Many of CLAHRC's projects work with marginalised groups with the aim of reshaping services to make them more accessible. This includes the adolescent programme of work in the Diabetes theme where qualitative work has been undertaken to review experiences and values of young people, their parents and practitioners, and this has now informed service planning. The Diabetes theme work is further complemented by a User Centered Healthcare Design (UCHD) project that aims to increase engagement of currently disengaged young people with diabetes through co-design of tools, particularly around access to information. CLAHRC's Stroke theme, Depression theme, and Health Inequalities (HI) theme are also undertaking work to improve access for marginalised people to services that link to Coronary Heart Disease care pathways, services for older people and the homeless.

NIHR CLAHRC for South Yorkshire

One project, Enhancing the Quality of Oral Nutritional Support (EQONS), has this year successfully implemented the use of the MUST+ tool that was developed in the previous reporting year, to improve nutrition in adults with long-term conditions in the Trust.

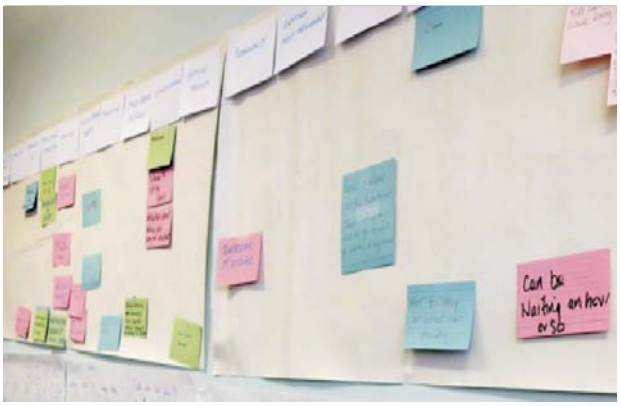
Frontline clinical staff are now able to translate knowledge into their day-to-day actions, and act as 'champions' with responsibility for developing practice. The team will now support, monitor and evaluate the action plans and audit current documentation to achieve sustainable change, and gain a patient perspective on nutritional care.

The UCHD project BOSOP (Better Outpatients Service for Older People) was completed this year and was based on engagement with patients and carers to discuss current problems with accessing NHS services and to co-design solutions.

Patient Mr Alec Butteriss uses a telehealth device at his home in Barnsley

The outputs from this project have informed the design of a new appointment letter that patients find more helpful and less confusing, as well as the proposals for altering the patient transport service to reduce waiting times and to redesign the road layout outside the outpatients department to reduce confusion for users of the service.

Fourteen CLAHRC projects include the development and implementation of 'telecare' and technology into services. These exciting new projects allow local patients to trial the use of the Bosch Telehealth Plus monitoring system, which is designed to enable healthcare professionals to monitor the condition of their patients remotely, allowing those patients to maintain their independence, with fewer visits to the clinic and reduced healthcare costs.



Patient feedback helps design service amendments

NIHR Bone Biomedical Research Unit

Established in 2008, the Sheffield Bone Biomedical Research Unit (BRU) was set up to carry out research into new treatments for musculoskeletal conditions and diseases. The team aims to translate advances in medical research into clinical practice for patient benefit and work in areas such as osteoporosis and joint arthroplasty. This research unit is collaboration between Sheffield Teaching Hospitals NHS Foundation Trust and the University of Sheffield, funded by the National Institute of Health Research (NIHR) as part of the Government's Best Research for Best Health strategy.

The Unit was formally opened by her Royal Highness The Duchess of Cornwall as part of her role as the President of the National Osteoporosis Society. During 2010-11, the NIHR Bone Biomedical Research

Unit (BRU) continued in its goal of producing high quality, leading-edge research.

The BRU continued to grow - welcoming five new staff members, four clinical fellows and three PhD students and had the highest intake of BMedSci students yet, running five projects. Recruitment was completed for some of the Unit's longest running studies and it received ethics approval to begin another five clinical research studies.

BRU researchers attended national and international conferences, submitting 56 abstracts, including 23 for oral presentation. In addition, several of the Unit's investigators were invited to chair symposiums and give guest lectures. We brought in six awards across the conferences, including two Young Investigator awards and the Golden Femur award.
The BRU formed collaborations with a number of industrial partners and academics, as well as formalising two new programmes of research to add to the existing six. Programme 7 will link bone research with cardiovascular research. Programme 8 will focus on bone and renal research.

The BRU's investigators co-authored over 25 publications in peer-reviewed journals. We had two articles published in the prestigious New England Journal of Medicine, and nine others in top sub-speciality journals. They also successfully secured grants from industry, charity and research bodies, to bring in over £1,500,000 new funding for research in 2010 alone.

NIHR Cardiovascular Biomedical Research Unit

The NIHR Sheffield Cardiovascular Biomedical Research Unit (CVBRU), opened in 2009, is one of only five such Units in England. The Sheffield CVBRU aims to facilitate the discovery of new ways of preventing, diagnosing and treating cardiovascular (heart) disease and pulmonary hypertension.

National Institute for Health Research (NIHR) funding was used to set up the 'Cardiovascular Biomedical Research Unit Tissue Bank', a cohort study aiming to recruit 1000 patients with heart disease and pulmonary hypertension. The ultimate aim of this Biorepository and Database is to use the samples and information to increase our understanding of the causes of these conditions, how they cause symptoms and clinical illness, and help us to develop new treatments. This study has recruited well in 2010: the CVBRU research nursing team has recruited over 400 participants to date.

During 2010-2011, the CVBRU had 9 Clinical Fellows, 3 PhD students and 7 BMedSci students all undertaking projects in different aspects of cardiovascular disease and pulmonary hypertension. Collaboration with

colleagues at Guy's and St Thomas' NHS Foundation Trust has resulted in a prestigious grant from the Engineering and Physical Sciences Research Council. In March 2010, the CVBRU was awarded funding by the NIHR Research for Innovation, Speculation and Creativity (RISC) Programme. We have played a leading international role in research into a novel anticlotting drug ticagrelor which has shown how this drug can save lives in heart attack victims and we are continuing to seek better treatments for preventing heart attacks. Ultimately, results from these studies will be used to enhance clinical decision making during different aspects of cardiac treatment.

The Sheffield CVBRU is also looking at which genes cause cardiovascular disease. Cutting edge advances in genetic technology (Next Generation Sequencing) allow very powerful analysis of thousands of genes in a way that was previously impossible. Sheffield CVBRU works in close partnership with the MRC Next Generation Sequencing hub in Liverpool (one of only three in England) and is one of the first centres in the world to apply this technology to heart disease. This ongoing work will contribute towards identifying new diagnostic tests and treatments for patients with cardiovascular disease.

Sheffield Hospitals Charitable Trust launched the South Yorkshire Heart Appeal in November 2010 as part of the charity's ongoing work to support research and improve specialist treatment for patients with heart conditions.

A year in view - Research and innovation

April 2010

£2.9m groundbreaking research into continence

The Trust successfully secured a £2.9 million grant for a groundbreaking research project to address continence management. The research project - called the TRUST programme - 'Training Urology Scientists to develop Treatments' saw Sheffield form an international collaboration with partners in Europe and the United States of America.

The project aim is to develop new technology relating to the management of continence and new treatments will be evaluated using tissue engineering for both incontinence and prolapse.

The Trust's Urology Department will lead on the project in partnership with specialist researches from the Kroto Institute and the Biomedical Science Institute in the University of Sheffield, and the Biomedical Research Facility at Sheffield Hallam University.

Professor Christopher Chapple, Consultant Urological Surgeon and Lead for the research project explains: "Lower urinary tract symptoms are a particularly important clinical issue, because they do affect up to 40% of the population by the age of 65 and this is going to be increasingly important with the increasing age, as the population demography changes.

"We are very excited that this funding has been secured in Sheffield and it will aid the education of new researchers in the field and really help in tackling the problem which affects many people in Sheffield."

May 2010

Centre of Excellence for blood cancer research

World class blood cancer research conducted in Sheffield was recognised by the national charity Leukaemia & Lymphoma Research, which named the research facilities a 'Centre of Excellence'.

Leukaemia & Lymphoma research has £1.7 million currently invested in five projects. The research is focused on two important areas of blood cancer research - improving treatments for children with leukaemia and developing new drugs for patients with myeloma, a blood cancer which affects older adults. The naming of Sheffield as a 'Centre of Excellence' is part of the charity's plans to focus investment in leading research institutions across the UK. At a special ceremony, patients joined researchers and doctors for the unveiling of a special plaque at the Royal Hallamshire's School of Medicine. Members of the public and charity supporters were also given laboratory demonstrations and presentations on the research taking place.

June 2010

Sheffield scientist won prestigious award for research into new treatments for myeloma

Sheffield Teaching Hospitals and the University of Sheffield carry out world-class research into myeloma, an incurable cancer which causes devastating bone damage. Leukaemia & Lymphoma Research scientist Dr Andrew Chantry was awarded the "Research Medal Award for Haematology 2010" by the Royal College of Pathologists.

This prestigious award is made annually to recognise a young specialist doctor who is carrying out outstanding research that is advancing treatments and diagnosis for patients affected by blood cancers and other blood disorders.

Dr Chantry said, "I feel very strongly that the credit for this award lies with the broader team, including the charity Leukaemia & Lymphoma Research which has supported my career, and the careers of other blood cancer scientists here in Sheffield."

July 2010

Trial showed new drug does not improve survival rates of breast cancer patients

The results of a long awaited trial aiming to find new treatments for breast cancer concluded that Zoledronic acid does not improve disease-free survival among patients.

The AZURE* trial, which was led by Professor Rob Coleman tested patients with stage II/III breast cancer. The AZURE trial included 3,360 patients from 174 centres. Professor Coleman and colleagues randomly assigned the patients to standard therapy or to standard therapy plus zoledronic acid. The primary outcome was disease free survival and the researchers found no difference in disease free survival in the overall population.
Whilst the ultimate findings were negative in the larger population of participants some benefits were seen in post-menopausal women. 1101 patients were five years post-menopause, which accounted for 30 percent of the overall group. Out of these participants there was a 29 percent improvement in overall survival. Whilst these findings are significant, they are also a secondary outcome of the trial meaning that further study will be required.

Professor Coleman said: "In the larger population, we did not see a difference but in the post-menopausal women a survival advantage like this is quite remarkable, and the difference in outcome between this group and the younger population is unlikely to be a chance finding. We will clearly want to investigate further in this population."

August 2010

New 'dentist' test to detect oral cancer will save lives

A new test for oral cancer, which a dentist could perform by simply using a brush to collect cells from a patient's mouth, is being developed by researchers at the University of Sheffield and Sheffield Teaching Hospitals.

The current procedure used to detect oral cancer in a suspicious lesion involves using a scalpel to perform a biopsy and off-site laboratory tests which can be time consuming. The new test will involve removing cells with a brush, placing them on a chip, and inserting the chip into the analyser, leading to a result in 8-10 minutes. This will have a number of benefits including cutting waiting times and the number of visits, and also cost savings for the NHS.

The team in Sheffield, led by Professor Martin Thornhill, a Consultant in Oral Medicine at Sheffield Teaching Hospitals and Professor of Oral Medicine at the University of Sheffield, has begun carrying out clinical trials on patients at Charles Clifford Dental Hospital for two years to perfect the technology and make it as sensitive as possible.

If the trials confirm that the new technology is as effective as carrying out a biopsy then it could become a regular application at dentist surgeries in the future.
If oral cancer is detected early, the prognosis for patients is excellent, with a five-year survival rate of more than 90 percent.

Professor Thornhill said: "This new affordable technology will significantly increase our ability to detect oral cancer in the future. Diagnosis currently involves removing a small piece of tissue from the mouth and sending it to a pathologist. This is typically done at a hospital, can take a week or more and involve extra visits for the patient. With the new technology, a brush would be used to painlessly remove a few cells from the lining of the mouth that would be analysed within minutes in the presence of the patient, so that the patient would know the result before leaving the clinic."

September 2010

Volunteers help with ground breaking lung research

The Royal Hallamshire Hospital enlisted volunteers with Chronic Obstructive Pulmonary Disease (COPD) to help them develop a new way to take pictures of the lungs using a technique exclusively available in Sheffield.

The technique called Hyperpolarised Helium Magnetic Resonance Imaging is a very safe technique because it does not use radiation unlike pictures taken using X-rays. Interested volunteers came to the hospital for a normal check up but had additional scans taken and breathing tests done. The tests involve patients being given a specially prepared version of helium to breathe in.

This shows up clearly on scans and will allow researchers a chance to gather detailed images of where the gas goes within the lung. Images can also be processed to show the sizes of the airspaces within the lungs as well as if the air gets to similar places in the lung as does blood.These measurements of lung structure and function are especially important in COPD. The disease is caused by smoking and pollution associated with heavy industry, and is a particularly common one in Sheffield with around one in five emergency medical admissions to hospital in the city relating to this condition.

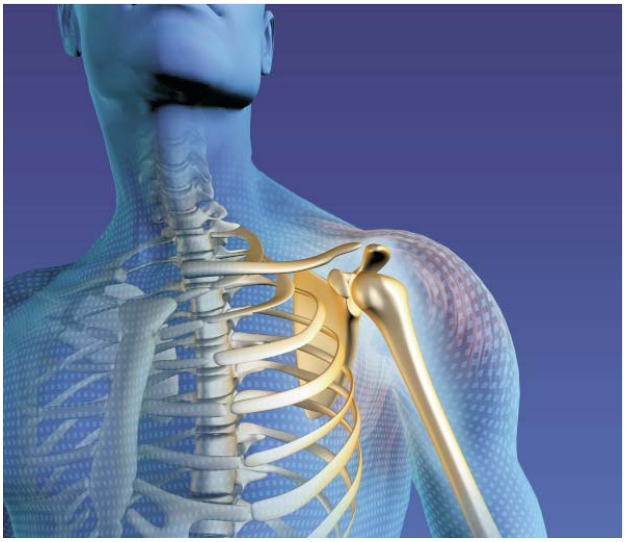
Trust researchers Dr Rod Lawson and Dr Jim Wild have gained support from the major pharmaceutical company GSK to test this technique out further. Rod Lawson, Consultant in Respiratory Medicine, said: "We hope the findings of this study will lead not only to a better understanding of COPD, but will also allow new treatments to be tested more quickly and effectively."

October 2010

Volunteers help with ground breaking lung research

A research team led by one of the Trust's Honorary Consultants found that a common treatment for a life-threatening heart condition has limited benefit for patient outcomes.

Professor Martin Thornhill, Professor of Oral Medicine assessed the impact of the prescription of antibiotics on the prevention of infective endocarditis - the inflammation of the inner lining of the heart - prior to invasive dental procedures.



November 2010

New Devices 4 Dignity report provides hope for patients

The lives of people who find communication difficult could be dramatically improved following a report published by Devices for Dignity (D4D), into Voice Output Communications Aids.

The report led by Barnsley Hospital and NHS Sheffield as part of a D4D consortium hosted by Sheffield Teaching Hospitals, is designed to improve the development of new technologies and stimulate further research in the Augmentative and Alternative Communication (AAC) field.

The report found that not being able to effectively communicate can be deeply frustrating and detrimental to people's lives but that Voice Output Communications Aids provide them with a voice, improving their quality of life.

Voice Output Communications Aids are part of Augmentative and Alternative Communication - extra ways of helping people who find it difficult to communicate by speech or writing.

D4D felt that users had not been given a voice regarding the effectiveness of their devices and in response to the lack of previous research commissioned the two-year project to investigate user requirements, future improvements and areas for future research.

The report has already led to a number of companies speaking to D4D on how it can be implemented in their technologies. The report has also inspired D4D to engage users in the design process because the feedback given by users indentified a number of shortcomings of existing devices. User involvement will help to make the devices more reliable, durable, portable, and simple to use.

December 2010

Pioneering MS drug trialled at Royal Hallamshire

A pioneering drug for multiple sclerosis (MS) patients is being trialled at the Royal Hallamshire Hospital. The treatment called ATX-MS-1467 is targeted at the immune system.

It was designed to stop the body from attacking the protective 'sheath' which surrounds nerve cells, whilst allowing the immune system to fight infections and viruses as normal. Many drugs treat the symptoms of MS but this new drug treats the underlying cause of the disease. It has been developed for relapsing forms of MS where symptoms appear then disappear. MS is now one of the most common diseases to affect the nervous system in young adults.

There are around 100,000 sufferers in the UK and three times as many women as men have the condition, according to figures from the MS Society charity. Around 1,844 people in South Yorkshire have the chronic condition which can leave people disabled. The Royal Hallamshire is one of several sites across the UK taking part in the early stage trials for this new potential therapy. If the results are successful then the drug could be approved for widespread use.

January 2011

Young volunteers help with meningitis study

A new research study into how meningitis develops in young adults could lead to a new vaccination programme which tackles the bacteria at source.

Meningococcal meningitis is caused by the bacterium Neisseria meningitidis, which around a quarter or more of young adults carry in their throats. Students are particularly at risk of becoming infected due to the close proximity of other students in shared accommodation.

A nationwide research study into how meningitis vaccines tackle these bacteria recruited first and second year university student volunteers across the country - including more than 700 from Sheffield.
The national study is being led by Professor Robert Read, Professor of Infectious Diseases at the University of Sheffield and is supported by the Sheffield Teaching Hospitals NHS Foundation Trust.

It is already known that when these vaccines are injected into young adults, antibodies are produced in the blood which can protect against meningitis. However, information is needed to find out whether these vaccines can also act by stopping the Neisseria meningitidis bacteria from colonising the throat. It is hoped that the vaccine could reduce meningitis disease by stopping transmission between the throats of young people. If so, this information would help public health policy makers to decide how to best use these vaccines to reduce the incidence of meningitis amongst young adults.

Volunteers are visiting the Clinical Research Facility at the Royal Hallamshire Hospital six times over 12 months as part of the study. Professor Robert Read said: "This is an important study which will help to determine how effective the new MenB vaccine is likely to be in practice. We hope that the MenB vaccine will dramatically reduce the number of people who carry these potentially dangerous bacteria in their throats, and this in turn will almost eradicate this devastating disease."

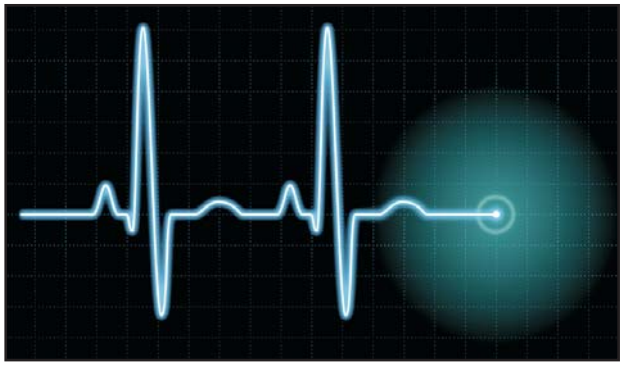
February 2011

New research highlighted risk in use of indigestion tablets

Professor Richard Eastell, of the Sheffield Bone Biomedical Research Unit and Senior Researcher for the National Institute for Health Research (NIHR), collaborated on new research into the risks of using some indigestion tablets alongside a commonly used osteoporosis treatment.

