In hospital and in the community

proud to make a difference

Sheffield Teaching Hospitals NHS

NHS Foundation Trust

Annual Report & Accounts 2011-12

Incorporating the Quality Report 2011/12

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

Sheffield Teaching Hospitals NHS Foundation Trust.
Annual Report and Accounts 2011-12 incorporating the Annual Quality Report 2011-12.

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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 and in the local community.

Our hospitals are:
- Northern General
- Royal Hallamshire
- Weston Park
- Jessop Wing
- Charles Clifford Dental Hospital

We are one of the largest providers of community health services in the UK and have a number of community health centres providing care to the local population.

Among the largest employers in the region, Sheffield Teaching Hospitals employs around 15,100 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 the past year the Trust carried out 230,441 inpatient episodes and day cases and 956,416 outpatient appointments totalling nearly 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.

Proud to make a difference

Every day the skills and dedication of our staff improve people's lives.

The commitment of our staff, the excellence of our clinicians and academics, the quality of our partner organisations, and the support we have from our patients and local community have enabled us to continue to deliver the highest quality care for our patients in 2011/12.

We continue to be recognised for having some of the best clinical outcomes and our patients consistently say they are happy with the care and kindness they experience in our hospitals and in the community. It is because of this that, for the third time in 6 years, we were once again named Hospital Trust of the Year (North) in the Good Hospital Guide.

The challenges of the economic recession and NHS reforms have inevitably meant we have focused our efforts on transforming the way we deliver care to ensure we deliver the right care in the right place at the right time and as efficiently as possible. This has culminated in services being further improved in the areas which really matter to patients:

- safety,
- high quality of care,
- short waiting times,
- cleanliness of our hospitals
- and how responsive we are to our patients' differing needs.

Over the next few pages you can read about some of these advancements and the people whose lives they have changed.

We are proud to make a difference by providing expert care in a safe, clean, comfortable and friendly environment.

World class clinical quality

Sheffield Teaching Hospitals NHS Trust is home to many internationally renowned specialists and researchers achieving some of the best clinical outcomes anywhere in the world. Once again in 2011/12, our mortality rates were significantly lower than expected, given the nature and complexity of the cases we treat. This is a measure that is widely regarded as an indicator of clinical excellence overall and why patients continue to chose us for their healthcare needs.

We have also pioneered new treatments for multiple sclerosis, cancer and many long term conditions through innovative translational research trials. The futuristic advancements of the virtual physiological human bring healthcare into a new dimension right here in the heart of the UK.

Adult Community Services, that were part of NHS Sheffield, became 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 to harness the skills and expertise of both acute and community staff and develop new ways of delivering services for the patients we serve.

Right care, right time, right place

We want our local population to achieve the highest physical and mental health status possible and by strengthening existing partnerships and forming new alliances, we want to play a leading role in closing the gap in health, wellbeing and life expectancy that is experienced in different parts of South Yorkshire. 2011/12 saw the City's partners in health and social care come together to form an innovative partnership which aims to set aside organisational boundaries to ensure 'the right care is delivered at the right time, in the right place, by the right person and in a way which is as efficient as possible. Throughout the year the partners have introduced new ways of working in line with international best practice so that we can achieve better value, respond to growing health needs, deliver care closer to home, and continuously improve quality.

Quality counts

Public sector finances face unprecedented challenges and the whole of the public sector is having to make difficult choices to help reduce the country's overall deficit. All hospitals are being asked to contribute to the 20% efficiency savings that are needed by the NHS over the next four years and Sheffield Teaching Hospitals NHS Foundation Trust is no exception.

The major financial concern for the Trust in 2011/12 was therefore to maintain financial stability, while meeting the demands of increasing numbers of patients and more stringent operational targets. In the last 12 months, through our Quality and Efficiency programme, we have been reviewing our costs and the way in which we work in order to become more efficient and deliver better value at a much greater pace. Our focus is on doing more of what adds value; improving the productivity of our clinical areas – using our operating theatres, outpatient clinics and inpatient beds more efficiently; streamlining procurement, and generating more income. Delivering higher quality at lower cost is the only way we will achieve our ambition to continue to deliver care to the highest standards.

Investing in new facilities

Once again we achieved a strong financial outturn in 2011/12 which will enable us to continue to invest the small surplus we made in new facilities and ways of working which will benefit patients. Throughout the year

we continued to invest in the very latest in medical treatments as well as state-of-the-art equipment. We also continued to refurbish our wards and departments to enhance patients' experience of visiting our hospitals. One example is the improvements made to the Outpatients Department at the Royal Hallamshire Hospital to better meet the needs of patients who have dementia. The new area is light and spacious with carefully selected furniture and artwork to create less confusing, relaxing space in which patients feel more comfortable.

More than £16million was invested in a new state-of-the-art laboratory complex at the Northern General Hospital which will result in tests results being available faster, which in turn enable a diagnosis to be made much more quickly.

A new Frailty Unit which is planned to open at the Northern General Hospital will enable older patients to be cared for in many cases without the need to admit them to hospital. In readiness for this new development we have increased the number and range of community health and social care services available to provide support particularly for older people and those suffering from long term conditions such as diabetes or chronic lung disease.

Sheffield Teaching Hospitals NHS Foundation Trust produces some of the best clinical outcomes in the UK - evidenced by one of the best survival rate records in the NHS.

Improving the patient experience

We are proud to have some of the shortest waiting times in the NHS for operations and treatment but we also believe the experience our patients and their visitors have during their contact with us should be as positive as possible . For example our Outpatient Transformation Programme aims to make improvements in all aspects of a patient's journey through the service. From making an appointment, to attending the clinic, through to discharge and follow-up care in the community.

Working with Sheffield Health and Social Care Trust we have focused on supporting the needs of the growing number of people who live with dementia. One example of the improvements underway within the hospitals is the introduction of a new dedicated ward for older patients with dementia undergoing surgery for a hip fracture. The ward's multidisciplinary team has used the latest research into dementia care to create an environment which is less confusing and upsetting. This has had a positive impact with the length of time patients need to stay in hospital after their operation being significantly reduced.

Five year strategy to Make a Difference

While we have been able to make significant improvements over the part 12 months we believe that we can still do much more to offer consistently high service quality, the best outcomes and, in partnership with our academic partners, excellence in education and research. To this end, during 2011/12 we have developed and consulted on a new five year corporate strategy titled: **"Making a difference."**

Our vision is to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

Our mission is therefore:

To improve health and well-being, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. We aim to work at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most.

Over the next five years we will be working hard to achieve this so that we can continue to provide the very best for those people who choose us for their care, our staff and our local communities.

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. We are also very grateful for the support of our local community through our membership and Governors' Council. Our members have grown in number and the work of the Governors continues to make a positive impact on services.