Working with Professor Bo Abrahamsen from the University of Southern Denmark, he gathered information from more than 38,000 Danish osteoporotic men and women taking the osteoporosis drug alendronate between 1996 and 2005.

The researchers found that almost one third of these patients, who had an average age of 70 years, also took 'proton pump inhibitors' (PPIs) to control stomach acid. The researchers calculated that in patients taking only alendronate (one of a group of medicines called bisphosphonates), the risk of suffering a hip fracture decreased by 39%. However, if the patients were taking alendronate as well as a PPI (e.g. omeprazole), the risk of fracture was only reduced by 19%.



Professor Eastell commented: "It is essential that we examine how different medicines interact with each other, particularly when they are so widely used as the ones in this study. This important research is relevant to many people and should help to improve the treatment of patients with both indigestion and osteoporosis.

March 2011

Trust shone with award for innovation

Sheffield Teaching Hospitals was awarded a major grant to carry out a groundbreaking new way of treating patients with leukaemia and other haematological cancers (cancers of the blood).

The Trust, in partnership with the School of Health and Related Research (ScHARR) at the University of Sheffield, has been given £75,000 from the Health Foundation as part of the prestigious Shine Awards 2011, in order to pilot a project to treat patients requiring intensive chemotherapy or bone marrow transplants outside of the normal inpatient hospital setting.

The project, aimed at patients with acute leukaemia, lymphoma and myeloma, will see some patients treated on an 'ambulatory' day-case basis, whilst staying in a purpose-built flat with a designated carer, near to the Royal Hallamshire Hospital.

Ordinarily, blood cancer patients require long hospital stays, typically four weeks or more. Many patients with these cancers experience the highest use of hospital beds compared to other patients with cancer.

With the new ambulatory treatments lengthy hospital admissions may be significantly reduced, with patients receiving earlier discharge from hospital, or having some of their planned treatments in day-care before there is any need for admission. If the project is successful some patients may even be able to be treated at home.

Dr Christopher Dalley, Consultant Haematologist, who has led the project, said: "We are delighted to have been awarded this funding to run this important scheme. Patients who suffer from blood cancer often have to face lengthy hospital stays because of the highly intensive treatments they frequently need. This can be difficult for them as they spend much of this time away from family and friends."

A team of experts from the Trust and ScHARR will carry out the scheme with support from the Health Foundation.

Training the healthcare professionals of the future

Throughout the year the Trust maintained the excellent standards achieved in undergraduate and postgraduate education and training for all professions by ensuring the best possible 'student' experience.

The Trust has also worked with the Universities to ensure that Curriculum development is keeping pace with and is relevant to modern clinical practice.

The MPET review of funding presents a challenge to the provision of education and training and will require ingenuity and innovation to maintain high standards in what we anticipate will be a reduced and reformed funding system in the future. Actions will include:

- Development of infrastructure to provide a city- wide video conferencing facility connecting all the principal teaching sites,
- Building the new clinical skills facility on the central campus as a high standard hub for the future including clinical staff from all health sectors and developing the Medical Education Centre on the Northern campus to balance the clinical skills training capacity on all sites
- Developing Quality assurance systems to facilitate excellence in education including a medical workforce monitoring board, educational supervision for all trainees and close liaison with the merged Yorkshire and Humber Deanery,
- Carefully planning the redistribution of trainee doctors, undergraduates in medicine, nursing and allied health professions, their trainers and teachers to optimise training opportunity
- Learning from the HEIC proposal based on the 3 themes of patient safety, to enhance the translation of research into education and practice building particularly on the experience of the CLAHRC and Devices For Dignity.
- From the HEIC initiative, develop the notion of a Quality Observatory.

Our greatest asset

Taking care of and developing our staff is as important as caring for our patients and during the year we have introduced a range of initiatives to strengthen our support to staff, encourage more staff engagement and develop our leadership strategy.

The Trust recognises the importance of staff engagement to productivity and good patient care and thus identified it as a key pillar in the Corporate strategy.

During 2010 a staff engagement strategy was approved by the Trust Board which is in the process of being implemented. This identified three workstreams which are integral to effective staff engagement.

- Health and Wellbeing
- Staff Journey (experience)
- Staff Involvement.

A staff engagement lead has been identified for every directorate who attends the Staff Engagement Steering Group, chaired by the Chief Executive. The staff side chair and a staff governor are also invited to attend.

In addition the 'Let's talk 'events started on a Trust wide basis during 2009, have been rolled out to Care groups and Directorates and work is ongoing to address the issues raised via these and the staff survey. For example the appraisal system is being simplified following the publication of new national guidance.

Staff also have the opportunity to give feedback at regular team brief sessions and managers participate in a weekly interactive online meeting with the Chief Executive.

The Trust also holds bi-monthly Joint Negotiating Consultative Committee (JNCC) meetings consisting of representatives of the recognised Trade Unions and the Trust Executive Group. The meetings play an important role in facilitating high-level discussion on strategic issues concerning the Trust including strategy, finance and policy. The Joint Consultative Committee (JCC) has a more operational remit where the Trade Unions bring issues raised by their members to the table for further discussion and resolution. The Trust employs a staff side chair to coordinate discussions with all the Trade Unions and management.

It is clear that the uncertainty due to the forthcoming changes in the NHS is impacting on how staff feel and steps are being taken to address concerns raised. However it is pleasing to note that 75% of staff would recommend the Trust to their family and friends as a place to receive treatment which is above the national average for acute trusts in the NHS (63%).

National staff survey results 2010/11

NB all NHS scores refer to the average for acute trusts.

	STH 2009	NHS 2009	STH 2010	NHS 2010
Response rates	45%	55%	49%	52%

Top four ranking scores

Key Finding	2009 STH	2009 NHS	2010 STH	2010 NHS	Improvement/ deterioration
KF 8 Working unpaid extra hours	59%	65%	57%	66%	Improvement
KF33 Staff intending to leave jobs	2.47	2.51	2.38	2.53	Improvement
KF29 Staff feeling pressure to work when unwell in last 3 months	28%	26%	24%	26%	Improvement
KF37 Believe STH provides equal opportunities for career progression/promotion	92%	90%	92%	90%	No change

Bottom four ranking scores

Key Finding	2009 STH	2009 NHS	2010 STH	2010 NHS	Improvement/ deterioration
KF6 Effective team working	n/a	n/a	3.48	3.69	-
KF14 Staff appraised with a personal development plan	42%	59%	41%	66%	Improvement
KF12 Appraised in last month	50%	70%	51%	78%	Improvement
KF31 Able to contribute to Improvements at work	60%	61%	50%	62%	Deterioration

The key finding that showed the most improvement was KF 33 i.e. a reduction in the number of staff intending to leave.

Staff's intention to leave

Key Finding	2009 STH	2010 STH
Summary score, 1 being unlikely to leave 5 being highly likely to leave in next year	2.47	2.38

Most deterioration

Key Finding	2009 STH	2010 STH
KF3 Staff feeling valued by work colleagues	78%	70%
KF31 Able to contribute towards improvements at work	60%	50%
KF35 Staff motivation at work	3.78	3.67
KF31 Staff satisfaction	3.42	3.42

A healthy approach

There has been a Health & Wellbeing group running in the Trust since November 2008. The group meet regularly and review potential opportunities to improve the health & wellbeing of our staff.

Staff Health & Wellbeing forms a key strand in the staff engagement strategy for the Trust. During the past year members of the group have developed various initiatives to support staff health and wellbeing.

In 2010/ 2011 the Group continued to make progress against the various local and national strands contained in NICE guidelines and the Boorman Report.

The Trust has recently approved a new policy called "Purchasing Annual Leave" which allows staff to "buy" up to two additional weeks' annual leave, and have the cost spread out over a 12 month rolling period. This will benefit both the member of staff and save money for the Trust.

During the year, the group commissioned an in house intranet Health & Wellbeing web site to be developed. Having taken soundings from a number of staff and staff groups, it was decided to commission an external facing website so that staff can access the benefits packages from home, not just from work.

We introduced a private company, PAYPLAN, who provide independent debt management advice. Whilst take up has initially been slow, we have devised a strategy to advertise the benefits of this service to a targeted audience in conjunction with staff side colleagues We are in the process of giving all staff access to the Sheffield Credit Union, independently regulated by the Financial Services Authority. This is a savings and loans co-operative which will be open to all members of staff.

We continue to publicise initiatives offered by third parties where we feel these will benefit staff. For example;

- we advertised Sheffield City Council's free insulation scheme to staff
- we have informed staff of the NHS Black card - a cash back scheme that gives staff a 5% return on expenditure when used in many stores
- we have signed up to several discount voucher schemes including NHS discounts, Groupon, Sheffield deal of the day and vouchercodes to name some. These will be advertised on both websites to allow staff to access them wherever they may be.

- We have re-negotiated corporate rates for gym membership for a number of gyms throughout the city.

We have been planning for the inaugural Health & Wellbeing Festival 2011 which will showcase all the various strands of what the group is doing and hoping to achieve in the future.

Leadership for the future

Leadership Development was identified in the Trust's corporate strategy as one of the three very important enabling strategies which will need to underpin the vision, and support our aims.

Over the next 3 years Sheffield Teaching Hospitals arguably faces its biggest challenges to date; it has to remain economically viable in the face of major public spending cuts and in response to The White Paper (Equity and Excellence, July 2010), it has to make decisions about the type of organisation it wants to be, change its profile to accommodate the transfer of community services and compete in a more market oriented health economy.

It is becoming clear that leaders will have to work in different ways to create viable plans that reflect a tighter income base, whilst at the same time engaging staff in the new agenda and embracing innovation to ensure we continue to deliver high quality patient care. This will require effective leadership at all levels, with clinical leadership playing a vital role.

Therefore the Trust's new Leadership Development Strategy has three key themes;

1. Identifying and developing emerging talent and potential leaders
2. Supporting and developing the current leadership team
3. Identifying and attracting external leadership talent where appropriate

Our ambition is to develop an integrated leadership development programme that

- ensures the leaders of our organisation are the kind of leader everyone wants to work for, the kind who can really make a difference to patient care and the kind who live out the values of the NHS Constitution.

- offers support and development to leaders who are already in complex roles.

- develops alongside them a pool of leaders to be ready to apply for such roles.

All senior leaders will have the opportunity to attend a Development Centre to help them identify their development needs, access coaching, mentorship and learning set support to achieve their aims. The Trust has a partnership agreement with Pfizer, a FTSE 100 company to support the Development Centre.

All senior leaders will also have the option to attend a University accredited Work Based Learning leadership development programme which will cover 8 key leadership themes identified as crucial for continued success.

A Medical Leadership programme for Doctors has also been developed and proved highly successful to date.

To continue to support the professional development and provide inspiration for leaders, including those who chose not to access the taught element of the leadership development programme, a new Leadership Forum will run four times per year with invited celebrity speakers, top NHS leaders and recognised leaders from the private sector as well as seminars on leadership skills such as mentoring and coaching.

Everyone Counts

Sheffield Teaching Hospitals recognises that it serves a very diverse community and is committed to ensuring equal access to all patients irrespective of race, nationality or ethnic background, disability, gender, gender reassignment, sexual orientation, pregnancy, marital status, religion or belief, or age.

The Trust Secretary chairs the Equality and Human Rights Steering Group, which reports to the Trust Executive Group, and to the Healthcare Governance Committee, which is a committee of the Board of Directors.

This ensures that equality and diversity issues are considered at a strategic level. Operationally each care group has identified an Equality and Human Rights lead to promote the sharing of good practice in equality and diversity across the Trust. The Trust publishes an annual Equality and Human Rights report which can be found on the Trust web site.

In 2010/2011 the Trust continued to take forward its work on Equality and Human Rights. The Trust Equality and Human Rights Steering group met regularly to discuss development of the Trust Equality and Human Rights strategy. This strategy will set out the objectives that the Trust will take forward from 2012.The Trust plans to involve staff and patients in developing the strategy and will make the strategy as widely available as possible once it is complete.

The Trust operational leads have also met regularly this year, this group provides a focus for good practice and governance and a mechanism for sharing information which can then be distributed through the Trust.

A new lead for Equality and Human Rights was appointed in September 2010. The Trust has been taking forward the positive work undertaken so far and has started to review the Trusts existing equality schemes so that the actions within these schemes, that are still ongoing, can be taken forward through the new strategy.

The Trust has also been involved in taking forward changes associated with the Equality Act 2010. The Trust made a number of changes linked to the Equality Act in October 2010 and is currently reviewing the new Public Sector Equality Duty which is in force.

In 2010/2011 the following areas were of particular note:

1 The Trust continued to take forward nationally recognised work to improve the experience of people with learning disabilities using acute services.

2 In March 2011 the Trust in partnership with other health organisations in the city held an event to meet with representatives of a wide variety of people in the city who for a number of reasons sometimes

experience barriers and poor experiences of health services. The new Public Sector Equality Duty was discussed at the event and also a national proposal for a single system for the NHS to support health organisations' work on Equality and Human Rights. This will be called the NHS 'Equality Deliver System'.

3 In March 2011 The Trust reported back to a meeting convened by the Sheffield Royal Society for the Blind to discuss work the Trust has been taking forward on making services and information accessible for people with sight impairments.

These are examples of some of the work that the Trust is taking forward. More detail will be found in the Trust Annual Equality and Human Rights report which will be published in the summer of 2011.

Information about the Diversity of Trust staff and Trust Members

Diversity of Trust Staff

Ethnicity	2009	2010
White - British	80.38%	80.69%
White - Irish	0.74%	0.70%
White - Any other White background	4.34%	4.05%
White Unspecified	0.00%	0.00%
Mixed - White & Black Caribbean	0.28%	0.31%
Mixed - White & Black African	0.32%	0.36%
Mixed - White & Asian	0.40%	0.38%
Mixed - Any other mixed background	0.43%	0.50%
Asian or Asian British - Indian	2.82%	2.72%
Asian or Asian British - Pakistani	1.41%	1.39%
Asian or Asian British - Bangladeshi	0.15%	0.14%
Asian or Asian British - Any other Asian background	1.12%	1.20%
Black or Black British - Caribbean	0.90%	0.86%
Black or Black British - African	3.04%	3.19%
Black or Black British - Any other Black background	0.22%	0.21%
Chinese	0.52%	0.57%
Any Other Ethnic Group	0.86%	0.83%
Not Stated	2.07%	1.92%

Disability Of Staff In Post	2009	2010
Yes	0.40%	0.59%
No	0.08%	4.54%
Not Declared	0.00%	1.96%
Not Stated	99.52%	92.92%

Gender of Staff in Post	2009	2010
Female	76.78%	76.44%
Male	23.22%	23.56%

Age of Staff in Post	2009	2010
Under 20	1.01%	1.30%
20 to 29	17.68%	19.59%
30 to 39	25.22%	24.73%
40 to 49	28.40%	28.24%
50 to 54	12.00%	11.95%
55 to 59	8.99%	8.59%
60 to 64	5.01%	4.28%
65 and Over	1.69%	1.31%

Diversity of Trust members

	Public in Catchment	Patient out of Sheffield	Patient in Sheffield
	Age	**Age**	**Age**
0 to 16 years	0.6%	0.2%	0.1%
17 to 21 years	6.4%	1.0%	1.2%
22 years +	93.0%	98.8%	98.7%
	Ethnicity	**Ethnicity**	**Ethnicity**
Not specified	2.8%	2.3%	2.7%
White	85.9%	94.7%	94.1%
Mixed	1.9%	0.5%	0.9%
Asian or Asian British	5.5%	1.7%	1.4%
Black or Black British	2.9%	0.7%	0.6%
Other Ethnic Group	0.9%	0.2%	0.3%
Other	0.0%	0.0%	0.0%
	Gender	**Gender**	**Gender**
Male	34.3%	49.5%	44.6%
Female	65.4%	50.5%	55.2%
Not specified	0.2%	0.0%	0.3%

Ensuring good governance

We want to make sure that our patients receive the highest quality care possible and are always working to ensure this, looking at our internal systems and learning from national assessments, which examine the services we provide and how we handle our resources.

Care Quality Commission

The Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission ceased to exist on 31 March 2009 and were replaced by the Care Quality Commission (CQC). As well as making sure essential standards are met through the registration system, the CQC also helps to drive up improvements by conducting reviews of services and assessments of commissioning. This system replaces the Standards for Better Health process that required annual declarations resulting in a Trust rating. Following registration with the CQC in March 2010 the Trust is legally required to continually monitor and ensure compliance with the essential standards of quality and safety to maintain registration. These standards can be grouped into five key outcome areas:

- Involvement and information
- Personalised Care, Treatment and Support
- Safeguarding and Safety
- Suitability of staffing
- Quality and Management

In response to the CQC approach a number of new processes has been developed to enable the Trust to monitor compliance with the essential standards. These build on some of the existing assurance structures but add an element of continual review and evaluation. Where concerns are identified an action plan is developed to address these. The responsibility for ensuring these processes are in place rests with the Patient and Healthcare Governance Department. The Trust has no compliance concerns associated with registration.

Health and Safety

Ensuring the health and safety of our patients, staff and visitors remains a top priority. Constructive meetings have been held between the Trust and the Health and Safety Executive during 2010/11. The Trust has received no improvement notices this year.

Clinical Audit

Approximately 460 clinical audit and service review projects were registered within the Trust Clinical Effectiveness Unit during 2010/11. Almost 60% of this activity was Clinical Audit. Clinical Audit is the process that helps ensure patients and service users receive the right treatment for the right person in the right way. It does this by measuring the care and services provided against evidence based standards and then narrowing the gap between existing practice and what is known to be best practice. Each year the Trust determines a Trust Clinical Audit Programme which is a prioritised programme of around 150 audits that reflects both national and local priorities including those of our commissioner, NHS Sheffield. A clear approach has been implemented for the development of the Programme based on the national prioritisation model which assumes a hierarchy of importance, 1 to 4, with priority 1 being the most important. This delivers a balance between bottom up initiatives and top down imperatives. A significant proportion of audit revolves around the measurement of compliance of current practice with National Institute for Health and Clinical Excellence (NICE) guidance both within the Trust and at the boundary with other services. The implementation of the Programme is monitored by the Trust Clinical Effectiveness Committee and reported to NHS Sheffield quarterly. Clinical audit is a multi-disciplinary activity involving clinicians and managers involved in the care or services being reviewed, supported by the Clinical Effectiveness Unit. Patients are involved in the process wherever appropriate, including representation at the Trust Clinical Effectiveness Committee and patient views, experiences and

outcomes are surveyed in around a quarter of registered service review projects. The Trust has a strong commitment to education and to providing clinicians with the opportunity to access training and support for clinical audit within the Trust and through our close links with Sheffield Hallam University via the Postgraduate Certificate in Clinical Audit & Effectiveness. This accredited course is open to students across the UK with the current cohort set to complete in July 2011 and a new intake scheduled for September 2011.

Dr Foster Real Time Monitoring (RTM) and Practice & Provider Monitor (PPM) continue to be used routinely across the Trust. These systems enable organisations to recognise where there is variation in outcomes or activity compared to our peers and to see whether or not that variation is statistically significant. Mechanisms are embedded in the organisation to ensure mortality outcomes are routinely reported to the Clinical Effectiveness Committee and that any variances are explored in conjunction with the relevant clinical directorates. The Trust Hospital Standardised Mortality Ratio (HSMR) is monitored by the Healthcare Governance Committee on a quarterly basis and a new measure, the Summary Hospital Level Mortality Indicator (SHMI), is eagerly awaited for 2011. The Dr Foster Good Hospital guide 2010 rated the Trust 2009/10 HSMR value as "significantly low". The Trust was one of only 26 hospitals in England who retained a significantly low HSMR from the previous year.

Information Governance Assurance

The Trust has a continuing programme of work to ensure that person identifiable data (PID) is safe and secure when it is stored and transferred within and outside the organisation. As part of the Information Governance Assurance Framework (IGAF) mandated by the Department of Health and Connecting for Health the Trust has ratified the Controlled Document 'Mandated Procedures for the Transfer of Person Identifiable Data and Other Sensitive or Confidential Information' and has encrypted all known laptops and supplied encrypted USB sticks to staff. IGAF continues with support for the Senior Information Risk Owner (SIRO) and the Trust Information Asset Owners (IAOs)

There were no Information Governance Serious Untoward Incidents (IG SUIs), data breaches or losses reported during the year. See table below:

Summary of Other Personal Data Related incidents in 2010/11

Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	Nil
Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	Nil
Insecure disposal of inadequately protected electronic equipment, devices or paper documents	Nil
Unauthorised disclosure	Nil
Other	Nil

A good corporate citizen

Throughout the year,the Trust has identified opportunities to "punch its weight" in contributing to the health and economic wellbeing of the city. .For example,we have offered 67 apprenticeship places providing opportunities for local young people to develop skills and gain meaningful employment. The trust has actively engaged in the review of the Sheffield First partnership arrangements in 2010/11 and the development of the Sheffield City Strategy 2010-2020.The Trust is a member of the Sheffield Executive Board.

Caring for the environment

The Trust launched the Sustainable Development Programme in Spring 2010, committing to "have a positive impact on local health and wellbeing while reducing our negative impacts on the climate and environment. We will work in partnership with staff, patients, visitors and the community, to ensure their personal mission statement is to 'be green'".

One year on, the Sustainable Development Programme is progressing against this mission. As part of the NHS the Trust recognises that we have a corporate social responsibility to effectively manage our activities and is now beginning to develop mechanisms to incorporate sustainable development as a guiding principle to streamline the service we provide and the work we do.

The Trust also has a responsibility to monitor and report annually on figures relating to the sustainability of the Trust, this will allow us to focus measures to realise the national NHS carbon reduction targets, relating to the Climate Change Act targets (10% reduction by 2015 based on 2007 levels and 34% reduction by 2020 and 80% reduction by 2050 based on 1990 levels). The Sustainable Development Strategy Group is continuing to collaborate with specialist local and national organisations, to ensure the journey the Trust takes is aligned with the community strategies. Organisations the Trust engages with include Sheffield City Council, the Universities, the NHS Sustainable Development Unit, Sheffield Campaign Against Climate Change CO2Sence, Marks and Spencer, and others.

Energy

Specific measures are either completed or have been planned to reduce our energy carbon footprint in line with the 2015 targets of 10% reduction. Measures have included installing an automatic computer shutdown programme, energy efficient lighting, voltage optimisation, variable speed drives, improvements to building management system controls, the reduction of losses from the heating systems and improvements to the thermal insulation of buildings and building services across the Trust.

Waste

The Waste Management Department has implemented some major changes to where and how waste is disposed of. A combination of new contractors and differing disposal technologies have been used to structure the future of waste management at Sheffield Teaching Hospitals. Our targets mirror what is outlined above in the NHS carbon reduction strategy. In some instances the Trust has already achieved those goals, in other areas progress has been made towards those goals. The largest volume of waste the Trust produces is general household waste. Through current arrangements, this waste is diverted away from landfill to a local MRF (Materials Recycling Facility), where overall recycling and recovery rates average between 85%-95%, dependant on the types of material. The remaining percentage at the facility is currently sent to landfill.

Waste type	2009 - 2010 Tonnes	2010 - 2011 Tonnes
Household (Recovery)	2521.99	2043.307
Household (Landfill)	196.57	360.584
Clinical (HTI)	108.92	122.168
Clinical (Non Burn)	1518.5	1477.785
Recycling	206.46	135.967
Household waste spend	£287,651.00	278,260.00
Clinical waste spend	£739,324.00	£950,122.21
Recycling spend	£15,283.00	£11,478.00
Hazardous waste spend	£13,090.00	£14,447.75
Total spend	£1,055,348.00	£1,249,942.00
Percentage of Household waste Recycled / Recovered	93.28%	85.80%
Percentage of household waste Landfilled	6.72%	14.20%

Travel

The conflict between the need for staff to get to work and the environmental impact of car travel is a challenge faced constantly by the Trust, as indeed it is by other large organisations. However, with the help of the Trust's Travel Plan we strive to manage our travel and transport needs in a more sustainable manner. A successful Travel Plan has benefits for the organisation itself and also for staff, patients, visitors and the local community. The plan outlines the way in which the Trust will, where appropriate, manage the journeys of employees, patients and visitors in a more sustainable way by encouraging Car Sharing, Public Transport, Cycling and Walking, with an emphasis on reducing single occupancy car travel to the sites.

In the wider Sheffield area, the Trust has demonstrated its willingness to invest in sustainable transport by working in partnership with South Yorkshire Passenger Transport Executive (SYPTE), The University of Sheffield, Sheffield Hallam University, Sheffield City Council and Sheffield Children's Hospital. With the price of fuel at its all time high, it is no surprise that the number of registrations on the Trust's Car Share site has more than doubled over the last year. Registration is free and staff

who register do not have to agree to share with anyone unless they are completely happy to do so. To encourage more staff to join the scheme, the Trust is exploring possible incentives for the year ahead including some designated parking spaces. Recently the scheme has been extended by teaming up with the University of Sheffield Car Share and thus increasing the chances of finding a suitable match.

The H1 Hospital Shuttle bus which transports staff between the hospital sites continues to grow in popularity. Total patronage of the shuttle bus has increased by over 40% year on year since June 2009. The number of STH staff using the service has increased by up to 35%, but there has been an increase of between 70 - 85% in use of the service by other passengers, thus confirming the benefit of this service to the local community.

During August 2010 the Trust took part in BikeBoost, funded by Sheffield City Council and Get Cycling. 83 members of staff signed up for the challenge and were loaned a bike and all the necessary safety equipment for a period of 3 weeks. Each challenger was given the option to have a 2 hour free training session and asked to try and use the bike for 50% of their commuting journeys. Feedback was extremely good and several of the BikeBoost challengers went on to acquire a bike through the i-Choose scheme.

i-Choose a Bicycle, part of the Trust's salary sacrifice scheme was launched in February 2009 and offers staff the opportunity to select a bicycle and safety accessories and make Tax and National Insurance savings. The scheme has proved to be extremely popular and around 450 members of staff have acquired a bicycle through the scheme thus far. In conjunction with Sheffield City Council, we run monthly Bike Doctor Clinics. Bike Doctor, which provides a health and safety check for bicycles, is free to all members of staff. The Bike Doctor Clinics continue to be very popular all year round.

During Walk To Work Week 2010 the Trust teamed up with the Ramblers to promote 'Get Walking Keep Walking', with a very successful uptake from Trust staff. The Trust will again be taking part in 'Walk to Work Week' during mid-May 2011 and several new initiatives have been planned to encourage staff to leave their cars at home and discover the benefits of a healthier lifestyle.

Resources and raw materials

The Trust is aiming to improve its understanding of our impacts through procurement and the Trust's potential to specify more sustainable goods.

Staff awareness and motivation

A major part of 'be green' is the Be Green Representative (BGR) project. So far 154 members of staff have attended a 2-hour training session in how they can help identify projects (technological, service or behaviour based ideas) directly in the areas they work in and know well. Each BGR is then joined by the Sustainable Development Manager on a walkabout in their area, to provide further training on how to notice and identify ideas. BGRs are the eyes and ears and minds of the 'be green' campaign, their local knowledge is valued and they provide opportunity for embedding real change. Additional, more general 'be green' communication includes: Intranet page with regular news and information updates, frequent emails sent to staff and managers of staff without regular contact with IT, poster campaigns and items in team briefs.

Community awareness and motivation

The 'be green' campaign also communicates with the community, through the internet pages **http://www.sth.nhs.uk/about-us/be-green** and through the 'be green' 'Twitter' site **http://twitter.com/KatarinaMcC**. The campaign also works directly with our suppliers. We have held a 'be green' event subtitled 'Local roads to make your business future-proof and reduce your carbon footprint', to provide an opportunity for our suppliers to find out about the 'green' guidance and support available in both in Sheffield and nationally. We also incorporated an exhibition so delegates could make contact with local organisations to learn about the services they offer and to encourage sustainable local partnerships.

Working in partnership with the community

We are committed to the community we serve. This is reflected in our work at all levels: through our involvement in national initiatives that will change the way we provide care and services for that community, by working directly with local people and by encouraging them to become involved in what we do.

Foundation Trust Membership

Public Constituency	5,547
Patient Constituency	3,764
Staff Constituency	14,267
Total membership	**23,578**

As well as providing people with the opportunity to become involved in the development of their local hospitals, members receive a free copy of 'Good Health', a quarterly newspaper providing health information and news about hospital services.

We also run a series of exclusive members' events including lectures on topics of interest to the general public. Over 300 people attended the 2010/11 lecture series.

One of our key strengths remains the involvement of people who live locally or who have received treatment at one of our hospitals in our Governors' Council. The Council is made up of 37 foundation trust governors.

The Governors' Council purpose is:
- Promoting the achievement of the Trust's objectives
- Holding the Board to account and ensuring continued success through effective management, partnership working and maintaining NHS values and principles.

Formal meetings of the Governors' Council are held four times a year. The Trust's executive directors also attend Council meetings facilitating the sharing of information and specialist knowledge to support the Council's functions.

This enables governors to become involved in discussions and strategic planning at an early stage. Governors also make valuable contributions to specific projects by providing relevant expertise or offering a different perspective. Arrangements are also now in place for non-executive directors to individually meet the Governors at the Governors' Forum where they can develop a mutual understanding of their respective roles.

We expect governors to take reasonable steps to maintain a dialogue with their membership constituencies and / or sponsoring organisations. This enables them to canvass views on questions of strategic importance and report back on decisions that are made.

The Council appoints the Trust's non-executive directors, including the chair and determines their remuneration.

The Council also approves the appointment or removal of the Trust's auditors following a recommendation from the Audit Committee which is a committee of the Board.

The governors have involvement in specific activities and membership of a range of different groups and committees. Individual governors sit on a range of groups, many directly related to patient and user involvement, covering a wide range of the Trust's work, as well as attending one-off events throughout the year. Governors have also undertaken an extensive programme of visits to see departments of the Trust at work and report their findings to the Trust Executive.

All the public and patient governors are elected for a three-year term of office while the term for governors representing partner organisations is negotiable by their employing organisation. At the end of March 2011, membership of the full Governors' Council was as shown:

Membership of Governors' Council at the end of March 2011

Constituency	Governor	Expiration of term of office
Patient	John Holden	30-06-12
	Caroline Irving	30-06-13
	John Laxton	30-06-11
	Shirley Lindley	30-06-12
	Graham Thompson	30-06-11
	Christina Wakefield	30-06-11
	Michael Warner	30-06-12
Public North	Georgina Bishop	30-06-11
	George Clark	30-06-11
	Kaye Meegan	30-06-13
Public South West	Andrew Manasse	30-06-12
	Philip Seager	30-06-11
	Susan Wilson	30-06-13
Public West	Anne Eckford	30-06-13
	John Warner	30-06-11
	Beryl Wilson	30-06-11
Public South East	Yvonne Challans	30-06-12
	Hetta Phipps	30-06-13
	Danny Roberts	30-06-12
Staff		
Medical & Dental	Frank Edenborough	30-06-12
Nursing & Midwifery	Rose Bollands	Retired March 11
Allied Health Professionals, Scientists & Technicians	Viv Stevens	30-06-12
Managerial, Administrative & Clerical	Mark Hattersley	30-06-12
Ancillary, Works & Maintenance	VACANT	
Partner Organisation	**Governor**	
NHS Sheffield	Jeremy Wight	
Sheffield City Council	Steve Ayris, Richard Webb	
University of Sheffield	Vacant	
Sheffield Hallam University	Rhiannon Billingsley	
Sheffield College	Heather MacDonald	
South Yorkshire Police	Simon Torr	
Sheffield Health & Social Care NHS FT	Michael Rooney	
Sheffield First Partnership	Jack Scott	
Voluntary Action Sheffield	Vacant	
NHS Yorkshire & the Humber	Vacant	
Non-Sheffield PCT	Vacant	

GOVERNORS COUNCIL MEMBERS AND ATTENDANCE AT MEETINGS

NAME	8.6.10	21.9.10	7.12.10	22.3.11
Public/Patient Governor				
G Bishop	✓	Apols	X	✓
R Bollands	✓	Apols	Apols	Apols
Y Challans	✓	Apols	X	✓
G Clark	✓	✓	✓	Apols
A Eckford	✓	Apols	✓	✓
F Edenborough	✓	✓	✓	✓
M Hattersley	✓	Apols	✓	✓
J Holden	✓	✓	✓	Apols
C Irving From July 2010	-	✓	Apols	Apols
J Laxton	✓	✓	✓	Apols
S Lindley	X	✓	Apols	Apols
A Manasse	✓	✓	✓	Apols
K Meegan	✓	✓	X	Apols
H Phipps From July 2010	-	✓	Apols	✓
D Roberts	✓	Apols	✓	✓
P Seager	✓	X	X	X
V Stevens	✓	✓	Apols	Apols
G Thompson	✓	✓	✓	✓
C Wakefield	✓	✓	Apols	Apols
J Warner	✓	✓	Apols	✓
M Warner	✓	X	✓	✓
B Wilson	X	X	X	X
S Wilson From July 2010	-	✓	Apols	✓
Partner Governor				
R Billingsley	X	✓	X	Apols
S Torr from Sept 2010	-	X	✓	Apols
R Webb	Apols	Apols	Apols	✓
M Rooney from Sept 2010	-	X	X	X
H McDonald	Apols	✓	✓	Apols
S Ayris from Sept 2010	-	Apols	Apols	X
J Scott	X	X	X	X
J Wight	✓	✓	✓	✓
Exec/ NED Officer				
D Stone, Chairman	✓	✓	✓	✓
A Cash	✓	✓	Apols	✓
N Priestley	✓	✓	Apols	✓
H Chapman	✓	Apols	✓	Apols
M Richmond	✓	✓	Apols	Apols
C Linacre	Apols	✓	✓	✓
M Gwilliam	✓	✓	✓	✓

Meet the Board of Directors

The Board of Directors comprises the chairman, seven non-executive directors and six executive directors. Together they bring a wide range of different skills and experience to the Trust, enabling it to achieve balance and completeness at the highest level.

The non-executive directors, including the chairman, are people who live or work in the area and have shown a genuine interest in helping to improve the health of local people. They are not employees of the Trust. The non-executive directors are determined by the Board to be independent in both character and judgement.

The chairman, executive and non-executive directors have declared their interests as set out on below. The Board is satisfied that no conflicts of interest are indicated by any external involvement. This disclosure is updated regularly and is available to the public on our Internet site at **www.sth.nhs.uk**

The Board of Directors can be contacted by writing to:

Trust Secretary, Sheffield Teaching Hospitals NHS Foundation Trust 8 Beech Hill Road, Sheffield S10 2SB.

Senior Independent Director

In January 2007 the Board of Directors agreed the requirement for a senior independent director to act with 'independence of mind' and provide a channel through which foundation trust members and governors are able to express concerns, other than the normal route of the chairman, chief executive or finance director.

Mr Vic Powell was subsequently appointed in April 2007 from the six non-executive directors then sitting on the Board and remains in this role.

Appointments

Non-executive directors are appointed via an open advertisement and formal interview process, which the NHS Appointments Commission manages on behalf of the Trust.

The final appointment of non-executive directors, including that of the chair, is made by the Nomination Committee of the Governors' Council, which also determines their remuneration.

Development of the Board

During 2010/11 the Board held a number of development time outs, designed to strengthen its work in relation to the Trust's corporate strategy for 2008-2012. The Board continued its focus on the effectiveness with which it works through the introduction of After Action Reviews at the conclusion of each Board meeting and the continued use of strategic seminars at set points in the financial year to debate key strategic issues and provide updates on key emerging issues.

Meetings of the Board

The Board of Directors meets every month. The majority of these, including any extraordinary meetings, are held privately with only the Board of Directors, associated employees, and employees of the Trust making presentations to the Board, in attendance.

The Chairman

David Stone CBE, Chairman

Mr David Stone CBE has been Chairman of the Board since the formation of the Trust in 2001 and steered the Trust to Foundation Trust status in 2004.

He was previously Chairman of Weston Park Hospital and Central Sheffield University Hospitals NHS Trusts and was Chair of the UK University Hospitals Chairs Group from 2005-2008.

The Executive Directors

Sir Andrew Cash OBE

Chief Executive

Sir Andrew Cash joined the NHS as a fast track graduate management trainee and has been a chief executive for over 20 years.

He has worked at local, regional and national level. He has worked by invite at the Department of Health, Whitehall on a number of occasions. He is a visiting Professor in Leadership Development at the Universities of York and Sheffield. Andrew has been Chief Executive of Sheffield Teaching Hospitals NHS since it achieved Foundation Trust in July 2004.

Neil Priestley

Director of Finance

Neil Priestley was appointed to the post of Director of Finance of the newly merged Sheffield Teaching Hospitals in February 2001.

He had previously held the post of Head of Finance at the NHS Executive Trent Regional Office, from where he had been seconded to the Northern General Hospital as acting Director of Finance prior to the Trust merger. Mr Priestley is a Fellow of the Chartered Association of Certified Accountants.

Mark Gwilliam

Director of Human Resources and Organisational Development

Mark took up his post as Director of Human Resources and Organisational Development in May 2009 and brings with him a wealth of experience.

He was previously an Associate Director of Human Resources at Central Manchester University Hospitals NHS Foundation Trust where he worked for 3 years. Prior to this he worked as Head of HR at Central Manchester and Manchester Children's University Hospital.

Professor Hilary Chapman

Chief Nurse/Chief Operating Officer

Hilary joined the Trust in March 2006 as Chief Nurse before taking up her current role of Chief Nurse/Chief Operating Officer in December 2009.

Hilary began her nursing career at the Northern General Hospital, where she undertook training and worked as Staff Nurse, then Sister in both the cardiothoracic and critical care areas. Before joining the Trust as Chief Nurse in 2006, Hilary held the post of Chief Nurse at the University Hospitals Coventry and Warwickshire NHS Trust. Hilary is a Member of the NIHR Advisory Board and an expert member of the National Quality Board She is a Visiting Professor, Faculty of Health and Wellbeing, Sheffield Hallam University.