And lastly we are very fortunate to be supported by some exceptional charities, individual fundraisers and local businesses. We would like to take this opportunity to thank each and every one of them for their continued support.

2012/13 promises to be one of our most challenging years yet but we intend to rise to that challenge and deliver the best possible clinical outcomes, provide a high standard of customer services, employ caring and cared for staff, spend money wisely and deliver excellent research, innovation and teaching.

Tony Pedder
Chairman

Sir Andrew Cash OBE
Chief Executive

Year in View 2011 - 2012

We have had another exciting year during 2011/12 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 NHS Foundation Trust over the past 12 months.

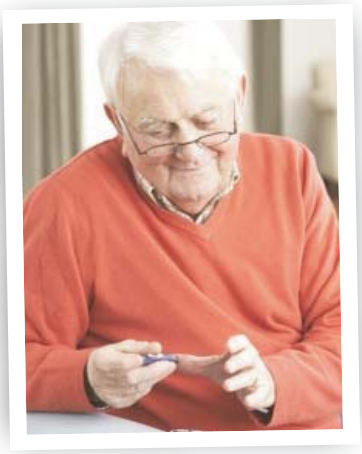
April 2011

Enabling patients to take more control of their diabetes

Diabetes is a common condition in Sheffield, currently affecting around 5% of the population. Many sufferers, particularly of Type 2 diabetes, are elderly and find travelling to hospital to manage their diabetes can be difficult.

These patients, however, are benefiting from the roll out of a successful pilot scheme, enabling them to have access to specialist diabetes care in their local community. 27 GP practices have taken part in a pilot scheme involving a team of two specialist diabetes nurses, a dietician, a podiatrist and a Consultant Diabetologist. The team supported staff in the GP practices and assessed and treated patients who would normally have had to travel to hospital. The specialist service has proved to be a convenient and effective way of helping many patients to manage their diabetes.

Dr Adrian Scott Consultant Diabetologist explains: *"For people with less complex problems this new service means that many patient can have their care and monitoring at their local surgery. Early feedback suggests that patients prefer this and we have begun to see improvements in their blood glucose control. Diabetics with more complicated problems still need to be seen at the hospital."*



The community team are also training practice nurses and GP's in the use of some of the newer treatments for diabetes and further schemes are planned in which GPs can access advice from hospital consultants electronically.

May 2011

Leading the way in new stem cell treatment for Multiple Sclerosis

Samantha Ramsey became one of only a handful of people in the UK to receive a pioneering new treatment called Autologous Stem Cell Transplantation at the Royal Hallamshire Hospital after she was diagnosed with a very aggressive and malignant form of Multiple Sclerosis.

The treatment involved collecting her bone marrow stem cells using a machine before freezing them. Samantha was then given a high dose of chemotherapy before the stem cells were thawed and given back to her to rebuild her blood and immune system. This in turn helped to control the inflammation that was destroying her nervous system.

Samantha explains: *"Ten months ago I was working as a carer of young adults with Autism and I was driving, going out - doing normal things, but then in a matter of months my life became completely different."*

"The way the team at the Hallamshire Hospital supported me has been so wonderful. I can't thank them enough. They have saved my life but I know I still have a fight ahead of me."

Dr Snowden, Consultant Haematologist, said he hoped that with Samantha's now 'rebooted' immune system she will continue to show signs that the inflammation and damage is being reduced and that her nervous system is capable of repairing itself.

Management commentary

June 2011

Tiny tot returns to say thank you to Jessop Wing

A boy who was born weighing only 480g and given only a tiny chance of survival returned to thank the team who cared for him at the Jessop Wing. Kai Brown was born at the hospital by planned elective caesarean at 26 weeks because there were serious concerns that he would not grow and that he could die if his mother's placenta failed.

Now aged five Kai was excited to visit the Jessop Wing to see the staff who helped him in his first days of life. His mother Cat, from Barnsley, said she would always be thankful for the care that she and Kai received during those first few months of her son's life. She said: *"Everyone who looked after us at the Jessop Wing were so kind and caring. Knowing that we had that level of support was crucial to me and my husband."*

During the year, the Jessop Wing was also praised at the national British Journal of Midwifery awards for their excellent Stop Smoking Service. The team were awarded third place in the Team of the Year category for their work in implementing a new strategy to help pregnant women stop smoking which enabled 183 pregnant smokers to kick the habit, along with 22 of the women's partners.

July 2011

Breakthrough as first Sheffield patient receives pioneering cancer treatment

The first patient in Sheffield to receive a revolutionary new treatment for liver cancer spoke of his gratitude to the team who cared for him.

Bill Milton, 71, of Deepcar, received the experimental treatment at the Northern General Hospital after being told that other treatments his doctors had tried were not working. The treatment has shown promising results and the tumours in his liver have shrunk.

The treatment, called Selective Internal Radiation Therapy (SIRT), involves injecting millions of tiny radioactive 'beads' into the liver, effectively delivering a localised form of radiotherapy to the tumour cells. Although not regarded as a cure, it is considered an effective alternative to chemotherapy in shrinking tumours and improving patients' prognosis and quality of life.

Grandfather-of-five Bill said: *"I can't express enough how thankful I am to have received this treatment - the whole team of surgeons, doctors and nurses were absolutely fantastic."*

August 2011

Changing the way we help people with dementia

At any time 20-25% of patients at Sheffield Teaching Hospitals either have or are suspected of having dementia.

It is for this reason that experts in elderly care at the hospital, in partnership with specialists from Sheffield Health and Social Care Trust, GPs, community health and social care teams are designing a new system to quickly identify and care for people with the condition. As well as the care in hospital, a key focus of the partnership is to make sure that when patients get home that a package of care is in place to help them and their family cope with all the different challenges that the condition brings.

One example of the improvements underway within the hospitals is the introduction of a new dedicated ward for older patients with dementia undergoing surgery for a hip fracture. The ward's multidisciplinary team has used the latest research into dementia care to create an environment which is less confusing and upsetting. This has had a positive impact on the length of time patients need to stay in hospital after their operation being significantly reduced.

Matron Dianne Fawbert explains: *"We have created a more homely environment and our Specialist Dementia Nurse has introduced a number of initiatives to support patients such as reminiscing libraries; 'This is me' - patient passports to remind them of their lives; communal eating and dementia dolls which are used for calming distressed patients. We have also introduced extra support with rehabilitation with the help of our wonderful WRVS volunteers. We have already received excellent feedback from relatives and patients themselves."*

£16m investment in new state of the art Hospital laboratory complex

A 'topping out' ceremony was held to mark a significant construction milestone in the building of a new £16m, state-of-the-art laboratory complex at the Northern General Hospital. The new facility will bring together the majority of existing pathology laboratories on to one purpose built site. The new complex will house some of the most advanced diagnostic equipment in Europe and will enable patients to receive their results even more quickly.

The building will also generate savings when fully operational as a result of its environmental design which will see overall energy costs reduced by two thirds compared to the existing older laboratories.

Professor Tim Stephenson, Clinical Director of Laboratory Medicine said: *"We already have some of the best scientists in the NHS working within our hospital laboratories and this new major investment will now also provide Sheffield with some of the most leading edge laboratory facilities in Europe. It will increase our capacity and enable us to process test results even more quickly."*

The new building is part of our ongoing commitment to provide the best quality of care to patients not just at Sheffield Hospitals, but also we will be able to provide specialist test reporting for patients from many other neighbouring hospitals.

September 2011

Mouth Cancer survivor delivered powerful message after pioneering surgery

Dave Rogers, 62, whose jaw had to be reconstructed using a bone from his shin, urged people in Sheffield to learn the warning signs of mouth cancer and thanked his skilled surgeon for saving his life.

The grandfather from Doncaster first realised that something was wrong when it was noticed that some of his front teeth required root canal work and after being referred to Charles Clifford Dental Hospital he was told the cause was an aggressive form of cancer. Dave was referred to Royal Hallamshire Hospital's Oral and Maxillofacial team and underwent two operations totalling 36 hours which involved cutting away his jaw and replacing it with bones and skin from his shin.

He said: *"At the hospital they made you feel that you were part of their inclusive team and you were fighting this together."* Following his operation Dave had to learn to walk properly again due to the bones in his leg being weaker and also had to cope with other effects of the operation. He added: *"It's been hard as I've had to relearn to do some of the things I took for granted before the operation. I've had to learn to walk properly again as the operation removed some bone from one of my legs. I even copied my two-year-old grandson trying to walk for the first time. I've also had to learn to speak and breathe properly again."*

Despite the challenges, Dave has had a remarkable recovery, running a 3km race for Weston Park Hospital Charity in June. He now enjoys walking 5km a day and spending time with his grandson Alfie.

October 2011

Mortality rates at Sheffield hospitals are among the lowest in the UK

Figures published by the health watchdog Dr Foster showed the Trust continues to have mortality rates which are amongst the lowest in the country. Dr Foster used the Summary Hospital-level Mortality Indicator to review all deaths in hospital plus those occurring within 30 days after discharge.

The report also shows that the Trust also has a low mortality ratio for several of the most common conditions, which include:

- Stroke
- Heart failure
- Lung cancer
- Septicaemia
- Pneumonia

Low mortality rates were just one area that ensured Sheffield Teaching Hospitals was awarded the title of Trust of the year (North) by expert independent healthcare analysts Dr Foster. Sheffield achieved the recognition for the third time as a result of the clinical performance through the year and analysis of the outcomes of care. Every acute hospital in the county is analysed as part of the process.

The data in the Good Hospital Guide shows that:

- Mortality rates post surgery are amongst the lowest in the UK.
- The results of quality of care indicators for many key procedures/operations are better than many other hospitals across the country.
- Patients rate staff very highly and overall are pleased with the information they receive and feel they are treated with dignity and respect.

November 2011

Centre for HIV celebrates a successful 24 years

Sheffield's Centre for HIV and Sexual Health celebrated 24 years of innovative health promotion and HIV prevention at the official opening of its new building.

The new centre at Brincliffe House will not only offer improved training facilities for HIV prevention and health promotion, it will also serve as a community resource for integrating work between Sheffield City Council and the city's sexual health services.

As part of the centre's commitment to improving the wellbeing of people living with or affected by HIV in Sheffield, the team launched a new, informative and interactive website in partnership with HIV services at the Royal Hallamshire Hospital. 'Positively Sheffield', which is funded by the Sheffield City Council AIDS Support Grant, provides people living with or affected by HIV access to a wide range of information and resources about living with HIV in the City. Steve Slack, Director of Centre for HIV and Sexual Health, said: "The website provides invaluable online support to people who may be isolated as a result of HIV-related stigma and prejudice."

December 2011

Inspirational Katie Piper opens new Burns Unit and World Champion Steve Peat opens new Hand Unit.

Former model and television presenter Katie Piper, who suffered a brutal acid attack, visited staff and patients at the official opening of the new Burns Unit at the Northern General Hospital.

The state-of-the-art facility provides a comprehensive service for inpatients and outpatients in Sheffield and North Trent. With 6 beds and full inpatient, outpatient and emergency services, it is one of the UK's leading centres of care for burns patients.

Sheffield-born World Champion Mountain Biker Steve Peat officially opened the Sheffield Hand Centre which is a new purpose designed unit dedicated to providing excellence in health care for patients with hand problems. The Unit is one of only 5 of its kind in the UK and provides a world-class, predominantly day-case facility for trauma, elective & rehabilitation hand services for the population of Sheffield and South Yorkshire.

January 2012

Pioneering operation helps man to give accident the elbow and serve his country

A council worker whose arm 'disintegrated' following a 20ft fall from scaffolding has gone onto serve his country in Afghanistan after surgery in Sheffield.

Michael Warren's fall shattered his elbow in several places and left him unable to use his left arm at all. He said: *"Before the accident I was very active, I enjoyed doing my job and took great pride in serving in my local Territorial Army regiment"*. The accident meant that all these activities were threatened.

Michael was referred to the Elbow Unit at Sheffield Teaching Hospitals where it was felt that his elbow might be salvaged using an allograft (bone from someone who had died) together with a total elbow replacement. Michael was not just able to keep his arm but also had restoration of full movement.

David Stanley, Consultant Shoulder and Elbow Surgeon, said: *"The technique has previously been used in this country around the hip and knee but Sheffield is the only centre in the United Kingdom with significant experience of the procedure at the elbow."*

Michael said he was completely amazed with the results and was able to fulfil his ambition of serving with his regiment in Afghanistan.

February 2012

Life is blooming good for couple after wife donates kidney

A husband who was in need of a life-saving kidney transplant is enjoying life to the full after his wife proved to be the perfect match.

David Marshall, 37, was given a kidney donated by his wife Jo after doctors diagnosed him with kidney failure. The couple, who run a florist shop together are now enjoying excellent health after the lifesaving transplant.

David began to experience health problems in 2004, regularly feeling tired and breathless. He was suffering from Type 1 diabetes and high blood pressure, and doctors soon diagnosed that his kidneys were failing and that he needed a transplant.

David's wife Jo volunteered to donate her kidney and David and Jo underwent the transplant surgery.