Professor Mike Richmond

Medical Director

Professor Mike Richmond was initially appointed as a consultant anaesthetist and honorary senior lecturer to the Jessop Hospital for Women in February 1988 having trained in Sheffield, Oxford and the Royal Air Force.

He has 12 years' experience as a clinical director. Professor Richmond has had a long involvement with the Royal College of Anaesthetists, acting as a final fellowship examiner for the past 10 years. He was appointed as the Trust's Medical Director in April 2008

Chris Linacre

Director of Service Development

Chris Linacre joined the NHS in 1971 and has worked in hospital management and specialist personnel management in Sheffield since that time.

He has held post as Director of Organisational Development at the Royal Hallamshire Hospital and General Manager of Lodge Moor and Kind Edward Hospitals prior to becoming Director of Corporate Strategy for the former Central Sheffield University Hospitals NHS Trust when it was established in 1992. He has held the post of Director of Service Development since Sheffield Teaching Hospitals was formed in April 2001.

The Non Executive Directors

Vic Powell

Victor Powell is an accountant by profession and worked for KPMG in Sheffield throughout his professional career.

He was involved in the management of the North-East Region in general and the Sheffield office in particular where he was Business Unit Managing Partner for nine years until his retirement.

Iain Thompson

Iain Thompson has held senior supply chain positions in the flour milling and brewing industries.

He returned to Sheffield in 2003 following early retirement and joined the Board of Directors in May 2008.

Professor Anthony Weetman

Tony Weetman is Pro Vice Chancellor of the Faculty of Medicine, Dentistry and Health and the Sir Arthur Hall Professor of Medicine at the University of Sheffield.

He is also an Honorary Consultant Physician in the Trust (from 1991) and was formerly a non-executive Director at the Northern General Hospital NHS Trust.

John Donnelly

John Donnelly was a Chief Superintendent with South Yorkshire Police and Commander for the district that covers the Trust's hospitals.

He joined the police as a cadet in 1966 and, in time, headed up the Force's Research and Development, Community Relations, and Police Traffic Departments. He retired from the police service in 2005.

Vickie Ferres

Vickie Ferres is Chief Executive of Age Concern in Doncaster, a position she has held since 1983.

A Sheffield resident, Vickie has extensive experience in working with older people and understanding the health and social care issues that affect them. She was formerly a non-executive Director at the Northern General Hospital NHS Trust.

Shirley Harrison

Shirley Harrison's professional career has been in marketing and public relations, both as a practitioner and an academic.

She was formerly the Director of Public Relations at Sheffield City Council. She is a former chair of the Human Fertilisation and Embryology Authority chair of the South Yorkshire Probation Board and former chair of the Human Tissue Authority.

Jane Norbron

Jane Norbron has held senior management posts at Marks and Spencer, Meadowhall and has expertise in both human resources and commercial management.

She is currently a business consultant and performance coach and has a special interest in helping more women achieve senior management positions.

The following Directors also attend the Board of Directors meetings.

Julie Phelan

Communications Director

Julie Phelan spent her early career as a journalist in both print and broadcast media before moving into public sector communication in local government and health.

She was previously Head of Communications at Sandwell and West Birmingham Hospitals NHS Trust, Head of Communications for Birmingham Women's Hospital and Director of Communications for Worcestershire Acute Hospitals and Worcester Health Authority. Before joining the Trust in June 2008, Julie was Director of Communications for University Hospitals Coventry and Warwickshire NHS Trust.

Neil Riley

Trust Secretary

Neil Riley is a graduate of Queens College, Oxford and in 1981 joined the National Health Service as a management trainee.

He has subsequently worked in a number of NHS settings across the country and in 1995 was appointed as Chief Executive of Weston Park Hospital. In 2002 Mr Riley was appointed to the post of Assistant Chief Executive at Sheffield Teaching Hospitals NHS Trust and most recently, was appointed to the post of Trust Secretary for Sheffield Teaching Hospitals NHS Foundation Trust.

Attendances at Board of Directors, Meetings and Associated Committees - 2010/11

Date of Meeting	David Stone	Andrew Cash	Hilary Chapman	John Donnelly	Vickie Ferres	Mark Gwilliam	Shirley Harrison	Chris Linacre	Jane Norbron	Julie Phelan	Vic Powell	Neil Priestley	Mike Richmond	Andy Riley	Neil Riley	Iain Thompson	Tony Weetman
21.4.10	✓	APOL	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
19.5.10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
4.6.10 (Strategic)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	APOL	APOL	✓	✓	✓	✓
16.6.10	✓	✓	✓	✓	✓	✓	✓	DEP	✓	APOL	✓	✓	✓	✓	✓	✓	✓
21.7.10	✓	✓	✓	✓	✓	✓	APOL	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
18.8.10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	DEP	✓	✓	✓	✓
15.9.10	✓	✓	✓	✓	✓	✓	✓	✓	✓	APOL	✓	✓	✓	✓	✓	APOL	✓
20.10.10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
17.11.10	✓	✓	✓	✓	✓	APOL	✓	✓	APOL	✓	✓	✓	✓	✓	✓	✓	✓
15.12.10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	APOL
19.1.11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
16.2.11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
16.3.11	✓	✓	✓	✓	✓	✓	APOL	✓	✓	✓	✓	✓	✓	✓	✓	✓	APOL

DEP = Deputy

Audit Committee

Date of Meeting	John Donnelly (Chair)	Shirley Harrison	Vic Powell	Prof A Weetman
13.4.10	✓	✓	✓	✓
27.5.10	✓	APOL	✓	✓
2.8.10	✓	✓	✓	APOL
2.11.10	✓	✓	✓	✓
1.2.11	✓	✓	✓	✓

Human Resources Committee

Date of Meeting	Jane Norbron (Chair)	Mark Gwilliam	Shirley Harrison (wef 1/9/10
21.5.10	✓	✓	X
23.7.10	✓	✓	X
20.9.10	✓	✓	✓
26.11.10	✓	✓	✓
17.1.11	✓	✓	APOL

Finance Committee

Date of Meeting	Vic Powell (Chair)	Andrew Cash	Hilary Chapman	John Donnelly	Mark Gwilliam	Chris Linacre	Neil Priestley	David Stone
12.4.10	✓	APOL	✓	✓	✓	✓	✓	APOL
10.5.10	✓	✓	DEP	✓	✓	APOL	✓	✓
7.6.10	✓	✓	✓	✓	✓	DEP	✓	✓
12.7.10	Part	✓	✓	✓	✓	✓	✓	✓
9.8.10	✓	APOL	APOL	APOL	✓	✓	✓	✓
6.9.10	✓	✓	✓	✓	✓	✓	✓	✓
11.10.10	✓	✓	✓	✓	✓	✓	✓	✓
8.11.10	✓	✓	DEP	✓	✓	✓	✓	✓
6.12.10	✓	APOL	✓	✓	APOL	✓	✓	APOL
10.1.11	✓	APOL	✓	✓	✓	✓	✓	✓
7.2.11	✓	✓	✓	APOL	✓	APOL	✓	✓
No March Mtg								

DEP = Deputy

Healthcare Governance Committee

Date of Meeting	Vickie Ferres (Chair)	Hilary Chapman	Mark Gwilliam	Shirley Harrison	Chris Linacre	Mike Richmond	Neil Riley	Iain Thompson	Tony Weetman
26.4.10	✓	APOL	✓	✓	✓	✓	✓	✓	✓
17.5.10	✓	✓	DEP	✓	✓	DEP	✓	✓	APOL
29.6.10	✓	DEP	✓	APOL	✓	✓	APOL	APOL	APOL
26.7.10	✓	✓	DEP	APOL	APOL	✓	APOL	✓	✓
NO MTG IN AUGUST									
20.9.10	✓	✓	APOL	✓	APOL	✓	APOL	X	APOL
25.10.10	✓	✓	✓	✓	✓	✓	✓	✓	
29.11.10	✓	DEP	✓	✓	APOL	APOL	✓	✓	✓
20.12.10	✓	✓	APOL	✓	✓	✓	✓	✓	✓
24.1.11	✓	✓		✓	APOL	✓	✓	✓	✓
21.2.11	✓	✓	✓	APOL	APOL	✓	✓	APOL	APOL
21.3.11	✓	✓	✓	APOL	APOL	DEP	APOL	✓	✓

DEP = Deputy

Standards of business conduct - declaration of interests members of the Board of Directors and other Executive Directors 1st April 2010 to 31st March 2011

Interest declared

DATE	NAME	JOB TITLE	INTERESTS
9.3.11	Sir Andrew Cash	Chief Executive	Visiting Professor to the University of York's Centre for Leadership and Development, Department of Health Studies Non-Executive Director, Medilink (Yorkshire & The Humber) Ltd Professor (Visiting Chair) at the University of Sheffield Leadership Centre Honorary Colonel, 212 Field Hospital Director of Quality Healthcare Advice Limited Director of Trent Healthcare Limited Brother -Northern Regional Chairman of Building Design Partnership
1.3.11	Professor Hilary Chapman	Chief Nurse/Chief Operating Officer	Member - NIHR Advisory Board Visiting Professor, Faculty of Health and Well-Being, Sheffield Hallam University Member of National Quality Board
1.3.11	Mr. John Donnelly	Non Executive Director	Trustee - Sheffield Hospitals Charitable Trust Chair - General Medical Council Fitness to Practice Panels
16.3.11	Ms. Vickie Ferres	Non Executive Director	Chief Executive - Age Concern, Doncaster Member - Weston Park Hospital Cancer Trust Husband - Non Executive Director, Sheffield Health and Social Care Trust
2.3.11	Ms. Shirley Harrison	Non Executive Director	Member, North Trent Consumer Research Panel (unpaid) Lay peer reviewer: NHS SDO R&D Programme Associate Consultant, SCALE Consultants Ltd. Consumer representative, Cancer Research UK Clinical Trials Awards Advisory Committee Consumer representative, Governance Board, Stratified Medicine Project
3.3.11	Mr. Chris Linacre	Director of Service Development	Non Executive Director of Medipex Ltd. Non Executive Director of EPAQ Ltd (a company in which the Trust has a shareholding) Non Executive Director of Zilico Ltd (formerly called Aperio Diagnostic - a company in which the Trust has a shareholding)

DATE	NAME	JOB TITLE	INTERESTS
7.3.11	Ms. Jane Norbron	Non Executive Director	Company Director of Jane Norbron Limited - Acts as Business Consultant and Performance Coach Involved with organisation International Women of Excellence (Registered Charity) (unpaid) - promotes the appointment of women to senior positions Accredited management assessment centre for the Institute for the Motor Institute (Sector Skills Council)
9.3.11	Mr. Vic Powell	Non Executive Director	Member of DoH Foundation Trust Finance Facility
9.3.11	Professor Mike Richmond	Medical Director	Undertakes Private Practice at Thornbury Hospital Visiting Professor, Faculty of Health & Wellbeing, Sheffield Hallam University. Director, Quality Healthcare Advice Limited Director, Trent Healthcare Limited
4.3.11	Mr. Neil Riley	Trust Secretary	Visiting Professor, Faculty of Health and WellBeing, Sheffield Hallam University
2.3.11	Mr. David Stone	Chairman	Trustee of Freshgate Foundation Trustee of Sheffield Botanical Gardens Trust Honorary Consul, Republic of Finland Chairman, Cutlers Hall Preservation Trust
1.3.11	Professor Anthony Weetman	University Representative	Chair, Medical Schools Council Chair, Clinical Endocrinology Trust Board member, UK Clinical Aptitude Test Member of Council, Royal College of Physicians of London Member, Health and Education National Strategic Exchange Member, Joint Medical Consultative Committee Member, UUK Health and Social Care Advisory Committee

NIL RETURNS

DATE	NAME	JOB TITLE
1.3.11	Mr. Neil Priestley	Director of Finance
1.3.11	Mrs. Julie Phelan	Communications Director
9.3.11	Mr. Iain Thompson	Non Executive Director
16.3.11	Mr. Mark Gwilliam	Director of Human Resources

Audit Committee

The Audit Committee (AC) is appointed by the Board of Directors and consists of four non-executive directors of the Trust and the Chair of the Healthcare Governance Committee. The Director of Finance, Trust Secretary, the Head of Internal Audit and a representative from the external auditor normally attend meetings.

The AC plays a role in internal control and management reporting, internal audit, external audit, financial reporting, special assignments and corporate governance. It meets regularly (not less than three times a year), is authorised by the Board of Directors to investigate any activity within its terms of reference and is authorised to seek any information it requires from a Trust employee in achieving this objective. Outside legal or other independent professional advice may also be sought if considered necessary by the committee.

Other committees of the Board include: the Finance Committee, Human Resources Committee, Healthcare Governance Committee and Remuneration Committee.

Governance code

The Board has considered the Monitor Code of Governance and is compliant. So far as the Board of Directors is aware, all possible steps have been taken to ensure that all relevant audit information has been disclosed in full to the auditors.

Remuneration

Further details of remuneration are given in the remuneration report on page 81. The accounting details for pensions and other retirement benefits are set out in the accounts on page 104.

Countering fraud and corruption

The Board remains committed to maintaining an honest and open atmosphere within the Trust; ensuring all concerns involving potential fraud have been identified and rigorously investigated. In all cases appropriate civil, disciplinary and/or criminal sanctions have been applied, where guilt has been proven. The local counter fraud specialist has been instrumental in creating an anti-fraud culture, which has enabled maximum deterrent and prevention measures to become embedded in the Trust. Fraud against the NHS is never acceptable and any concerns may be reported via the Fraud and Corruption Hotline on 0800 028 4060. By maintaining fraud levels at an absolute minimum the Trust ensures that more funds are available to provide better patient care and services.

Remuneration Report

Remuneration committee

The Pay and Remuneration Committee is a formally appointed committee of the Board of Directors. Its Terms of Reference comply with the Secretary of State's "Code of Conduct and Accountability for NHS Boards".

The membership of the committee comprises the non-executive directors of the Board, together with the Chairman and Chief Executive (except where matters relating to the Chief Executive are under discussion).

The Directors of Finance and Human Resources are in attendance at all meetings to advise the committee and ensure that an appropriate record of proceedings is kept.

Remuneration of Chairman and non-executive directors

The remuneration of the Chairman and non-executive directors is determined by the Remuneration Committee of the Governors' Council.

The committee comprises six governors and the Trust's Chairman. The Chairman does not attend or participate in any meetings of the Governors' Council Remuneration Committee when matters relating to the Chairman's remuneration are discussed. The decisions of the Remuneration Committee are reported to the Governors' Council. In determining the remuneration for the Chairman and non-executive directors, account is taken of the guidance provided by the Foundation Trust Network.

Remuneration of senior managers

In determining the pay and conditions of employment for senior managers, the committee takes account of national pay awards given to the Pay and Non-Pay Review staff groups, together with the "NHS Board Room Pay Report" findings for executive directors produced by Incomes Data Services Ltd.

Assessment of performance

All executive and non-executive directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to the following 31 March.

During the year regular reviews take place to discuss progress, and there is an end of year review to assess achievements and performance. The executive directors are assessed by the Chief Executive; following this there is a meeting between the Chairman and each executive director to discuss their performance. The chairman undertakes the performance review of the Chief Executive and non-executive directors. Individual performance review is well established in the Trust, and is an integral part of developing the executive and non-executive directors' personal development plans.

Performance pay

No element of the executive and non-executive directors' remuneration is performance related.

Duration of Contracts

All executive directors have a substantive contract of employment with a 12-month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the executive director.

Name	Date Of Contract	Unexpired term at 31 March 2011
Andrew Cash	1 July 2004	10 years
Hilary Chapman	1 February 2006	12 years
Chris Linacre	1 July 2004	3 years
Neil Priestley	1 July 2004	15 years
Mark Gwilliam	1 March 2009	18 years
Mike Richmond	28 April 2008	10 years

The Chairman and the Non-executive director appointments are due for renewal as shown:

Name	Position	Term of Office Commenced	Term of Office Ends
David Stone	Chairman	Reappointment commenced 1 July 2008	30 June 2012
John Donnelly	Non-executive director	Reappointment commenced 1 July 2010	30 June 2014
Vickie Ferres	Non-executive director	Reappointment commenced 1 July 2009	30 June 2013
Shirley Harrison	Non-executive director	Appointment commenced 1 November 2007	31 October 2011
Jane Norbron	Non-executive director	Appointment commenced 1 July 2007	30 June 2011
Vic Powell	Non-executive director	Reappointed commenced 1 July 2007	30 June 2011
Iain Thompson	Non-executive director	Appointment commenced 1 May 2008	30 April 2012
Anthony Weetman	Non-executive director	Reappointment commenced 1 July 2009	30 June 2013

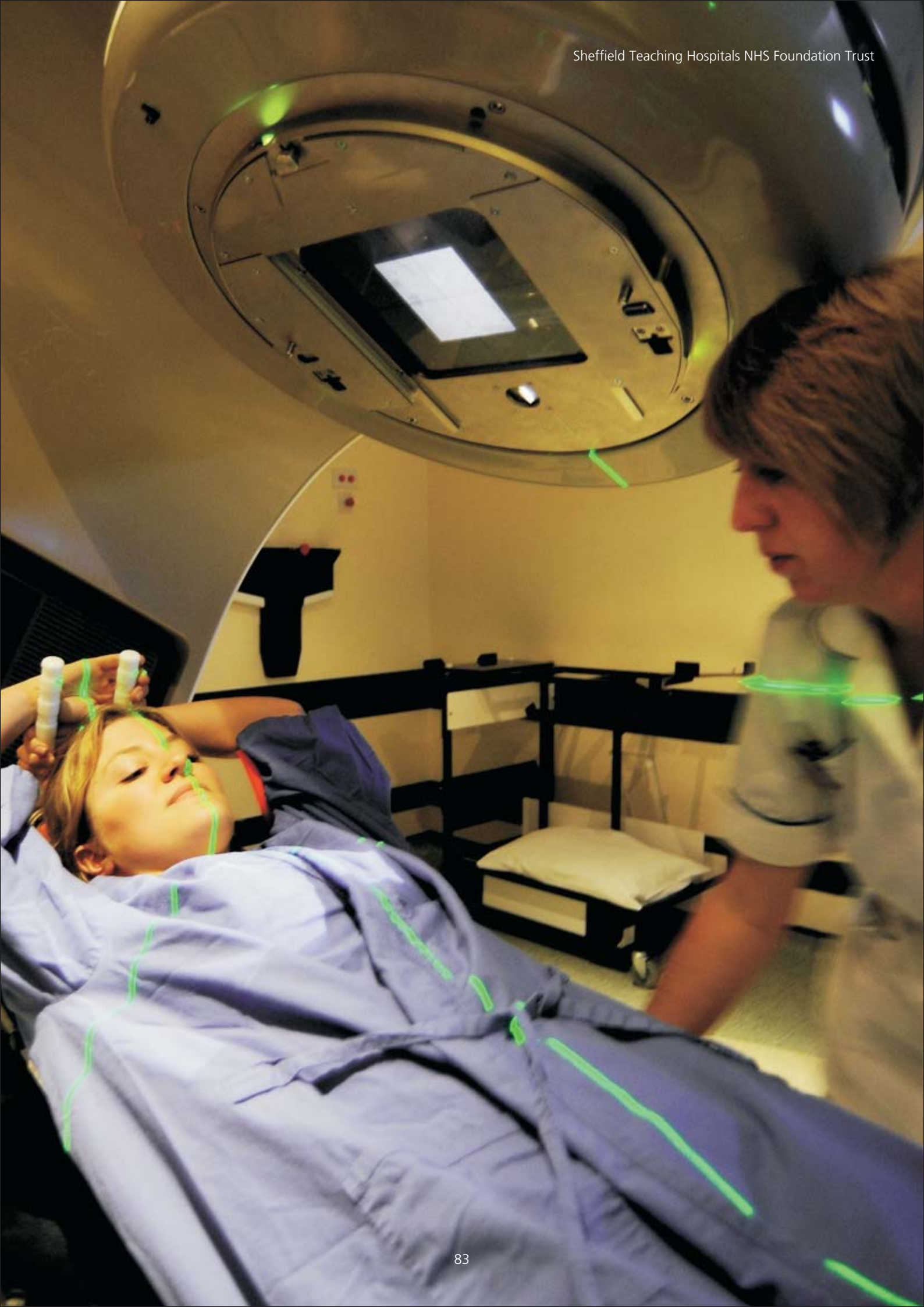
Early Termination Liability

Depending on the circumstances of the early termination the Trust would, if the termination were due to redundancy, apply redundancy terms under Section 16 of the Agenda for Change Terms and Conditions of Service or consider severance settlements in accordance with HSG94 (18) and HSG95 (25).