David explains: *"Only after the transplant did I realise quite how ill I had been. I'm extremely grateful to the team of specialists and nurses that has looked after me so well."*

The Sheffield Kidney Institute is one of the country's leading kidney transplant centres, with a catchment population of 1.8 million people across South Yorkshire, North Derbyshire and North Nottinghamshire. Each year it carries out around 60 transplants, of which around a third are living donor transplants.

Patients with kidney failure are also being helped to take control of their dialysis thanks to a special project at Sheffield Teaching Hospitals. The project will develop a system of self-management where nurses train and support those people who want to manage aspects of their own care. This ranges from routine tasks such as weighing themselves and taking their blood pressure, to inserting needles or cannulas and setting up the dialysis machine.

Patient David Pargeter, who has been on dialysis for two years, says taking part in the new pilot has completely changed his attitude to his care.

He said: *"When I first went on dialysis I found it very depressing, you feel you have lost control of your life but since I have been part of this project I feel I have seized back that control."*

March 2012

£10m for Olympic legacy National sports medicine centre of excellence in Sheffield

Sheffield will be one of three hubs forming the first ever National Sports and Exercise Medicine Centre of Excellence.

The Centre which will be made up of three network partners, will promote sport and exercise medicine across the country. The Centre will help more people to be more active, treat injuries caused by exercise and conditions associated with lack of exercise. This will mean people who are injured return to physical health and work quickly. It will also help people use the benefits of physical activity to cope with existing medical conditions, such as diabetes. The establishment of the Centre will also fulfil one of the Government's key 2012 Games bid commitments and will be a lasting legacy of the Games.

Sir Andrew Cash, Chief Executive of the Trust said: *"The focus of the Sheffield arm of the three Olympic Legacy centres of excellence is centred on the promotion of physical activity and improvement of the health and productivity of the people of Sheffield. The City is well placed to ensure this project is successful. Sheffield has world class sport and medical facilities complemented by world class research and educational programmes in the Cities two Universities. In addition Sheffield has award winning public health and voluntary sector programmes aimed at engaging "at risk" groups and communities and reducing health inequalities."*

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.

Patient Experience Report

The Trust's quarterly Patient Experience Report which brings together all types of patient feedback including complaints, patient surveys, mystery shopping and website feedback has been further developed over the last year. The report 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. It also provides information on new projects or actions we have taken to improve our services. Each report has included a focus on a theme or a specific element of care. Themes covered during 2011/12 have included nutrition, staff attitude, hygiene and waiting times/delays.

We aim to ensure we are making best use of all the patient experience information we have by sharing it with the staff who are best placed to understand what matters most to their patients, implement improvements and make a difference to patient experience in their area. In addition to producing Trust wide reports over the next year, detailed patient experience information will be reported on and provided to each directorate, ward and department.

Working in Partnership

A 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 and available to all our staff. To date over 500 people have registered their interest and new members are recruited on an ongoing basis. The database holds details of the particular interests of each person, which may be certain specialties such as elderly care or cancer, or certain topics such as nutrition or patient information. Patients and members of the public identified from our users database were involved in a series of important consultation events when community services were transferred to the Trust. The database has also been useful in engaging patients with a number of initiatives across the Trust, including feedback on the A&E service at the hospital. Over the next year we plan to consider how modern technology such as texting, email and web based discussions can be used to ensure we make it easier for people to be involved.

Customer Care Standards

During 2011, customer care standards for reception areas were developed in partnership with patients, carers, governors and staff to ensure consistent delivery of excellent customer service across the Trust. Main reception areas were selected for introduction of the standards as the first experience patients have at hospital can often be at reception.

Training workshops to support the implementation of customer care standards took place throughout the year with over 250 reception and administrative staff completing the training to date. To measure the impact of the standards a mystery shopping programme was carried out before and after the implementation of the standards. The results showed that significant improvements had been achieved. The reception areas will continue to be monitored and consideration is now being given to how the customer care standards and training can be adapted and targeted at other staff groups.

Annual Survey Programme

A programme of patient surveys has been carried out across the Trust last year. Using hand held electronic devices, patients' views can be collected by trained volunteers enabling results to be reported quickly. This provides a focus for quality improvements. The total number of surveys carried out using Frequent Feedback were:

In-patients 2480
Accident and Emergency 329
Children and Young Peoples Survey 297

Some examples of surveys that we have run include:

- Patients views on the Hospital Pharmacy at the Royal Hallamshire Hospital
- Patients Feedback on Renal Outpatients
- Patient Satisfaction with Hospital Catering Services
- Patients opinions on the 7 day provision of Therapy Services

Findings from the surveys are used to help us learn what patients views are on a range of specific issues in particular clinical areas or departments to involve patients in decisions about how services are developed and to identify where improvements need to be made.

National In-patient Survey

The Trust performed well in the 2011 In-patient Survey which gathered patient's views on their care and was based on a random sample of 816 patients who were admitted to our hospital and stayed overnight between May and July 2011. The Trust scored well; over 95% of patients rated their care as either excellent, very good or good. Just under 3% said their care was fair and only 2% reported that they had received poor care.

The key area identified in the In-patient Survey was the need to improve the quality of information included in letters sent from the hospital to family doctors so that patients can better understand them.

National Outpatient Survey

The National Outpatient Survey was carried out to understand what patients think about aspects of their outpatient care and treatment. The survey was based on a random sample of outpatients who attended an appointment at Sheffield Teaching Hospitals NHS Trust during May 2011. 839 patients were sent a questionnaire in this survey and the Trust obtained a 53% response rate which is the same as the national average. In summary Sheffield Teaching Hospitals was considered to be better than other Trusts in the arrangements made for patients prior to their appointment and the comparable to other Trusts in all other sections.

Individual questions where Sheffield Teaching Hospitals received particularly good scores from patients were on the experience of seeing the doctor or other healthcare professional in clinic, and the overall impression of their experience.

91% of patients felt they were treated with respect and dignity at Sheffield Teaching Hospitals and 82% felt that the main reason they went to the outpatient department was dealt with to their satisfaction. 97% or respondents felt their care was excellent, very good or good.

The areas where Sheffield Teaching Hospitals scores indicated further room for improvement included information given to patients about waiting times in clinic, information about tests and treatment, availability of suitable food and drink and also car parking.

Improving the experience and learning from Feedback, Complaints and Compliments.

Complaints and compliments continue to provide a valuable source of feedback about our services. The Trust's system of risk assessing and scoring all new concerns ensures that serious issues receive attention quickly.

Between April 2011 and March 2012 the Trust received 1354 complaints, 81% of which were responded to in 25 working days.

During 2011/12 the Patient Services Team who are responsible for overseeing the complaints service has focused on improving the process of responding to complainants. It has improved the information available to staff to follow up and demonstrate that actions have been taken as a result of the things we have learned from complaints.