Other Information:

Please refer to the notes in the 10/11 Accounts contained on pages 103-104 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Changes in Pension at age 60 during 10/11
- Value of the cash equivalent transfer value at the beginning of the year
- Changes in the cash equivalent transfer value during 10/11.



Director of Finance Report

The 2010/11 financial year has been another challenging one and is indicative of the difficult financial environment the Trust will face in the coming years.

The Accounts show a year-end surplus of £2.4m which is 0.3% of turnover. The Trust's 2010/11 Financial Plan was for a surplus of £6.7m but if the technical non-cash impact of estate revaluations is excluded, the Trust's operating position was marginally ahead of plan. Overall, therefore, the results represent a very satisfactory position with continued financial stability for the Trust alongside its significant service achievements.

The Trust's income grew only marginally in 2010/11 as shown below:-

	£M	% increase over 2009/10
Income from patient services	658.5	1.6
Other operating income	145.1	3.9
Total Income	803.5	2.0

Whilst Primary Care Trusts still received significant allocation increases in 2010/11, the Trust's low level of growth in income from patient services reflects the NHS's preparations for the more austere financial environment expected from 2011/12. The outturn position was very close to plan in overall terms but non-elective work was significantly above plan leading to an elective under performance.

The Trust again faced a major efficiency requirement of £39.2m, although part of this was to create the planned surplus referred to above. The cumulative requirement for the 5 years up to and including 2010/11 was £153m. The Trust failed to deliver around £5m of its efficiency plans in 2010/11 which reflects the difficulty of this cumulative challenge. However, the coming years will almost certainly require even greater levels of efficiency savings which is a major concern.

Neil Priestley
Director of Finance

Pay Costs rose by 3.4% in the year which reflects pay awards and a small increase in hosted/externally funded staff. Drug costs rose by 3.4%, clinical supplies and services by 3.9% and purchase of healthcare from non-NHS bodies rose by less than 1%, indicative of the much reduced expansion in hospital services. Clinical Negligence costs, having almost doubled in the previous year, increased by a further 8.8% in to just under £11m. Depreciation and financing costs reduced by 11.4% and this was crucial to the overall results.

Total capital expenditure for the year was £39.0m which again represents a major investment in the Trust's facilities and equipment. Slippage, due to planning and operational pressures, resulted in an underspend against available resources of £15.1m. However, these resources will be carried-forward to undertake the planned schemes in 2011/12.

As in previous years, the Trust's capital programme sought to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk, improving the patient experience and facilitating new, improved and expanded services. The 2010/11 capital expenditure is analysed as follows:-

	£,000	£,000
Service Development	**23,155**	
Laboratory Medicine Facilities (NGH)		2,682
Office Accommodation		2,463
Plastic & Hand Surgery Unit		2,235
Schemes associated with Surgical Reconfiguration		2,179
Surgical Assessment Centre		1,990
2nd Gamma Knife		1,773
Conversion Renal F Floor		1,428
Cystic Fibrosis Inpatient Facilities		1,354
Clinical Skills		1,182
Reconfiguration of Burns Unit		1,163
Breast Screening Unit		1,093
Reconfiguration Ophthalmic Outpatient Department		738
NGH 2nd Fluoroscopy Room		667
Other smaller schemes		2,208
Medical Equipment	**5,940**	
Replacement Linear Accelerator WPH		1,966
Equipment Replacement Programmes eg, Ultrasound & Echocardiography machines, Ventilators, & Scopes		1,169
2 Replacement Gamma Cameras RHH & NGH		1,124
Digital Imaging Equipment WPH		345
Other		1,336
Statutory Compliance	**341**	
Fire Safety		137
Moving & Handling Equipment		49
Other (eg Security, Road Safety, DDA compliance etc)		155
Information Technology	**2,845**	
Single Patient Record & Admission System		1,095
Dental Hospital IT Infrastructure		270
Other		1,480
Infrastructure	**6,758**	
Energy Efficiency Schemes		1,707
Ward Refurbishments (inc Renal E Floor)		1,527
Generator Capacity Expansion		541
Brearley/Firth/CCDH Lifts		524
Catering Infrastructure		469
Batch Tunnel Washer - Laundry		411
Other		1,579
Total Expenditure	**39,039**	

Total capital income available to the Trust for the year was £54.1m. The capital income is analysed as follows:-

	£,000
Resources available from the Department of Health/Internally Generated	52,226
Donations to Cystic Fibrosis Inpatient Facility	1,000
Other Donations/External Income	880
Total Income	**54,106**

The Trust's net assets employed at 31 March 2011 were £361.3m compared with £361.0m at the previous year-end. Net current assets at 31 March 2011 were £23.6m, although this position is inflated by the high level of cash balances referred to below.

Outstanding "borrowings" relating to Foundation Trust Financing Facility loans and a PFI contract totalled £54.5m at the year-end.

Cash balances were £64.9m at the year-end, an increase of £22.8m over the year. Of the £64.9m, around £28m relates to resources committed to capital schemes in the next 2 years and around £18m relates to R&D and other commitments. This leaves an uncommitted balance of around £19m which the Trust believes is the minimum required to maintain a healthy working capital position and to provide a degree of financial security in the difficult years ahead.

On Monitor's Financial Risk Rating of one to five, where one represents very high risk and five very low risk, the Trust planned and achieved a risk rating of four. The Trust was at all times compliant with its Prudential Borrowing Limit and its private patient income was well within the level specified in the statutory cap.

Overall, therefore, the Trust's 2010/11 financial results are satisfactory, particularly when set alongside excellent service performance and the challenging financial environment. However, it is clear that the Trust, along with the rest of the NHS, faces an immensely difficult future as demands on services continue to grow but with no real terms funding growth for the next four years. Further major efficiency targets are therefore inevitable as there appear to be cuts to Education and Training funding following the Department of Health's MPET Review. In addition to this, other funding cuts are likely as commissioners seek to deliver significant savings through reduced use of hospital services and national contracts/business rules become ever more challenging for providers. The Trust remains committed to delivering high quality services and to achieving real efficiency savings to address the future financial pressures and to protect our services. However, the likely size of the potential efficiency requirement means that there can be little doubt about the size of the financial challenges ahead.

Independent Auditor's report to the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust

I have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Governors' Council those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with Monitor's requirements.

Certificate

I certify that I have completed the audit of the accounts of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Damian Murray
Officer of the Audit Commission
3 Leeds City Office Park
Holbeck
Leeds
LS11 5BD

27 May 2011

Statement of the chief executive's responsibilities as the accounting officer of Sheffield Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Sheffield Teaching 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 Sheffield Teaching Hospitals NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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

Sir Andrew Cash,
OBE, Chief Executive
Date: 26 May 2011

Financial statements

Sheffield Teaching Hospitals NHS Foundation Trust Foreword to the accounts

These accounts for the year ended 31 March 2011 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed

Sir Andrew Cash, OBE,
Chief Executive

Statement of Comprehensive Income for the year ending 31 March 2011

	NOTE	2010/11 £000	2009/10 £000
Operating Income from continuing operations	3.1	803,511	787,446
Operating Expenses for continuing operations	4.1	(788,990)	(826,668)
OPERATING SURPLUS / (DEFICIT)		**14,521**	**(39,222)**
FINANCE COSTS			
Finance income	7.1	408	243
Finance expense- financial liabilities	7.2	(2,663)	(2,549)
Finance expense-unwinding of discount on provisions		(59)	(56)
PDC Dividends payable		(9,759)	(12,570)
NET FINANCE COSTS		**(12,073)**	**(14,932)**
Surplus / (Deficit) from continuing operations		**2,448**	**(54,154)**
Other comprehensive income			
Impairment		(2,068)	(106,431)
Revaluation		177	4,093
Increases in donated asset reserve due to receipt of donated assets		1,856	901
Other recognised losses		(2,105)	(2,155)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**308**	**(157,746)**

The notes on pages 93 to 122 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement Of Financial Position 31 March 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Intangible assets	8.1	1,139	1,169
Property, plant and equipment	9.1	389,628	386,885
Investments	11.0	0	0
Trade and other receivables	13.1	5,243	4,522
Total non-current assets		**396,010**	**392,576**
Current assets			
Inventories	12.1	12,179	12,059
Trade and other receivables	13.1	29,939	32,185
Cash	22	64,895	42,072
Total current assets		**107,013**	**86,316**
Current liabilities			
Trade and other payables	15.1	(63,366)	(58,593)
Borrowings	17	(2,033)	(1,345)
Provisions due within one year	20	(4,489)	(1,678)
Other liabilities	16	(13,481)	(11,019)
Total current liabilities		**(83,369)**	**(72,635)**
Total assets less current liabilities		**419,654**	**406,257**
Non current liabilities			
Borrowings	17	(52,465)	(38,497)
Provisions due after one year	20	(2,308)	(2,498)
Other liabilities	16	(3,556)	(4,295)
Total non-current liabilities		**(58,329)**	**(45,290)**
Total assets employed		**361,325**	**360,967**
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		324,657	324,607
Revaluation reserve	21	24,355	27,346
Donated asset reserve		28,477	28,914
Income and expenditure reserve		(16,164)	(19,900)
Total taxpayers' equity		**361,325**	**360,967**

The financial statements on pages 89 to 122 were approved by the Audit Committee under delegated authority from the Board on 26 May 2011 and were signed on behalf of the Board by:

Sir Andrew Cash,OBE, Chief Executive
26 May 2011

Statement Of Changes In Taxpayers' Equity

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income & Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**360,967**	**324,607**	**27,346**	**28,914**	**(19,900)**
Surplus for the year	2,448				2,448
Revaluation gains on plant and equipment	177		87	90	
Impairment losses on property, plant and equipment	(2,068)		(1,726)	(342)	
Increase in the donated asset reserve due to receipt of donated assets	1,856			1,856	
Other recognised gains and losses	(2,105)		(1,352)	(2,041)	1,288
Public Dividend Capital received	50	50			
Taxpayers' Equity at 31 March 2011	**361,325**	**324,657**	**24,355**	**28,477**	**(16,164)**
Taxpayers' Equity at 1 April 2009	**514,313**	**320,207**	**121,081**	**41,563**	**31,462**
(Deficit) for the year	(54,154)				(54,154)
Revaluation gains on plant and equipment	4,093		3,577	516	
Impairment losses on property, plant and equipment	(106,431)		(94,496)	(11,935)	
Increase in the donated asset reserve due to receipt of donated assets	901			901	
Other recognised gains and losses	(2,155)		(2,816)	(2,131)	2,792
Public Dividend Capital received	4,400	4,400			
Taxpayers' Equity at 31 March 2010	**360,967**	**324,607**	**27,346**	**28,914**	**(19,900)**

Statement Of Cash Flows 31 March 2011

	NOTE	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Operating surplus / (deficit) from continuing operations		14,521	(39,222)
Non-cash income and expense:			
Depreciation and amortisation		24,525	26,357
Impairments		10,689	65,154
Reversals of impairments		(678)	(288)
Transfer from the donated asset reserve		(2,041)	(2,131)
Decrease / (increase) in Trade and Other Receivables		2,654	(1,413)
(Increase) in Inventories		(120)	(2,421)
Increase in Trade and other Payables		2,050	6,575
Increase in Other Liabilities		1,659	3,784
Increase / (Decrease) in Provisions		2,564	(5,944)
NET CASH GENERATED FROM OPERATIONS		**55,823**	**50,451**
Cash flows from investing activities			
Interest received		397	248
Purchase of financial assets		0	0
Sales of financial assets		0	0
Puchase of intangible assets		(242)	(376)
Purchase of Property, Plant and Equipment		(36,199)	(42,332)
Sales of Property, Plant and Equipment		0	0
Net cash (used in) investing activities		**(36,044)**	**(42,460)**
Cash flows from from financing activities			
Public dividend capital received		50	4,400
Loans received		16,000	0
Loans repaid		(780)	(780)
Capital element of Private Finance Initiative Obligations		(565)	(548)
Interest paid		(881)	(832)
Interest element of Private Finance Initiative obligations		(1,758)	(1,715)
PDC Dividend paid		(10,426)	(12,640)
Cash flows from other financing activities		1,404	984
Net cash generated from / (used in) financing activities		**3,044**	**(11,131)**
Increase / (decrease) in cash and cash equivalents		**22,823**	**(3,140)**
Cash and Cash equivalents at 1 April	22	42,072	45,212
Cash and Cash equivalents at 31 March		**64,895**	**42,072**

Notes to the Accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and liabilities.

1.1 Income

Income in respect of services provided is recognised when, and to the extent that performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

1.2 Expenditure on Employee Benefits

Short-term Employee Benefits:

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

NHS Pension Scheme

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

1.3 Expenditure on other goods and services

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

1.4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

Tangible fixed assets are capitalized where they

- individually have a cost of at least £5,000; or,
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

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

All assets are measured subsequently at fair value. From the 1st April 2009, the valuations are carried out primarily at depreciated replacement cost on a Modern Equivalent Asset (MEA) basis for specialised operational property, and existing use value for non-specialised operational property.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market valuations.

Revaluations are performed with sufficient regularity to ensure that the carrying amounts are not materially different from those that would be determined at the end of the reporting period. The current revaluation policy of the Trust is to perform a full valuation every five years, with an interim valuation in the third year. The full five yearly revaluation was carried out at 31 March 2010. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors' 'Red Book' (RICS) Appraisals and Valuation Manual.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the Foundation Trust Annual Report Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower or i) the impairment charged to operating expenses and ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

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

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

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged . Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

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

Private Finance Initiative (PFI) transactions

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

Life cycle replacement costs are capitalised where they meet the criteria for recognition set out above

1.5 Intangible assets

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

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

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

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

Subsequently intangible assets are measured at fair value.

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

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

1.6 Government grants

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

Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.8 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', 'Loans and receivables' or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

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

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

Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

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

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

Available-for-sale financial assets

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

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

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities.

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

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals or discounted cash flow analysis, as appropriate.

Impairment of financial assets
At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.9 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of Property, Plant and Equipment.

The annual rental is split between the repayment of the liability and a finance cost, so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability if discharged, cancelled or expires.

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

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.10 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% real terms, except for early retirement provisions and injury benefit provisions which both use HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 20, but is not recognised in the NHS foundation trust's accounts.

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

1.11 Contingencies

Contingent assets (that is, assets arising from past

events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.12 Public dividend capital

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

A charge, reflecting the forecast cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, net cash held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts

1.13 Value Added Tax

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

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

1.14 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their core health care activities. No significant commercial activity on which Corporation Tax would be applicable is undertaken.

1.15 Foreign exchange

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

Where the Trust has assets or liabilities denominated in a foreign currency at the balance sheet date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included in normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

2. Segmental Analysis

All of the Trust's activities are in the provision of healthcare, therefore no segmental analysis is required of the Trust's income and net assets under this note.

3. Income

3.1 Income from Activities

	2010/11 £'000	2009/10 £'000
Elective income	152,435	144,890
Non Elective income	174,856	173,208
Outpatient income	112,584	107,600
A&E Income	11,713	10,461
Other NHS Clinical income	202,835	208,377
Private Patient Income	4,028	3,335
Total income from activities	**658,451**	**647,871**
Other operating income		
Research and development	13,338	9,935
Education and training	67,514	68,543
Transfer from donated asset reserve in respect of depreciation on donated assets	2,041	2,131
Non-patient care services to other bodies	46,980	43,163
Other	14,509	15,418
Profit on disposal of other tangible fixed assets	0	97
Reversal of impairments of property,plant & equipment	678	288
Total other operating income	**145,060**	**139,575**
TOTAL OPERATING INCOME	**803,511**	**787,446**

3.2 Private patient income:

	2010/11 £'000	2009/10 (as restated) £'000	Base year (2002-03) £'000
Private Patient Income	4,150	3,452	2,919
Total patient related income	658,574	647,988	367,927
Proportion (as percentage)	0.63%	0.53%	0.79%

Section 15 of the 2003 Act requires that the Trust's proportion of private patient income in relation to its total patient related income does not exceed that same percentage whilst the Trust was an NHS Trust in 2002/03. This requirement has been met.

The private patient income declaration has been prepared in accordance with Monitor's publication "Private Patient Income Cap – revised and updated rules" (published 10 February 2010). The comparative information has been restated accordingly.

3.3 Operating lease income

	2010/11 £000	2009/10 £000
Rents recognised as income in the period	280	247
Contingent rents recognised as income in the period	16	8
	296	**255**
Future minimum lease payments due		
- not later than one year;	16	255
- later than one year and not later than five years;	346	458
- later than five years.	1,442	1,478
TOTAL	**1,804**	**2,191**

3.4 Operating Income (by type)

	2010/11 £'000	2009/10 £'000
Foundation Trusts	20	4
NHS Trusts	2	0
Strategic Health Authorities	3,285	1,354
Primary Care Trusts	646,795	634,844
Local Authorities	41	42
Department of Health	0	3,436
NHS Other	1,398	1,481
Non NHS: Private patients	2,940	2,431
Non NHS: Overseas patients (non-reciprocal)	1,088	904
NHS injury scheme (was Road Traffic Act Scheme)	2,744	3,234
Non NHS: Other*	138	141
Total Income from activities	**658,451**	**647,871**

*Non NHS Other income from activities comprises income from prescription charges

Other Operating Income		
Research and Development	13,338	9,935
Education and Training	67,514	68,543
Transfers from the donated asset reserve in respect of depreciation, impairment, and disposal of donated assets	2,041	2,131
Non patient care services to other bodies	46,980	43,163
Profit on disposal of other tangible fixed assets	0	97
Reversal of impairments of property, plant & equipment	678	288
Other **	14,509	15,418
Total Other income	**145,060**	**139,575**

**Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites. The largest individual components relate to the provision of car-parking, catering, and nursery facilities. All the above income, with the exception of Research and Development activities relates to the provision of mandatory services under the Trust's terms of authorisation.

4. Operating Expenses

	2010/11 £'000	2009/10 £'000
Services from other NHS Foundation Trusts	5,969	6,338
Services from other NHS Trusts	34	5,473
Services from other NHS bodies	7,346	7,483
Purchase of healthcare from non NHS bodies	12,268	12,157
Executive Directors' costs	1,220	1,307
Non-Executive Directors' costs	185	185
Staff costs	499,947	483,686
Drugs costs	79,970	77,307
Supplies and services - clinical	76,231	73,361
Supplies and services - general	7,517	7,417
Establishment	7,344	7,168
Research and Development	3,664	3,543
Transport	943	811
Premises	27,389	26,856
(Decrease)/Increase in bad debt provision	(107)	2,391
Other impairment of financial assets	0	169
Depreciation on property, plant and equipment	24,162	26,018
Amortisation on intangible assets	363	339
Impairments of property, plant and equipment	10,688	65,154
Impairments of intangible assets	1	0
Audit services - statutory audit	58	56
Further audit assurance services	8	3
Other Audit services	0	0
Clinical negligence	10,989	10,100
Legal fees	1,393	1,128
Consultancy costs	2,998	3,305
Training, courses and conferences	1,826	1,655
Redundancy	1,465	0
Insurance	775	766
Losses, ex gratia & special payments	137	903
Other	4,207	1,589
	788,990	826,668

	£'000	£'000
Limitation on Auditors' liability	**Unlimited**	**Unlimited**

4.2 Arrangements containing an operating lease

	2010/11 £'000	2009/10 £'000
Minimum lease payments	1,508	1,557
Contingent rents	0	0
Less sublease payments received	0	0
	1,508	1,557

4.3 Arrangements containing an operating lease

	2010/11 £'000	2009/10 £'000
Future minimum lease payments due:		
Within 1 year	49	205
Between 1 and 5 years	3,491	2,672
After 5 years	1,516	1,847
	5,056	**4,724**

4.4 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	To 31 March 2011				To 31 March 2010			
	Salary	**Other Remuner -ation**	**Benefits in Kind**	**Employee Short term benefits - Employer's National Insurance**	Salary	Other Remuner-ation	Benefits in Kind	Employee Short term benefits - Employer's National Insurance
	(bands of £5000) £000	**(bands of £5000) £000**	**Rounded to the nearest £100**	**Rounded to the nearest £100**	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	Rounded to the nearest £100
Sir A J Cash, OBE, Chief Executive	215-220			25,600	215-220			25,600
Mr. J Watts, Director of Human Resources (until 12 April 2009)					0-5			400
Mr N Priestley, Director of Finance	150-155			17,200	150-155			17,200
Professor M Richmond, Medical Director	165-170			22,300	165-170			22,100
Professor H Chapman, (Chief Nurse until 30 November 2009, Chief Nurse and Chief Operating Officer from 1 December 2009)	170-175			20,400	145-150			16,600
Mr C Welsh, Chief Operating Officer (until 30 November 2009)					65-70	45-50		13,300
Mr C C Linacre, Director of Service Development	140-145			16,400	135-140			15,700
Mr M Gwilliam, Director of Human Resources	115-120			12,900	100-105			10,100
Mr I Thompson, Non-Executive Director	15-20			1,300	15-20			1,300
Mr J P Donnelly, Non-Executive Director	15-20			1,300	15-20			1,300
Ms V R Ferres, Non-Executive Director	15-20			1,300	15-20			1,300
Mr V G W Powell, Non-Executive Director	15-20			1,600	15-20			1,600
Mrs J Norbron, Non-Executive Director	15-20			1,300	15-20			1,300
Ms S Harrison, Non-Executive Director	15-20			1,300	15-20			1,300
Professor A P Weetman, Non-Executive Director	15-20			1,300	15-20			1,300
Mr D Stone, Chairman	55-60			6,700	55-60			6,700

Salary and Pension entitlements of senior managers

B) Pension Benefits

	Real change in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real Change in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	£000	£000	£000	To nearest £100
Sir A J Cash, OBE, Chief Executive	-2.5--5.0	360-362.5	1,838	1,951	(191)	30,200
Mr N Priestley, Director of Finance	-0--2.5	202.5-205	838	900	(98)	20,100
Professor M Richmond, Medical Director	2.5-5	220-222.5	1,084	1,124	(85)	26,600
Professor H Chapman, (Chief Nurse until 30 November 2009, Chief Nurse and Chief Operating Officer from 1 December 2009)	45-47.5	272.5-275	1,016	930	49	24,500
Mr C C Linacre, Director of Service Development	-2.5--5.0	272.5-275	n/a	n/a	n/a	20,100
Mr M Gwilliam, Director of Human Resources	5-7.5	40-42.5	154	144	5	16,300

As Non-Executive members do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive members.

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 or arrangement when the member leaves a scheme and 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 2004-05 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 and Faculty of Actuaries.

In his budget of 22 June 2010, the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors. The new CETV factors have been used in the above calculations and are lower than the previous factors used. Therefore, the value of the CETV's for some Directors has fallen since 31 March 2010.

There are no CETV amounts for those Directors aged sixty or over at the Balance Sheet date. This is because these directors are not permitted to transfer benefits, hence no value is disclosed under this note.

Real Change in CETV - This reflects the change in CETV effectively funded by the employer. It takes account of the change 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.

5.1 Employee Expenses

	2010/11 Total £'000	Permanent	Other	2009/10 Total £'000	Permanent	Other
Salaries and wages	416,294	410,778	5,516	403,850	397,990	5,860
Social Security Costs	29,084	29,084	0	28,634	28,634	0
Employer contributions to NHSPA	45,853	45,853	0	44,815	44,815	0
Other pension costs	(7)	(7)	0	48	48	0
Termination Benefits	1,465	1,465	0	0	0	0
Agency/contract staff	9,943	0	9943	7,646	0	7,646
	502,632	**487,173**	**15,459**	**484,993**	**471,487**	**13,506**

The above figure of £502,632k is net of the amount of £1,952k (2009/10 £1,479k) in respect of capitalised salary costs included in fixed asset additions (note 9.1).

5.2 Average number of persons employed (WTE basis)

	2010/11 Total Number	Permanent	Other	2009/10 Total Number	Permanent	Other
Medical and dental	1,709	1,581	128	1,630	1,563	67
Administration and estates	2,500	2,409	91	2,506	2,392	114
Healthcare assistants and other support staff	1,437	1,374	63	1,397	1,339	58
Nursing, midwifery and health visiting staff	5,135	4,887	248	5,086	4,816	270
Scientific, therapeutic and technical staff	2,047	2,035	12	1,947	1,934	13
Total	**12,828**	**12,286**	**542**	**12,566**	**12,044**	**522**

5.3 Employee benefits

	2010/11 £000	2009/10 £000
Benefits	0	0
	0	0

5.4 Staff Exit Packages

Exit package cost band	Number of Compulsory redundancies	Number of other departures agreed	Total Number of Exit packages by cost band
<£10,000	0	41	41
£10,000 - £25,000	0	33	33
£25,001 - £50,000	0	30	30
£50,001 - £100,000	0	2	2
£100,001 - £150,000	0	1	1
Total Number of Exit Packages by type	**0**	**107**	**107**
Total Cost	**0**	**2,009,587**	**2,009,587**

5.5 Early Retirements Due to Ill Health

	2010/11 £'000	2010/11 Number	2009/10 £'000	2009/10 Number
Number of early retirements agreed on the grounds of ill health		13		12
Cost of early retirements agreed on grounds of ill health	901		709	

These costs were borne by the NHS Pensions Agency.

6. Performance on payment of debts

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against this code is set out below:

	2010/11	2009/10
Number of non NHS invoices paid	158,146	158,675
Number of non NHS invoices paid within 30 days	150,868	151,293
Percentage of invoices paid within 30 days	95.40%	95.35%
	£'000	£'000
Value of non NHS invoices paid	274,955	268,422
Value of non NHS invoices paid within 30days	259,332	252,222
Percentage of invoices paid within 30 days	94.32%	93.96%
Amounts included within Interest Payable (Note 7.2) arising from claims made under the Late Payment of Debts (Interest) Act 1998	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

7.1 Finance Income

	2010/11 £000	2009/10 £000
Bank account interest	408	243
	408	**243**

7.2. Finance costs - interest expense

	2010/11 £000	2009/10 £000
Loans from the Foundation Trust Financing Facility	905	834
Finance Costs in PFI obligations		
Main Finance Costs	1,425	1,459
Contingent Finance Costs	333	256
	2,663	**2,549**

7.3 Impairment of assets

	2010/11 £000	2009/10 £000
Loss or damage from normal operations	729	88
Abandonment of assets in course of construction	570	1,173
Changes in market price	9,390	63,893
Impairments charged to expenses	**10,689**	**65,154**
Reversal of impairments credited to income	(678)	(288)
	10,011	**64,866**
Changes in market prices charged to reserves	2,068	106,431
TOTAL	**12,079**	**171,297**

8.1 Intangible fixed assets

	Total £'000	Software licences £'000
Gross cost at 1 April 2010	**2,480**	**2,480**
Reclassifications	290	290
Additions - purchased	44	44
Disposals	(111)	(111)
Gross cost at 31 March 2011	**2,703**	**2,703**
Amortisation at 1 April 2010	1,311	1,311
Provided during the year	363	363
Impairments	1	1
Disposals	(111)	(111)
Amortisation at 31 March 2011	**1,564**	**1,564**
Net book value		
- Purchased at 31 March 2010	1,166	1,166
- Donated at 31 March 2010	3	3
Total at 1 April 2010	**1,169**	**1,169**
Net book value		
- Purchased at 31 March 2011	1,137	1,137
- Donated at 31 March 2011	2	2
Total at 31 March 2011	**1,139**	**1,139**

8.2 Intangible fixed assets 2009/10

	£'000	£'000
Gross cost at 1 April 2009	2,303	2,303
Reclassifications	111	111
Additions - purchased	72	72
Disposals	(6)	(6)
Gross cost at 31 March 2010	**2,480**	**2,480**
Amortisation at 1 April 2009	978	978
Provided during the year	339	339
Disposals	(6)	(6)
Amortisation at 31 March 2010	**1,311**	**1,311**

Note 8.3 Intangible assets acquired by government grants

	2010 /11 £,000
Initial fair value	0
Carrying amount at 31 March 2010	0
Carrying amount at 31 March 2011	0

Note 8.4 Economic life of intangible assets

	Min Life Years	Max Life Years
Intangible asssets - purchased		
Software Licences	5	5

9. Property, Plant and Equipment

9.1 Property, Plant and Equipment 2010/11	Total £'000	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under constr & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000
Gross Cost at 1 April 2010	489,587	16,738	296,946	2,226	12,967	114,135	1,022	22,449	23,104
Additions - purchased	37,240	0	7,967	0	24,996	3,515	72	466	224
Additions - donated	1,856	0	103	0	1,231	482	0	20	20
Impairments	(2,068)	0	(2,068)	0	0	0	0	0	0
Reclassifications	(290)	0	20,234	0	(24,359)	2,152	12	760	911
Other Revaluations	(10,153)	5	(10,479)	0	0	321	0	0	0
Disposals	(7,633)	0	0	0	0	(6,736)	(160)	(725)	(12)
Cost or valuation at 31 March 2011	**508,539**	**16,743**	**312,703**	**2,226**	**14,835**	**113,869**	**946**	**22,970**	**24,247**
Accumulated Depreciation at 1 April 2010	102,702	0	0	0	0	69,905	713	15,282	16,802
Provided during the year	24,162	0	12,025	112	0	8,264	75	2,451	1,235
Impairments recognised in operating expenses	10,010	0	9,447	0	0	491	0	68	4
Reclassifications	0	0	270	0	0	(270)	0	0	0
Other Revaluations	(10,330)	0	(10,652)	0	0	322	0	0	0
Disposals	(7,633)	0	0	0	0	(6,736)	(160)	(725)	(12)
Depreciation at 31 March 2011	**118,911**	**0**	**11,090**	**112**	**0**	**71,976**	**628**	**17,076**	**18,029**
Net book value									
- Purchased at 31 March 2010	344,396	15,853	259,384	2,047	12,891	41,012	291	7,105	5,813
- PFI at 31 March 2010	13,578	0	13,578	0	0	0	0	0	0
- Donated at 31 March 2010	28,911	885	23,984	179	76	3,218	18	62	489
Total at 31 March 2010	**386,885**	**16,738**	**296,946**	**2,226**	**12,967**	**44,230**	**309**	**7,167**	**6,302**
Net book value									
- Purchased at 31 March 2011	347,331	15,858	263,805	1,945	14,822	39,038	304	5,817	5,742
- PFI at 31 March 2011	13,822	0	13,822	0	0	0	0	0	0
- Donated at 31 March 2011	28,475	885	23,986	169	13	2,855	14	77	476
Total at 31 March 2011	389,628	16,743	301,613	2,114	14,835	41,893	318	5,894	6,218

9.2 Analysis of Property, Plant and Equipment

Net book value									
- Protected assets at 31 March 2011	389,628	16,743	301,613	2,114					
- Unprotected assets at 31 March 2011					14,835	41,893	318	5,894	6,218
Total at 31 March 2011	**389,628**	**16,743**	**301,613**	**2,114**	**14,835**	**41,893**	**318**	**5,894**	**6,218**

9.3 Property, Plant and Equipment 2009/10

	Total	Land	Buildings exc dwellings	Dwellings	Assets under constr & poa	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2009	670,949	28,870	468,803	2,448	19,267	106,905	1,047	21,821	21,788
Additions - purchased	38,119	0	9,195	11	26,245	2,112	61	80	415
Additions - donated	901	0	130	0	379	385	0	7	0
Impairments	(106,431)	(11,609)	(94,726)	(96)	0	0	0	0	0
Reclassifications	(111)	0	22,701	0	(32,924)	8,319	49	654	1,090
Other Revaluations	(109,816)	(523)	(109,156)	(137)	0	0	0	0	0
Disposals	(4,024)	0	(1)	0	0	(3,586)	(135)	(113)	(189)
Cost or valuation at 31 March 2010	**489,587**	**16,738**	**296,946**	**2,226**	**12,967**	**114,135**	**1,022**	**22,449**	**23,104**
Accumulated Depreciation at 1 April 2009	129,751	0	34,600	214	0	65,637	741	12,724	15,835
Provided during the year	26,018	0	14,212	106	0	7,829	69	2,671	1,131
Impairments	64,866	25	64,731	22	0	25	38	0	25
Reclassifications	0	0	0	0	0	0	0	0	0
Other Revaluations	(113,909)	(25)	(113,542)	(342)	0	0	0	0	0
Disposals	(4,024)	0	(1)	0	0	(3,586)	(135)	(113)	(189)
Depreciation at 31 March 2010	**102,702**	**0**	**0**	**0**	**0**	**69,905**	**713**	**15,282**	**16,802**
Net book value									
- Purchased at 31 March 2010	344,396	15,853	259,384	2,047	12,891	41,012	291	7,105	5,813
- PFI at 31 March 2010	13,578	0	13,578	0	0	0	0	0	0
- Donated at 31 March 2010	28,911	885	23,984	179	76	3,218	18	62	489
Total at 31 March 2010	**386,885**	**16,738**	**296,946**	**2,226**	**12,967**	**44,230**	**309**	**7,167**	**6,302**

9.4 Analysis of Property, Plant and Equipment

Net book value									
- Protected assets at 31 March 2010	315,910	16,738	296,946	2,226	0	0	0	0	0
- Unprotected assets at 31 March 2010	70,975	0	0	0	12,967	44,230	309	7,167	6,302
Total at 31 March 2010	**386,885**	**16,738**	**296,946**	**2,226**	**12,967**	**44,230**	**309**	**7,167**	**6,302**

9.5 Economic life of Property, Plant and Equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	5	45
Dwellings	15	25
Assets under construction	0	0
Plant and Machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture and Fittings	10	10

Non-Property Valuations

	Net Book Value covered by each method for determining fair value			
Method For Determining Fair Value	Plant & Machinery £,000	Transport Equipment £,000	Information Technology £,000	Furniture & Fittings £,000
Depreciated historical cost basis (as a proxy for fair value for short life assets)	41,893	318	5,894	6,218
	41,893	**318**	**5,894**	**6,218**

Property Valuations

Net Book Value of assets covered by valuation method	Land £,000	Buildings excluding dwellings £,000	Dwellings £,000
Modern Equivalent Asset (no Alternative Site)	16,743	301,613	2,114
Modern Equivalent Asset (Alternative Site)	0	0	0
Other Professional Valuations	0	0	0
Total	**16,743**	**301,613**	**2,114**

10.1 Non-current assets for sale and assets in disposal groups 2010/11

There were no non-current assets for sale and assets in disposal groups in 2010/11 and 2009/10

11. Fixed asset investments

The Trust has holdings in Zilico (formerly Aperio) Diagnostics and Epaq , companies commercially developing intellectual property. The Trust holding in these companies carry a minimal value at the balance sheet date (31 March 2011 and 31 March 2010)

The Trust owns 45.95% (40% 31 March 2010) of the share capital of Epaq, and 22.22% (22.22%, 31 March 2010) of the share capital of Zilico.