The experience of making a complaint has been reviewed through a complainant survey. The majority of respondents indicated that they felt it was easy to make a complaint, knew what would happen, felt that their response was open and honest and knew what to do if they remained unhappy.

The Trust places a high value on complaints as a resource to support service improvement. During 2011/12 the Patient Services Team has introduced a system for recording, reporting and following up every action that has been agreed as a result of complaint investigations.

Examples of some of the actions taken by different wards and departments as a result of complaints are listed below;

Radiology have made improvements to the process of booking appointments including;

- A new telephone line has been installed to make it easier for patients to contact the call centre if they need to do so.
- Patients are now advised how they can contact the department via email if they wish to do so rather than by telephone.

Operating services have changed the process of ordering supplies in Ophthalmic theatres so that theatre staff can order directly from suppliers therefore reducing the time taken to process orders and receive stock.

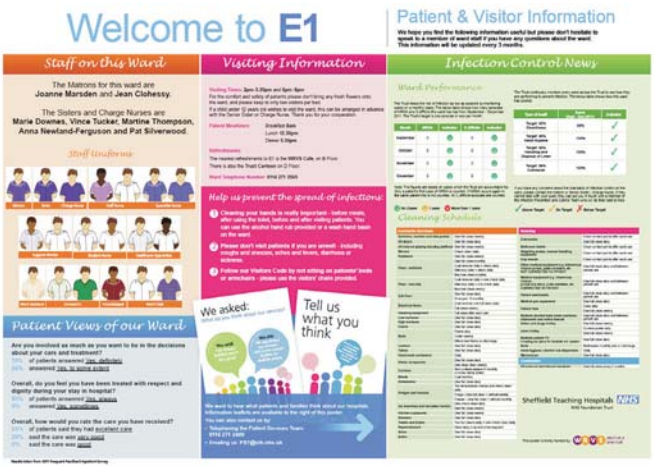
An extra consultation room has been opened in the spinal surgery outpatients clinic so that the Registrar can work alongside the consultant and the team can increase the number of patients seen.

Patient Turn Charts have been introduced in General Surgery so that a record is kept of when a patient is repositioned and made comfortable by nursing staff.

Work is being undertaken within the Emergency Medicine Directorate to look at reducing patient falls. The Falls Work Stream has introduced specific documentation for reporting falls, to determine cause and look at how the risk of falling can be minimised. Staff are asked to ensure that the patients' beds are at the lowest level, chairs are correct height, well fitting foot wear is worn, toileting needs are addressed and frames, buzzers and drinks etc are all within reach.

In addition to analysis of information from complaints, we routinely review other types of unsolicited feedback including patients' comments on our 'Tell Us what you think' reply slips and on websites. 564 feedback comments were received between April 2011 and March 2012. 70% of feedback we received was complimentary.

The patient feedback section on the Trust's website has been developed to make it even easer for patients and families to tell us what they think about any element of our services. Developments to the website include the introduction of a complaints form which can be completed online and a feedback form for patients to use.



Ward Posters

A new patient and visitor information poster has been displayed on each ward from July 2011 to provide key information to patients 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 details on how to make a comment or complaint so that people know how to tell us about their experience.

Enhancing the Healing Environment

The Trust collaborated in a very successful project to redesign and refurbish a major outpatient area at the Royal Hallamshire Hospital with the specific aim of improving the environment for people with dementia. Ideas were developed with design experts, patients and other key stakeholders through a series of workshops, interviews and questionnaires. Several styles of furniture

and seating were trialled to ensure it was both comfortable and fit for purpose. The main outpatient department on A Floor of the Royal Hallamshire Hospital was re-opened in December 2011. Key features include: a new purpose built reception desk so that there are reception staff available to welcome visitors and provide guidance if necessary and clear and concise signage that have been enhanced with symbols. A feature piece of glass artwork has been installed and frosted vinyl film has been placed on the windows to add interest whilst proving some privacy for people sitting in the waiting area. A vibrant art scheme ties the design together using natural imagery of leaves and flowers. The experience and knowledge developed in this project is now being used to inform and support patient focussed improvements to the environment in other parts of the Trust.

Arts in Health

The Sheffield Hospital Charity continues to support the Trust's Arts in Health Scheme to bring a range of projects across the Trust that have a very positive impact on overall patient experience. This includes a weekly calendar of music performances and workshops which have expanded to numerous wards including Spinal Injuries, Neuro-rehabilitation, Hadfield 5&6, Huntsman 6&7 and soon to start on Vickers 4. The music schedule also includes a monthly performance by charity music group The Lost Chord on Brearley 7, which is the Trust's specialised Dementia Ward. The Lost Chord specialise in interactive musical stimuli for people living with Dementia; the sessions have stimulated some remarkable responses from patients and continue to receive wonderful feedback from staff, patients and relatives.

Weekly art and reading groups continue on Osborn 4, and environmental improvements from vibrant art schemes to full refurbishments have been brought to numerous areas including the Hand Unit, Jessops and the Outpatients Entrance.

Unsung heroes

We are very fortunate to be supported by some exceptional charities and an army of unsung volunteers who work tirelessly to enhance our patients' experience of being in hospital.

Making life better for patients

Sheffield Hospitals Charity

During the last financial year Sheffield Hospitals Charity invested nearly £1.67 million in equipment, pioneering research, patient support, buildings and staff development. The charity's work benefits thousands of local patients. A recent example is the Specialist Nurse post that was funded to help save lives by detecting inherited cardiac conditions early. The charity also funded an advisory service to support cancer patients to manage their finances and to ensure they received the benefits they are entitled to. During 2012 and beyond, the charity will continue this vital work and strive to do more to improve care and treatment for everyone. More details are available at sheffieldhospitalscharity.org.uk.

Neurocare raises money to buy life saving equipment for use in the Neurosurgery theatres of Sheffield's Royal Hallamshire Hospital. The charity also funds research projects and specialist training so that people suffering from Neurological conditions can receive the best care available.

Weston Park Hospital is one of only four dedicated cancer hospitals in England and its reputation as a centre of excellence in the fight against cancer is recognised not only here in the UK, but also internationally. Weston Park Hospital Cancer Charity supports the incredible work of Weston Park Hospital. The vital funds that are raised by the Cancer Charity help to make it more than 'just a hospital', by focusing on three areas - cancer research, cancer treatment and cancer care. Each year the charity raises in the region of £1.3million to help keep Weston Park Hospital at the forefront of cancer treatment.

Our Vital Volunteers

From April 2012 the community services volunteer service will merge with the hospital volunteer service. The new single service means potential volunteers have better access to a wider range of volunteer opportunities and better support for volunteers based in community settings. Currently we have 750 active volunteers in a range of roles focusing on improving services for patients. These include providing directions and information in the hospitals main entrances, capturing patient feedback as part of the Trust's survey programme and providing assistance for patients at meal times. The meal time volunteer role has been rolled out to a further 7 wards over the past 12 months, and will continue to expand in the future.