12.1. Inventories

	31 March 2011 £'000	31 March 2010 £'000
Materials	12,179	12,059
TOTAL	**12,179**	**12,059**

12.2 Inventories recognised in expenses

	2010/11 £'000	2009/10 £'000
Inventories recognised in expenses	86,319	84,847
Write down of inventories recognised as an expense	210	64
Total Inventories recognised in expenses	**86,529**	**84,911**

13.1. Trade receivables and other receivables

	31 March 2011 Total £'000	31 March 2010 Total £'000
Amounts falling due within one year:		
NHS receivables	19,417	24,344
Other receivables with related parties	5,716	4,529
Provision for impaired receivables	(4,690)	(5,911)
Prepayments	1,463	1,488
Accrued income	24	13
PDC receivable	737	70
Other receivables	7,272	7,652
Sub Total	29,939	32,185
Amounts falling due after more than one year:		
NHS receivables	250	271
Other receivables	4,993	4,251
Sub Total	5,243	4,522
TOTAL	**35,182**	**36,707**

13.2 Provision for impairment of receivables

	2010/11 £'000	2009/10 £'000
At 1 April 2010	5,911	3,797
Increase in provision	1,897	3,466
Utilised	(1,114)	(277)
Unused amounts reversed	(2,004)	(1,075)
At 31 March 2011	**4,690**	**5,911**

13.3 Analysis of impaired receivables

Ageing of impaired receivables	£'000	£'000
Up to three months	123	1,762
In three to six months	331	223
Over six months	4,236	3,926
Total	**4,690**	**5,911**
Ageing of non-impaired receivables past their due date		
Up to three months	2,438	5,051
In three to six months	1,562	2,942
Over six months	2,736	1,564
Total	**6,736**	**9,557**

14. Current asset investments

	2010/11 Total £'000	2009/10 Total £'000
Additions	0	0
Disposals	0	0
Cost or valuation at 31 March 2011	**0**	**0**

15. Payables

15.1 Trade and other payables

	31 March 2011 Total £'000	31 March 2010 Total £'000
Amounts falling due within one year:		
NHS payables	13,451	12,610
Amounts due to other related parties	5,902	8,144
Trade payables - capital	9,191	6,475
Other trade payables	12,485	10,945
Other payables	382	138
Accruals	11,973	10,555
Social Security and other taxes	9,982	9,726
Total current trade and other payables	**63,366**	**58,593**

	31 March 2011 Total £'000	31 March 2010 Total £'000
Amounts falling due after one year:	0	0
Total non-current trade and other paybles	**0**	**0**

15.2 - early retirements detail included in NHS payables above

	31 March 2011 Total £'000	Number	31 March 2010 Total £'000	Number
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0
- outstanding pension contributions at 31 March 2011	5,704		5,548	

16 Other liabilities

Current	31 March 2011 £'000	31 March 2010 £'000
Deferred Income	13,167	10,596
Deferred Government Grant	314	423
Total Other Current liabilities	**13,481**	**11,019**
Non-current		
Deferred Income	733	2,475
Deferred Government Grant	2,823	1,820
Total Other Non-current Liabilities	**3,556**	**4,295**

17 Borrowings

	31 March 2011 £'000	31 March 2010 £'000
Current		
Loans from Foundation Trust Financing Facility	1,445	780
Obligations under Private Finance Initiative contracts	588	565
Total Current Borrowings	**2,033**	**1,345**
Non- current		
Loans from Foundation Trust Financing Facility	30,516	15,961
Obligations under Private Finance Initiative contracts	21,949	22,536
Total Non Current Borrowings	**52,465**	**38,497**

18 Prudential Borrowing Limit

	2010/11 £'000	2009/10 £'000
Total long term borrowing limit set by Monitor	166,700	169,300
Working capital facility agreed by Monitor	60,000	60,000
TOTAL PRUDENTIAL BORROWING LIMIT	**226,700**	**229,300**
Long term borrowing at 1 April 2010	39,841	41,169
Net actual long term borrowing/repayment in year	14,657	(1,328)
Long term borrowing at 31 March 2011	**54,498**	**39,841**
Working capital facility at 1 April 2010	0	0
Net actual borrowing/repayment in year	0	0
Net Working capital facility at 31 March 2011	**0**	**0**

	2010/11		**2009/10**	
	Limit	actual	Limit	actual
Minimum Dividend Cover	>1	4.99	>1	3.95
Minimum Interest Cover	>3	18.42	>3	20.47
Minimum Debt Service Cover	>2	12.88	>2	11.83
Maximum Debt Service to Revenue	<3%	0.50%	<3%	0.56%

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code . The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts. The financial ratios for 2010/11 (2009/10) as published in the Prudential Borrowing Code are shown above with the actual level of achievement for the period.

19.1 Finance Lease Obligations

	31 March 2011 £000	31 March 2010 £000
Gross lease liabilities	**0**	**0**
of which liabilities are due		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Finance charges allocated to future periods	0	0
Net lease liabilities	**0**	**0**
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0

19.2 PFI Obligations (On Statement of Financial Position)

	31 March 2011 £'000	31 March 2010 £'000
Gross PFI liabilities	**75,820**	**78,143**
of which liabilities are due		
- not later than one year;	2,436	2,323
- later than one year and not later than five years;	9,975	9,920
- later than five years.	63,409	65,900
Finance charges allocated to future periods	(53,283)	(55,042)
Net PFI liabilities	**22,537**	**23,101**
- not later than one year;	588	565
- later than one year and not later than five years;	2,430	2,423
- later than five years.	19,519	20,113

19.3 Amounts included in operating expenses in respect of PFI transactions deemed to be on the categories listed below

	2010/11 £000	2009/10 £000
Building Maintenance	277	248
Insurance	129	125
Other management services	90	86
Depreciation	356	436
	852	**895**

19.4 Finance charges in respect of PFI transactions are shown under note 7.2

19.5 Scheme details

Estimated capital value of PFI scheme	£13,822k
Contract start date	December 2004
Contract handover date	March 2007
Length of project(years)	32
Number of years to end of project	26
Contract end date	December 2036

19.6 The Trust is committed to make the following payments for the total service element for on-SoFP PFIs service concessions for each of the following periods

	31 March 2011 Hadfield Block £000	31 March 2010 Hadfield Block £000
Within one year	525	496
2nd to 5th years (inclusive)	2098	1,984
Later than 5 years	10,883	10,788

The PFI scheme is a scheme to design,build,finance and maintain a new medical ward block on the Northern General Hospital site (Sir Robert Hadfield Block). The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement.

20. Provisions for liabilities and charges

	Current		Non Current	
	31 March 2011 £'000	31 March 2010 £'000	31 March 2011 £'000	31 March 2010 £'000
Pensions relating to other staff	173	173	2,288	2,498
Legal claims	465	392	20	0
Agenda For Change	149	436	0	0
Other	3,702	677	0	0
	4,489	**1,678**	**2,308**	**2,498**

	Pensions relating to other staff £'000	Legal claims £'000	Agenda For Change £'000	Other £'000	**31 March 2011** Total £'000	**31 March 2010** Total £'000
At start of period	2,671	392	436	677	4,176	10,064
Change in discount rate	(160)	0	0	0	(160)	
Arising during the year	60	507	124	3,577	4,268	4,439
Utilised during the year	(169)	(286)	(269)	(322)	(1,046)	(9,817)
Reversed unused	0	(128)	(142)	(230)	(500)	(566)
Unwinding of discount	59	0	0	0	59	56
At 31 March 2011	**2,461**	**485**	**149**	**3,702**	**6,797**	**4,176**
Expected timing of cashflows						
Within one year	173	465	149	3,702	4,489	1,678
Between one and five years	646	20	0	0	666	655
After five years	1,642	0	0	0	1,642	1,843

Pensions relating to other staff represents the liability relating to staff retiring before April 1995 (31 March 2011 £589k, 31 March 2010 £633k) and Injury Benefit Liabilities (31 March 2011 £1,872k, 31 March 2010 £2,037k). Injury Benefits are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority.

The value shown is the discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown.

Legal claims relate to claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by the NHSLA, who provide an estimate of the Trust's probable liability. Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA and not included above.

Agenda for Change provision relates to amounts that may become due to members of staff if they accept the new rates of pay under Agenda For Change.

Other provisions relate to
- Costs likely to be incurred under the trust workforce reduction scheme (31 March 2011 £1,420k, 31 March 2010 £34k).
- Costs likely to be incurred under the trust's Mutually Agreed Resignation Scheme (31 March 2011 £2,010k, 31 March 2010 £0k)
- Costs likely to be incurred due to Carbon Trading scheme (31 March 2011 £122k, 31 March 2010 £79k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (31 March 2011 £150k, 31 March 2010 £564k)

The actual value of costs incurred under the Carbon Trading Scheme will depend on the actual quantity of CO2 produced in the years up to 2011/2012.

Of the above total provision and related payments, some £269,937 has been covered by "back-to-back" income arrangements with the Trust's major purchasers (2009/10 £290,703).

£62,307,909 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of the clinical negligence liabilities of the Trust (2009/10 £47,070,937).

21 Revaluation reserve

	Total Revaluation Reserve	Revaluation Reserve - intangibles	Revaluation Reserve -property, plant & equipment
Revaluation reserve at 1 April 2010	27,346	0	27,346
Impairments	(1,726)	0	(1,726)
Revaluations	87	0	87
Asset disposals	0	0	0
Fair Value gains/(losses) on Available-for-sale financial investments	0	0	0
Recycling gains/(losses) on Available-for-sale financial investments	0	0	0
Other recognised gains and losses	(1,352)	0	(1,352)
Other reserve movements	0	0	0
Revaluation reserve at 31 March 2011	**24,355**	**0**	**24,355**
Revaluation reserve at 1 April 2009	121,081	0	121,081
Impairments	(94,496)	0	(94,496)
Revaluations	3,577	0	3,577
Asset disposals	0	0	0
Fair Value gains/(losses) on Available-for-sale financial investments	0	0	0
Recycling gains/(losses) on Available-for-sale financial investments	0	0	0
Other recognised gains and losses	(2,816)	0	(2,816)
Other reserve movements	0	0	0
Revaluation reserve at 31 March 2010	**27,346**	**0**	**27,346**

22 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
At 1 April	42,072	45,212
Net change in year	22,823	(3,140)
At 31 March	64,895	42,072
Broken down into:		
Cash at commercial banks and in hand	183	257
Cash at Govt.Banking Service	64,712	41,815
Other current investments	-	-
Cash and cash equivalents as in Statement of Financial Position	64,895	42,072
Bank overdraft	-	-
Cash and cash equivalents as in Statement of Financial Position	**64,895**	**42,072**
Third party assets held by the NHS Foundation Trust	30	15

23. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £15.9m (31 March 2010, £6.2m). The major components of these commitments are as follows:

Scheme	Property, Plant & equipment 31 March 2011 Amount £'000
Laboratory Medicine Reconfiguration	12,587
Relocation of Clinical Skills	140
2nd Gamma Knife	680
Ward Refurbishment Programme	60
Other Estates Projects	30
Equipment Commitments	2,390
Total	**15,887**

24. Events after the reporting period

As at 1 April 2011, the Trust took over the provision of a number of Community Services for the residents of Sheffield from NHS Sheffield. The transfer covers 31 types of service, including District Nursing, Intermediate Care, Muskuloskeletal Care, Contraception & Sexual Health and GP Collaborative services. The value of the services transferred is around £50m and involves around 1,100 whole time equivalent staff.

25. Contingencies

	2010/11 £000	2009/10 £000
Gross value	(256)	(276)
Amounts recoverable	0	0
Net contingent liability	(256)	(276)

Contingencies represent the consequences of losing all current third party legal claim cases (see note 20).

26 Related Party Transactions

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

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sheffield Teaching Hospitals NHS Foundation Trust Details of Directors' remuneration and benefits can be found in note 4.4 and 4.5 to the accounts. The Declaration of Directors' interests is to be found on Page 78 of the Annual Report.

The Department of Health is regarded as a related party. During the year Sheffield Teaching 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 entities are listed below:

	2010/11		**2009/10**	
	Income £'000	Expenditure £'000	Income £'000	Expenditure £'000
Sheffield PCT	335,545	1,739	330,816	1,698
Bassetlaw PCT	7,595		7,591	
Derby County PCT	27,823		26,919	
Barnsley PCT	180,733		173,793	
Rotherham PCT	23,877		24,917	
Doncaster PCT	15,408		16,137	
Leicestershire County and Rutland PCT	32,660		31,752	
Yorkshire and The Humber Strategic Health Authority	68,351		66,197	
Yorkshire Ambulance Service NHS Trust		0		4,056
NHS Litigation Authority		11,483		10,557
National Blood Authority		7,714		7,709
National Health Service Logistics Authority		12,793		12,569
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	6,793	7,345	5,954	6,724
Sheffield Health and Social Care NHS Foundation trust	1,304	1,060	1,423	1,959
Sheffield Children's NHS Foundation Trust	6,868	4,040	6,578	4,168
Barnsley Hospital NHS Foundation Trust	4,722	2,202	4,684	2,094
Chesterfield Royal NHS Foundation Trust	3,381	2,098	3,237	1,487
The Rotherham NHS Foundation Trust	4,252	1,196	4,003	1,388

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 Education and Skills in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common control of Monitor During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non clinical support services. Of the Trust's total receivables of £35,182k at 31 March 2011 (£36,707k at 31 March 2010), (note 13.1) £19,667k (£24,615k at 31 March 2010) was receivable from NHS bodies. This sum comprises, in the main, monies due from Commissioners in respect of health care services invoiced, but not paid for, at the balance sheet date.

A provision of £1,976k has been made for impaired receivables (£3,550k at 31 March 2010) and, in the year ended 31 March 2011, the provision was reduced by £1,574k (increased by £1,274k in the year ended 31 March 2010). The remainder of the balance comprises income from NHS Trusts in respect of clinical support services provided. £4,148k was receivable from the University of Sheffield at 31 March 2011,(31 March 2010 £3,331k) in respect of clinical and estates support services provided.

During the year the Trust purchased healthcare from Thornbury Private Hospital which is sited in Sheffield in the sum of £3,159k (2009/2010 £4,107k.) The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at the above hospital and Claremont. This amounted to £10,660k (2009/2010 £7,525k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Payables falling due within one year of £63,366k (31 March 2010 £58,593k, note 15.1) include £13,451k owing to NHS bodies (31 March 2010, £12,610k). This sum includes monies owing to the Department of Health in respect of pension contributions, and to other NHS Trusts for clinical support services received.

During the year the Trust took out a loan in the sum of £16 million to help finance the Laboratory Services Reconfiguration Scheme. This loan was taken from the Department of Health Foundation Trust Finance Facility.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely. These governors represent the views of the staff and of the organizations with and for whom they work.

This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in the year from this Charity amounted to £1m (2009/10, £1.2m). The Trust has also received revenue and capital payments from a number of other charitable funds. Certain of the trustees of the charitable trusts from whom the Trust has received grants are members of the NHS Foundation Trust Board.

27 Financial Instruments

27.1 Financial Assets

	Loans and receivables	Assets at fair value through the SoCI*	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets (at 31 March 2011)	25,793	-	-	-	25,793
Cash and cash equivalents (at bank and in hand (at 31 March 2011)	64,895				64,895
Total at 31 March 2011	**90,688**	**-**	**-**	**-**	**90,688**
Trade and other receivables excluding non financial assets (at 31 March 2010)	28,545	-	-	-	28,545
Cash and cash equivalents at bank and in hand (at 31 March 2010)	42,072				42,072
Total at 31 March 2010	**70,617**	**-**	**-**	**-**	**70,617**

27.2 Financial liabilities by category

Liabilities as per Statement of Financial Position	Other financial liabilities £000	Liabilities at fair value through the SoCI* £000	Total £000
Borrowings excluding Finance lease and PFI liabilities	31,961	0	31,961
Obligations under Private Finance Initiative contracts	22,537	0	22,537
Trade and other payables excluding non financial assets	47,298	0	47,298
Provisions under contract	6,797	0	6,797
Total at 31 March 2011	**108,593**	**0**	**108,593**
Borrowings excluding Finance lease and PFI liabilities	16,741	0	16,741
Obligations under Private Finance Initiative contracts	23,101	0	23,101
Trade and other payables excluding non financial assets	43,319	0	43,319
Provisions under contract	4,176	0	4,176
Total at 31 March 2010	**87,337**	**0**	**87,337**

*Statement of Comprehensive Income - page 89

27.3 Fair values of financial assets at 31 March 2011

	Book Value £000	Fair value £000
Non current trade and other receivables excluding non financial assets	249	249
Other Investments	0	0
Other	0	0
Total	**249**	**249**

27.4 Fair values of financial liabilities at 31 March 2011

	Book Value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	0	0
Provisions under contract	6,797	6,797
Loans	31,961	31,961
Other	0	0
Total	**38,758**	**38,758**

Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has borrowings for capital expenditure, but is subject to affordability as confirmed by the FT Financing Facility. The borrowings are for a maximum remaining period of 24.0 years, in line with the associated assets, and interest is charged at 4.80% and 4.59%, fixed for the life of the respective loans. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with Primary Care Trusts, or the Department of Health, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

28 Third Party Assets

The Trust held £30,329 (31 March 2010, £15,034) at bank and in hand at 31 March 2011 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

29 Losses and Special Payments

There were 590 (148 in the year to 31 March 2010) cases of losses and special payments totalling £432k (12 months to 31 March 2010, £645k) approved during the financial year.

There was one case of an individual loss exceeding £100,000 (2009/10 one case)

30. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £9,689k (2009/10 £12,570k) bear to the average net relevant assets during the twelve month period of £279,187k (2009/10 £359,173k), that is 3.5% (2009-10 - 3.5%).

This is calculated as follows:

	31 March 2011 £'000	31 March 2010 £'000
Total Capital and Reserves	**361,325**	**360,967**
Less - Donated Asset Reserve	(28,477)	(28,914)
Less - Cash held at Office of the Paymaster General	(64,712)	(41,815)
Net Relevant Assets	**268,136**	**290,238**
Average Net Relevant Assets	279,187	359,173
Dividend paid per Cash Flow statement	10,426	12,640
Dividend Debtor	(737)	(70)
Total Dividend paid and payable per Statement of Comprehensive Income	9,689	12,570
Percentage	**3.5%**	**3.5%**

Statement On Internal Control 2010-11

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching 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 Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I recognise that risk management is pivotal to developing and maintaining robust systems of internal control required to manage risks associated with the achievement of organisational objectives and compliance with Terms of Authorisation as a Foundation Trust.

The leadership and accountability arrangements concerning risk management are included in the Trust's Risk Management Strategy and Policy, job descriptions and identified risk-related objectives. The Board of Directors is collectively and individually responsible for ensuring sound risk management systems are in place. The Board of Directors is supported by a number of formal committees with a remit to oversee and monitor the effectiveness of risk management, internal control and assurance arrangements including:

- Audit Committee
- Healthcare Governance Committee
- Finance Committee
- Human Resources Committee
- Remuneration Committee

The committees are chaired by non-executives and minutes and relevant reports are submitted to the Board of Directors.

As Chief Executive, I am accountable for risk management and my office, through the Trust Secretary, has an overarching responsibility for the development and maintenance of a cohesive and integrated framework and shared processes for the management of all risk.

Operationally, risk management is delegated to the Trust Executive Group which reports through me, as Chief Executive, to the Board of Directors. Executive Directors and Associate Directors are responsible for managing risk in accordance with their portfolios and as reflected in their job descriptions.

In addition to the corporate responsibilities outlined above, Clinical Directors, Directorate Managers and Departmental Heads have devolved responsibility for ensuring effective risk management in accordance with the Trust's Risk Management Strategy and Policy within their own areas.

The Risk Management Strategy and Policy indicates the level of training for all grades of staff commensurate with their responsibility for risk management. Training is determined by the personal development process at an individual level and by training needs analyses at a strategic level. Advice

on generic and specific risk management training, either internally or externally delivered, is available to staff and managers via the Department of Patient and Healthcare Governance and the Learning and Development Department.

Health and Safety Training, Information Governance and Equality and Human Rights are core topics in the Trust's mandatory training programme. All directorates are required to produce a risk-based induction and update plan for mandatory and job-specific training. The Patient and Healthcare Governance Department provides support and expert advice and guidance. Incidents, claims, patient feedback and risks assessments are reviewed as part of a scheduled programme. The results of audits, national surveys, external agency visits and accreditations reports and external reports are also routinely reviewed. Issues raised by such reviews are used to ensure lessons are learnt and to improve practice. In addition, the Trust is continuing to develop expertise and capacity to undertake root cause analysis.