Patient Information '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 a significant number which we have developed ourselves. Managing these resources is an ongoing task for staff in order to ensure they remain up to date and continue to meet patients' needs.

A particular focus during the last year has been the review of all patient information resources over 3 years old. This has resulted in over 1000 leaflets being reviewed or newly created over the year. In summary:

- 295 new leaflets have been developed
- 485 items have been reviewed and updated
- 304 items have been reviewed and identified as obsolete

Monthly reports are now produced to ensure all leaflets remain up to date. Routine archiving processes have been established to remove from circulation information over 3 years old. Supporting patients' access to personalised information was also a feature of 2011. The Trust was selected as one of 15 Beacon Sites to begin the roll out of Information Prescriptions (IPs) to cancer patients (www.nhs.uk/ips). For six months an IP Facilitator from the National Cancer Action Team provided training and support in the use of IPs to a range of staff to help them personalise their information giving. So far patients with skin cancer and bowel cancer have received individualised IPs from the new system and other departments are due to follow suit in due course.

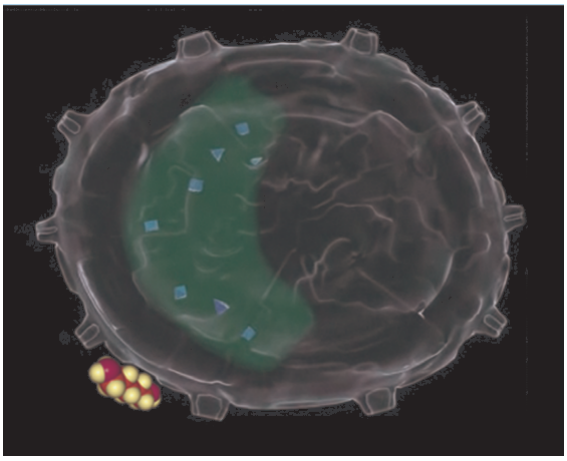
Research and Innovation

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.

A year in view - Research and innovation

April 2011

Sheffield plays key role in HIV vaccine breakthrough



Researchers at the Royal Hallamshire Hospital took part in a world-leading trial that has moved a step closer towards finding a vaccine against HIV.

The study showed that a trial vaccine has a significant impact on viral count in people with HIV, meaning it could be used to treat HIV-positive patients and also possibly to prevent people becoming infected at all. Involving 55 HIV-positive volunteers at six centres across the country, the trial is the first ever to produce such a result in humans.

Dr Christine Bowman, Clinical Director for Communicable Diseases at the Trust, explains: "This new vaccine targets only the parts of the virus that remain constant across all strains, meaning it could be effective in treating HIV-positive patients. In addition, if a future trial is successful, it is possible that the vaccine could be used to help prevent people from becoming infected in the first place."

Final human trials are due to take place in 2012/13. If successful, the vaccine could be available to patients in 3-5 years' time.

May 2011

Researchers find breakthrough in reducing recurrent miscarriages

Researchers found the first firm evidence that removing a common type of tumour in the womb can help to prevent recurrent miscarriages. The study, carried out by researchers at the Trust and the University of Sheffield, found that removing fibroids (non-cancerous tumours) that distort the womb lining can dramatically reduce the chances of miscarriage.

Led by Professor Tin-Chiu Li and his team, the study is the product of 20 years of research into recurrent miscarriage. Published online in Europe's leading reproductive journal, Human Reproduction, it showed for the first time ever that fibroids can contribute towards recurrent miscarriage as opposed to spontaneous miscarriage.

Professor Li carried out surgery to remove the fibroids from 25 women in whom the fibroids were causing a distortion of the womb. Among these women, miscarriage rates during the second trimester (phase) of pregnancy fell from 21.7% to zero. This translated to an increase in the live birth rate from 23.3% to 52%.

June 2011

New cancer research centre launched

A new pioneering cancer research centre was launched in Sheffield - a partnership between the Trust, the University of Sheffield, Cancer Research UK, Yorkshire Cancer Research and Weston Park Cancer Charity.

The Sheffield Cancer Research Centre becomes the latest link in a unique chain of Cancer Research UK Centres that have been launched across the UK. These Cancer Centres draw together world class research and medical expertise to provide the best possible results for cancer patients nationwide.

This latest Centre will be have its clinical base at Weston Park Hospital - one of only four dedicated cancer hospitals in the country, and link with laboratory facilities both within the Medical School and across the University of Sheffield. It will help set the pace for national and international progress in many different types of cancer, with particular interest in breast and lung cancers and a strong focus on the spread of cancers to the bones.

Head of the new Centre, Professor Rob Coleman explains: *"The new Centre will help build on Sheffield's world class research and bring together a variety of researchers and clinicians to work together to improve the lives of cancer patients across South Yorkshire and beyond."*

July 2011

£2m grant to help diabetes sufferers

A clinical trial being led in Sheffield attracted £2m in funding to assess a new approach to care for diabetes patients.

The trial, called REPOSE, is analysing how effective insulin pumps, in combination with an education course called DAFNE, are in treating patients with type-1 diabetes when compared with the more standard treatment of injections with education.

The trial is being carried out by the Trust and the University of Sheffield in partnership with six other hospital centres around the country.

Professor Simon Heller, Consultant Diabetologist explains: *"Insulin pumps are used widely elsewhere but relatively rarely in the UK, despite some promising signs that they are effective in some people. This study will allow us to assess quite how effective they are for patients who have been taught to self-care."*

August 2011

New ways of supporting young people with diabetes

The South Yorkshire Collaboration for Leadership in Applied Health Research and Care (CLAHRC), hosted by Sheffield Teaching Hospitals, is working with young people with type 1 diabetes and staff from Rotherham Hospital NHS Foundation Trust to design new and improved health services.

CLAHRC has been working with two parent and young people's support groups from Rotherham and Barnsley to understand the experiences above and devise innovative new services to support young people living with type 1 diabetes.

The project recognises that current clinic-focussed services, such as the one in Rotherham, gives primacy to NHS practices and health targets and there is an opportunity for new ways of delivering support that also value the needs and lifestyles of young people and their parents. The team will be testing out new additions to the diabetes service in 2012.

September 2011

Major trial gives hope to motor neurone disease sufferers

Patients suffering from a devastating disease are being given fresh hope through an innovative trial being led in Sheffield. The trial, led by the Trust in partnership with the Sheffield Institute for Translational Neuroscience (SITraN) within the University of Sheffield, is using a new device to see if it can help patients with motor neurone disease (MND) - a disease that leads to muscle weakness and ultimately death - to live for longer and with a better quality of life.

Patients with MND are having the device - called a diaphragm pacing (DP) system - implanted to help increase the strength of their main breathing muscle. Small electrodes are implanted into the diaphragm, while a small external stimulator delivers electric pulses, strengthening the muscle. Patients carry a small 'box-like' device that enables them to switch the pulses on and off.

The study, called DiPALS will compare use of the device with the standard treatment for MND, which involves providing the patient with ventilation through a mask.

Dr Christopher McDermott, Consultant Neurologist, who is leading the study, explains: *"The technique has shown promise in our pilot series, and so we are pleased to have the opportunity to fully assess the devices and establish if they can provide benefits to patients."*

October 2011

Deputy Prime Minister praises new Centre of Excellence in Rheumatology

The Deputy Prime Minister, The Right Honourable Nick Clegg MP, officially unveiled the new Centre of Excellence in Rheumatology in February. The prestigious title was awarded by leading health organisation the European League Against Rheumatism (EULAR), based on the Trust's outstanding record in rheumatology clinical research.

The Centre, which is a partnership between Sheffield Teaching Hospitals and the University of Sheffield, is one of only five in the country and joins a prestigious list of research centres across Europe.

Mr Clegg said: *"Everyone in Sheffield should be immensely proud of the great work being done here at this centre. Sheffield is at the cutting edge of rheumatology research and we have some of the finest minds in the field working right here. This award is not just recognition of the great work done here but it will help the clinicians and researchers go on to do more and more vital life changing work in future."*

Professor Gerry Wilson, Head of the Sheffield EULAR Centre of Excellence said: *"The EULAR Centre of Excellence award recognises the international leading research in Sheffield into the causes and treatment of common diseases of the joints such as rheumatoid arthritis and osteoporosis."*

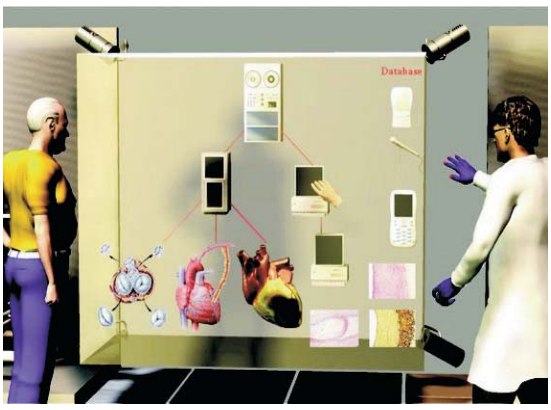
November 2011

Testing treatments in a virtual world

The Trust and the University of Sheffield have formed a partnership which has resulted in a newly formed Institute called INSIGNEO. Work being carried out by the Institute could change the face of healthcare in the future.

Researchers are developing models of different parts of the human body, which will ultimately build into a complete digital replica of a patient. Medical information, from details as simple as age and weight to more complex data taken from scans and x-rays, will be fed into the models to provide an overall picture of an individual patient's condition, against which different treatments can then be tested.

Dr Frangi of the INSIGNEO Institute said: *"By developing models of complete organ systems, such as the cardiovascular system, we can help clinicians predict whether a visible narrowing in a coronary artery, for example, is significant enough to cause constriction of blood supply, and whether the patient would benefit from having a stent."*



December 2011

Over £3m to support groundbreaking clinical research in Sheffield

The Government announced it is to invest over £3.1 million in a state of the art NHS Clinical Research Facility at the Trust to research and develop new treatments to benefit patients across Yorkshire and Humber and beyond.

The Trust, in partnership with the University of Sheffield, will use the funding from the National Institute for Health Research (NIHR) to support experimental medicine studies, investigating diseases and potential new drugs and treatments at two sites at the Royal Hallamshire and Northern General Hospitals. The research to be carried out includes exploring new treatments in areas such as motor neurone disease and Parkinson's disease, looking at new ways to prevent stroke, and researching new vaccines for meningitis.

The funding will be spread out over five years from September 2012 to March 2017.

Dr Chris Newman, Director of the Sheffield Clinical Research Facility said: *"This represents a significant step forward in clinical research in Sheffield, and will lead to many improvements in treatment and care for patients."*

January 2012

New devices could hold key to predicting premature births

Scientists and doctors in Sheffield are developing two novel devices that they say could lead to the improved prediction of premature births.

Two major trials, together worth nearly a million pounds in funding, are underway at Sheffield Teaching Hospitals and the University of Sheffield to evaluate the accuracy of the devices.

The innovative devices will be able to assess a woman's cervix to establish the risk of her having a premature birth, by using electrical impulses to take measurements of the resistance of tissue in the cervix.

In a trial funded by the Medical Research Council (MRC), 500 women will take part over the next two years. 300 of the women will be those deemed at high risk of having a premature birth because they have had such a birth at least once before. The remaining 200 will be women without a history of premature birth. A special device will be used to predict the outcome of the birth, before results are analysed to see if the predictions have been accurate.

Another device is being developed in a separate pioneering study. If the devices are shown to be accurate, they will enable clinicians to improve the care of women at risk. Doctors could, for example, use a hormone treatment called progesterone therapy in a more focussed way, which could help to prolong the pregnancy. Additionally, women could be transferred to a unit better equipped to provide high dependency neonatal care.

February 2012

Record recruits as "lab on a chip" study sends Sheffield to top of UK

A clinical trial developing cutting edge technology to diagnose oral cancer more quickly and effectively helped to send Sheffield to the top of a national research league table.

The "lab on a chip" trial, led in Sheffield by Professor Martin Thornhill, is working with researchers from Rice University in the USA to develop a device that could be used by a dentist to determine if a patient has oral cancer or other abnormalities in less than 20 minutes. It has recruited 275 patients in the past 18 months, helping Sheffield to recruit more patients into oral and dental research than any other research centre in the country this year.

The league table has been put together by the National Institute for Health Research (NIHR). The Trust and the University of Sheffield rank top out of over 400 research centres in the country for numbers of study recruits.

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 that can be time-consuming. The new test will involve removing cells with a brush, placing them on a chip, and inserting the chip into an analyser, leading to a result in a matter of minutes. This will have a number of benefits including cutting waiting times and the number of patient visits.

Patients are being tested on the new device, which is being compared to the standard biopsy procedure to test its accuracy and reliability. If the trial shows that the new technology is as effective as carrying out a biopsy then it could become standard procedure at dentist surgeries in the future.