The risk and control framework

In 2010, the Board of Directors commissioned external consultants to undertake a review of the effectiveness of the Trust's arrangements for the management of risk, primarily to identify opportunities to further improve risk management and to ensure alignment with overall strategic direction. The review, which used a combination of methods including staff interviews, observation of meetings, documentation review and focus groups, focused on four distinctive elements of risk management i.e. vision and strategy; process; people and organisational dimension; and culture. The findings and recommendations were presented to the Board in July 2010. An action plan, identifying responsible staff and timescales was approved by the Board in September 2010. Implementation of the action plan is monitored by regular progress reports to Trust Executive Group and the Board. The Risk Management Strategy and Policy is annually approved by the Board. It is maintained by the Department of Patient and Healthcare Governance and is regularly reviewed. It is widely promoted across the organisation and is available to all staff on the Trust intranet.

Changes to the organisational arrangements to support the implementation of the strategy and policy and to strengthen risk management and governance were introduced in early 2010 and the Safety and Risk Management Board and the Risk Validation Group are now firmly embedded in the Trust.

The strategy and policy sets out the organisation's strategic intent which aims to strike a balance between innovation, opportunity and risk, seeking to enhance performance and provide high quality care in a safe environment. It defines the framework and systems used to identify and manage risk; explicitly links risk management to the achievement of corporate and local risks and clarifies accountability arrangements and individual and collective roles and responsibilities for risk management at all levels across the organisation. It also provides guidance for staff to help identify, assess, action, and monitor risk including procedural guidance for completing risk assessment forms, when to escalate risks and how to use the Trust's electronic Risk Register, (Datix Risk Management System).

The policy and strategy clearly defines risk and includes guidance on the systematic identification, assessment and scoring of risk using a standard likelihood and consequence matrix. The score enables risks to be prioritised and identifies at what level in the organisation risk should be managed and when the management of a risk should be escalated within the organisation. This is an indication of the Trust's general approach to risk appetite but it should be acknowledged that decisions regarding acceptable or unacceptable levels of risk in relation to specific risk issues are also affected by financial capacity, the need to maintain service provision, and assessment of potential harm to patients, staff or public, together with the Trust's obligations in relation to legislation, regulation, standards or targets. At a corporate level, the Board of Directors utilise risk reports and other sources of information to consider their risk appetite.

The major risks facing the Trust are:

In-year:

- *Impact of a failure to meet Emergency Services 4-hour waiting target* which has been managed and mitigated by service developments such as the Surgical Assessment Centre, reconfiguration of Acute Medicine, A&E Consultant expansion, additional hours for medical and nursing staff; 24/7 therapy services, partnership working with commissioners, care trust and ambulance service, and improved monitoring and performance management via the Chief Operating Officer. Meeting the target continues to be challenging into 2011-12.
- *Transforming Community Services* which has been managed and mitigated via a project led by the Corporate Development Director and overseen by an Investment Committee established by the Board

of Directors. The first phase of the project involved a due diligence exercise and business case development in line with Monitor guidance. A Final Business Case, Finance Plan and Business Transfer Agreement were approved by the Board of Directors in February 2011. Risks around the second phase of transferring adult community services to the Trust over a period from 1 April to 30 September 2011 will be managed and mitigated via the project team and a Service Transition Team with approved management arrangements and overseen by the Investment Committee.

Future:

- *Failure to maintain financial balance in future years (2011/12 onwards)* which will be managed and mitigated by detailed annual planning; an active productivity and efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- *Infection Control* which will be managed and mitigated by a detailed annual work programme supported by a specialist Infection Prevention and Control Team led by the Director of Infection Prevention and Control under the executive lead of the Chief Nurse / Chief Operating Officer. Despite successfully meeting all targets in 2010-11, the Trust faces a considerable challenge in meeting reduced target cases for MRSA and CDiff for 2011-12.

All major risks are directly managed or operationally led by an Executive Lead. Progress against the action plan to mitigate the risk is updated in the Top Risk Report by the Executive Lead. The Top Risk Report is reported and reviewed by the Trust Executive Group and the Board of Directors on a quarterly basis. Outcomes are assessed by monitoring the progress reports against the action plan and by comparing the current residual risk with the target residual risk (which may be to eliminate the risk or to reduce the risk to a reasonable level, as agreed by the Board).

There are robust and effective systems, procedures and practices to identify, manage and control information risks.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Committee which is accountable to the Healthcare Governance Committee, a committee of the Board. The Information Governance Committee is chaired by the Medical Director who is also the Caldicott Guardian. The Director of Service Development, as the Board appointed Senior Information Risk Owner (SIRO), is the Deputy Chair of the committee. The SIRO was actively engaged in the review of this statement and has written to me endorsing the content.

The Information Governance Management Framework 2010/11 brings together all the statutory requirements, standards and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Framework Programme.

Supported by relevant policies and procedures, notably the Procedures for the Transfer of Person Identifiable Data (PID) and other Sensitive and Confidential Information and the Confidentiality - Staff Code of Conduct, the Trust has an ongoing programme of work to ensure that PID is safe and secure when it is transferred within and outside the organisation.

All Trust laptops are now encrypted and the introduction of port control and an approved list for removable media is planned to be introduced shortly.
In accordance with the Information Asset Policy, a centralised major information asset register is in place which supports the role of the Trust's Information Asset Owners who report to the SIRO. Any concerns identified through the registration and management of the Information Assets will be pursued through the recognised and accepted managerial line. Failure to deal with a concern through that route will be taken up by the SIRO with the appropriate Information Asset Owner within the Trust.

There were no serious data security incidents in the past year.

The Assurance Framework identifies the Trust's principal objectives and the high level risks to their achievement along with key controls and sources of assurance. Underpinning the Assurance Framework is the Trust's Risk Register which includes those strategic risks identified by the Trust Executive Group and reported via the Top Risk Report and operational risks identified by clinical and corporate directorates. Both reports inform and update the Board of Directors and the Trust Executive Group on key strategic risks and allows progress against Executive Director-led action plans to be effectively monitored.

The integration of the Assurance Framework and the Risk Register into the business planning process ensures that risk-based decisions can be made in relation to service developments and capital allocation.

Risk management is firmly embedded into the activity of the organisation and operational responsibility is delegated to the individual directorates' management teams. Each directorate is responsible for identifying, assessing, scoring and registering its own risks. It is also responsible for maintaining the local risk register and for developing and monitoring plans to mitigate unacceptable risks or escalating the risk management within the organisation, as appropriate.

Supplementing the work of the Board and its committees, there are a number of specialised committees within the Trust with a remit to oversee specific risks: Safety and Risk Management Board, Blood Transfusion Committee, Control of Infection Committee, Emergency Preparedness Operational Group, Information Governance Committee, Medical Equipment Management Group, Medicines Safety Committee and Radiation Safety Steering Group.

There are well established and effective arrangements in place for working with public stakeholders across the local health economy:

- NHS Sheffield (PCT)
- Yorkshire and the Humber Strategic Health Authority
- Yorkshire and the Humber Specialised Commissioning Group (South)
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- Neighbouring Trusts in South Yorkshire and North Derbyshire
- Sheffield City Council
- Sheffield and South Yorkshire Overview and Scrutiny Committees
- Sheffield First Partnership and more specifically Sheffield Executives Board

Wherever possible and appropriate, the Trust works closely with stakeholders to manage identified risks which affect them or which they can mitigate.

The Trust is also represented on various national forums such as Foundation Trust Network, NHS Confederation and Association of UK University Hospitals and is able to help influence national policies. The Trust is fully compliant with the requirements of registration with the Care Quality Commission. It is required to maintain ongoing compliance with the CQC essential standards of quality and safety for all its regulated activities across all its locations. The Board of Directors has approved a Trust Compliance Framework which describes how the CQC Compliance Review Group will oversee the development and systematic periodic evaluation of Provider Compliance Assessments against each of the essential standards as evidence of ongoing compliance.

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

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

The Trust aspires to be an organisation of best practice for positively encouraging equality and diversity in the workplace and providing services which take account of the diverse needs of service users. It has an established Equality and Human Rights Steering Group, (chaired by the Trust Secretary) and an Operational Leads Group.

Work is underway to review current systems and processes and to develop an equality and human rights strategy to meet the statutory requirements of the 2010 Equality Act and the regulatory requirements of the Equality and Human Rights Commission and the Care Quality Commission. The strategy development process is using the draft NHS Equality Delivery System to help identify the Trust's objectives and, in consultation with internal and external stakeholders, to develop an action plan. Currently all policies must have an equality impact analysis completed as part of the approval and dissemination process. A key element of the strategy is to improve the focus and effectiveness of undertaking and publishing equality impact analysis, at policy and at service level, whilst ensuring the Trust complies with legislation.

The Trust continues to complete outstanding actions to address the recommendations of an independent Equality Review commissioned by the Trust to identify current strengths and good practice within the organisation and opportunities for improvement and development to help the organisation exceed minimum standards and achieve excellence.

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

The Trust has established a Sustainable Development Strategy Group, (which I chair as Chief Executive) and a Partnership Group. The Sustainable Development Manager provides an operational lead on a number of projects, as detailed in the Trust's Sustainable Development Action Plan, which are delivered as part of a Trust-wide campaign called Be Green. Recent initiatives include setting up the Be Green Workforce Group, the recruitment of a network of Be Green representatives across the Trust, carbon footprinting for Energy, Water, Waste and Business Travel, the development and launch of a dedicated intranet site and the collation and publication of energy and emissions data. In addition, a number of specific sustainability projects have been launched including building insulation, PC power management and the Travel Plan.

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

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plans for improving productivity and efficiency in order to offset income losses, meet the national efficiency target applied to all NHS providers and fund local investment proposals. The financial plans reflect organisational-wide plans and initiatives but are also translated into Directorate budgets and productivity and efficiency plans. Financial planning at all levels is influenced by income assumed from national tariffs and local prices agreed with Commissioners. Financial plans are approved by the Board, supported by its Finance Committee. An Annual Plan is submitted to Monitor, reflecting finance and governance (including service and quality aspects), each of which is ascribed a risk rating by Monitor. This plan incorporates projections for the following two years, which facilitates forward planning by the Trust. In particular, the Trust has sought to develop capital investment and productivity and efficiency plans over a number of years.

The in-year use of resources is monitored by the Board and its committees via a series of detailed monthly reports, covering finance, activity, capacity, human resource management and risk. These documents are a consolidation of detailed reports that are provided at Directorate and Department level to allow active management of resources at an operational level. Quarterly monitoring returns are submitted to Monitor from which a risk rating is again attributed to the finance, and governance elements. The Trust's performance management processes are crucial in early identification of any variances from operational or financial plans and in ensuring effective corrective action. The use of capital resources is planned and monitored by the Trust's Capital Investment Team which reports quarterly to the Board.

The Trust continues to drive enhanced productivity and efficiency through targeting areas for improvement and through developing capability and capacity to deliver the required change. A key principle of the programme is to seek improvements to patient care alongside productivity and efficiency gains. The development of information and performance management systems has also been key elements of the Programme.

The Trust employs a number of approaches to ensure best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service re-design leading to improvements in the quality of services and patient experience as well as financial performance. External consultants are commissioned where appropriate to assist in identifying areas where economy, efficiency and effectiveness can be improved and in delivering the required changes. The Trust is continuing to develop its Service Line Reporting and Patient Level Costing System to enable better understanding of income and expenditure at various levels and, therefore, to facilitate improved financial and operational performance. The rollout to Directorates is almost complete and action plans are being developed by those areas which make significant losses. As mentioned below, the Board receives

assurance on the use of resources from a number of external agencies, for example Monitor's Financial and Governance risk ratings and the Care Quality Commission's Quality and Risk Profile and inspection reports. Such reviews are reported to the Board of Directors and its relevant committees.

All the above is underpinned by the Trust Scheme of Reservation and Delegation, Standing Orders and Standing Financial Instructions, which allow the Board to ensure that resources are controlled only by those appropriately authorised. These documents are reviewed annually.

The Trust also makes use of both Internal and External Audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits the Internal Audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed thereby assisting prioritised action plans which are agreed with management for implementation. All action plans agreed are monitored and implementation is reviewed regularly and reported to the Audit Committee as appropriate.

Annual Quality Report

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

Building upon the experience of the preparing the 2009-10 Quality Accounts, further guidance from Monitor and the findings and recommendations from External Auditors Dry Run of External Assurance on the Quality Reports, the Trust has refined the process for preparing this year's Quality Report. Overall responsibility for the Quality Report rests with the Medical Director but operational responsibility is devolved to the Head of Patient and Healthcare Governance. A Project Group was established with representation from Trust managers, clinicians and Governors. The Project Group reviewed progress against 2009-10 quality priorities and agreed three priorities for 2011-12 with an explicit commitment to consider areas where there was a recognised need to improve the quality of care as well as areas of known good practice. The priorities were agreed by the Overview and Scrutiny Committee, LINk, NHS Sheffield and the Governors Council and approved by the Board of Directors. Relevant specialists or managers in the Trust were approached to provide supporting data using established data sources which are subject to internal information quality assurance. A draft Quality Report was sent to the Overview and Scrutiny Committee, the local LINk and NHS Sheffield and comments sought.

Overall the stakeholder comments were positive and included constructive feedback on specific areas of concern. There was general appreciation of the Trust's responsiveness to the stakeholder priorities suggested in 2009/10 and further helpful suggestions for the future development of the quality report. Our external auditors have reviewed the Quality Report and have provided independent assurance to the Board of Directors and the Governors' Council that the content of the report is in accordance with Monitor's Annual Reporting Manual.

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 the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other Board committees with defined responsibilities for risk and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework and the Top Risk report provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Audit Committee continues to receive and monitor the Assurance Framework and relevant internal audit reports. It plays a central role in performance managing the action plans to address the recommendations from audits which have identified the presence of medium to high risks or weaknesses in internal control.

The preparation and publication of the Quality Report has been informed by an in-depth review of last year's process and by scrutiny of further guidance. All data incorporated into the Quality Report is from established sources which are subject to routine and regular audit of data quality. The comments from the Overview and Scrutiny Committee, the LINk and NHS Sheffield provide external assurance of the effectiveness of internal controls. The external assurance audit undertaken by our external auditors which will report to the Board and to the Governors Council will provide enhanced assurance.

The Trust is committed to continuous improvement of its risk management and assurance systems and processes to ensure improved effectiveness and efficiency.

My review is also informed by:

- Opinion and reports by Internal Audit who work to a risk-based annual plan with topics that cover Governance and Risk Management, Service Delivery and Performance, Financial Management and Control, Human Resources, Operational and Other Reviews.
- Opinion and reports by our external auditors (Audit Commission) and specifically their Annual Governance Report.
- Quarterly performance management reports by Monitor.
- DH reports such as Performance Indicators.
- Ongoing compliance with the Care Quality Commission's Essential Standards of Quality and Safety for all regulated activities across all locations, as part of the registration process.
- NHSLA assessments against Risk Management Standards and CNST for Maternity.
- Information Governance Assurance Framework and the Information Governance Toolkit
- Results of national Patient Surveys and the National Staff Survey.
- Investigation reports and action plans following Sudden Unexpected Incidents.
- User feedback such as Picker real-time monitoring of patient experience, complaints and claims.
- Governors' Council reports.
- Clinical Audit reports.

Conclusion

No significant internal control issues have been identified.

Signed

Sir Andrew Cash, OBE,
Chief Executive

Date: 26 May 2011

Glossary of terms and abbreviations

Acute trust
A Trust is an NHS organisation responsible for providing a group of healthcare services. An Acute Trust provides hospital services (but not mental health hospital services, which are provided by a mental health Trust).

Audit - see clinical audit

Audit Commission
The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS Trusts, primary care Trusts and Strategic Health Authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the Health Service, and, working with the Care Quality Commission, undertakes national value-for-money studies.

Balloon time - see PPCI

Board (of Directors)
The role of the Trust's Board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives with the support of the Executive Director team..

C Difficile
Clostridium difficile is a species of bacteria that causes severe diarrhoea and other intestinal disease.

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Council Health Scrutiny Committee
see overview and scrutiny committee

CQC - Care Quality Commission
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations.

CQUIN
(Commissioning for Quality and Innovation) A system where a proportion of providers' income is conditional on certain quality and innovation standards being met. The standards and targets are set by commissioners

Department of Health vital signs
See vital signs

Elective
A medical or surgical procedure that is planned and often put on a waiting list. The opposite of emergency.

Foundation Trust
A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts provide and develop healthcare according to core NHS principles - free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a board of governors comprising people elected from and by the membership.

Governors
Trust Governors are elected by the Foundation Trust members and are elected to sit on the Governors' Council. This aims to give people who use the hospitals a say in their running.

The Governors' Council holds the Trust Board of Directors to account and seeks to ensure the continued success of the Trust through effective management, partnership working and maintaining NHS values and principles.

There are 33 Governors in total. 12 represent the public, seven represent patients who have used services at the hospitals, five represent staff at the hospitals and there are nine partner governors appointed from key organisations we work with.

Haematologist
A doctor who specialises in the diagnosis, treatment and prevention of blood diseases.

Incidence
The number of times something happens

LINk
Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

Microbiologist
A doctor who specialises in the diagnosis and treatment of microbial diseases in patients.

Monitor
The independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Overview and scrutiny committees
Since January 2003, every local authority with responsibilities for social services (150 in all) have had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS - not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Patient governors - see Governors

PPCI - Primary Percutaneous Coronary Intervention
The key to improving outcomes after severe heart attack is to re-establish coronary artery blood flow as quickly as possible and so limit damage to the heart muscle.

Coronary angioplasty is a technique for unblocking arteries carrying blood to the heart muscle. A small balloon at the tip of a catheter tube is inserted via an artery in the groin or arm and guided to the blocked artery in the heart. The balloon is inflated and then removed, leaving in place a 'stent' - a rigid support which squashes the fatty deposit blocking the artery, and allowing blood to flow more easily.

Primary angioplasty (PPCI) uses the techniques of coronary angioplasty, delivered on an emergency basis, and within a maximum of 150 minutes of the patient calling for help - hence the standards for "call to balloon time" and "door to balloon time".

Primary Care Trust
A primary care trust is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet local people's needs.

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Staff governors
See governors

Stroke
A sudden disabling attack or loss of consciousness caused by an interruption in the blood supply to the brain.

Teaching Trust
A Trust that provides teaching for student doctors, nurses and other clinical professions and is linked to a University Medical School.

Tertiary Centre
A Trust that provides Tertiary care, which is the third and highly specialised stage of treatment, usually provided in a specialist hospital centre. It is often provided by departments that are linked to medical schools or teaching hospitals. They treat patients with complex conditions who have usually been referred by other specialists. The other sections of health care are Primary Care Services, that are provided at the first stage of treatment when you are ill - by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, together with district nurses and health visitors, and Secondary Care, usually provided by a hospital.

Tissue Viability
Tissue Viability is about the maintenance of skin integrity, the management of acute and chronic wounds, and the prevention and management of pressure damage to the skin and underlying tissue.

Triage
The assignment of degrees of urgency to decide the order of treatment.

Vital signs
"Department of Health vital signs" are standards specified by the Department of Health that are used to measure the effectiveness and performance of a service.

This Annual report and Accounts has been produced by Sheffield Teaching Hospitals NHS Foundation Trust.
For further information on any aspect of this report or enquiries regarding our services, please visit www.sth.nhs.uk or write to:

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