Martin Thornhill, Professor of Oral Medicine at the University of Sheffield and Honorary Consultant in Oral Medicine at the Trust, said: *"This new technology is an exciting development in the search for quicker and more effective diagnosis of oral cancer. The current procedure we have for making a diagnosis – taking a biopsy – can take a week or more to produce results and can involve extra visits from patients. With our new technology, a brush can be used painlessly to remove a few cells and a result could be produced in minutes."*

March 2012

Patient praises unique clinic that builds on landmark research

A patient with a family history of a little known disease caused by sensitivity to gluten spoke out in praise of a unique clinic made possible by research by a Sheffield investigator.

Isobel Dickinson, 62, of Wadsley, suffers from gluten ataxia – a neurological condition that can affect balance, co-ordination and speech. Until her diagnosis six years ago, little did she know that her difficulty balancing was being caused by sensitivity to gluten.

Isobel is the sixth person in her family to suffer from ataxia (a term referring to the symptom of loss of balance and loss of co-ordination), but is the first to have sensitivity to gluten diagnosed as the cause, thanks to a clinic at the Royal Hallamshire Hospital that is the only one of its kind in the World.

Isobel visited Dr Marios Hadjivassiliou, Consultant Neurologist, who first described gluten ataxia in the 1990s. After seeing a number of patients with unexplained balance and coordination problems, he began systematically testing them for gluten sensitivity, and found a heightened immune response to gluten but not necessarily a diagnosis of coeliac disease.

Following this research, Dr Hadjivassiliou coined the condition gluten ataxia and has since established the Sheffield Ataxia Clinic – the only clinic in the World specialising specifically in the neurological manifestations of gluten related diseases.

Dr Hadjivassiliou and his team diagnosed Isobel with gluten ataxia after eliminating other possible causes including genetic ataxias.

Retired IT specialist Isobel, a mother-of-two, said: *"My great grandmother, grandmother, mother, great uncle and uncle all suffered from ataxia – all with very bad problems that severely limited their mobility. In later life, my mother had to use a wheelchair. She knew she had ataxia, but the cause of it was never identified.*

"When I was diagnosed at the clinic, I was advised that I would have to go on a strict gluten-free diet. This has meant cutting out a wide range of foods but I am doing really well on the diet.

"I'm so grateful to the team that has cared for me – especially Dr Hadjivassiliou and ataxia nurse Diane Friend. They have been fantastic and look after me so well."

Devices for Dignity Healthcare Technology Cooperative

The Devices for Dignity (D4D) Healthcare Technology Co-operative is an STH hosted national resource - delivering technology solutions to support people with long term conditions, preserving their dignity and independence.

D4D focuses on the three key areas of assistive technologies, urinary continence management and renal technologies with a drive to make a difference to the lives of large numbers of people whilst also delivering real cost improvements to the delivery of health and social care provision.

D4D does this by delivering innovation from the initial identification of unmet clinical needs through to new products, processes and services - working with a wide range of healthcare professionals to identify where a new technology solution could greatly increase a patient's quality of life, dignity and independence.

Following identification of high priority unmet clinical needs, D4D translates these into high quality R&D projects to deliver commercially attractive technology based solutions to the NHS.

D4D has an established track record in identifying and securing funding from a range of sources – and has to date received over £6 million to support these activities. Over the past four years, D4D has reviewed over 250 unmet clinical needs, initiated 42 R&D projects and currently has 24 active projects across its three core themes.

Current activities include an NIHR funded project to develop a new neck collar that will be aesthetically pleasing and comfortable, as well as functional, for people with Motor Neurone Disease (MND).

The project was initially proposed by the Dementias and Neurodegenerative Diseases Research Network (DeNDRoN) Clinical Studies Group for MND, with support from carers and patients, who approached D4D with the view that current cervical orthoses are inadequate in terms of function, comfort and cosmesis

Many people with MND develop weak neck muscles, leading to pain and restricted movement, as well as problems with swallowing, breathing and communication. Ideally a neck collar would help to alleviate these problems. However neck collars currently available are of limited use for people with MND, and are often rejected by them.

With over 15 million people living with long term conditions in the UK today, D4D's assistive technology theme aims to develop systems, devices and services to assist people to live with more independence.

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 South Yorkshire 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 South Yorkshire, 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

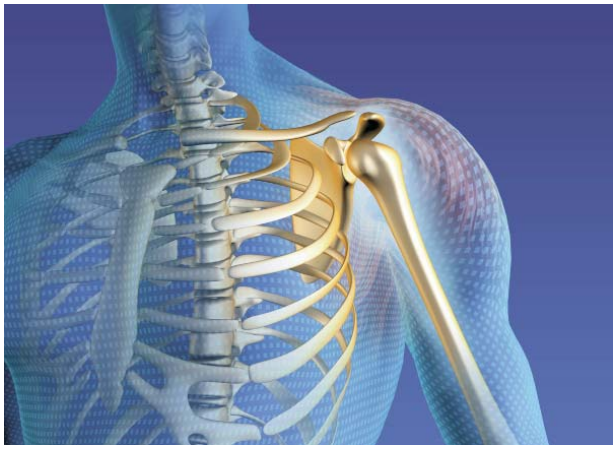
Healthcare Design (UCHD) project that aims to increase engagement of currently disengaged young people with diabetes through co-design of tools, particularly around access to information. CLAHRC's Stroke theme, Depression theme, and Health Inequalities (HI) theme are also undertaking work to improve access for marginalised people to services that link to Coronary Heart Disease care pathways, services for older people and the homeless.

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.

NIHR Bone Biomedical Research Unit

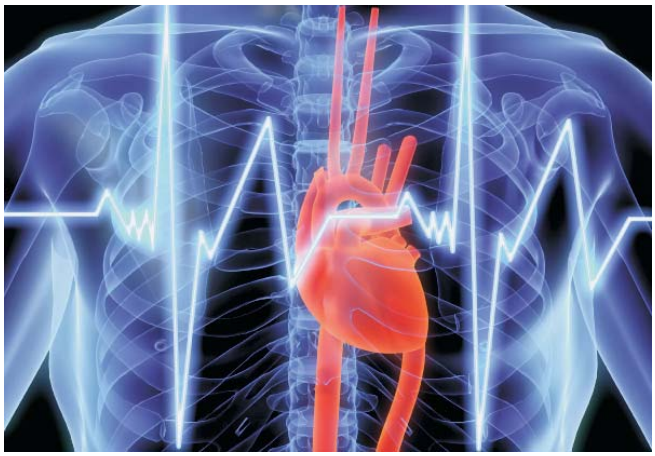
Established in 2008 with funding for 3 years, the Sheffield Bone Biomedical Research Unit (BRU) was set up to carry out research into new treatments for musculoskeletal conditions and diseases. The team aims to translate advances in medical research into clinical practice for patient benefit and work in areas such as osteoporosis and joint arthroplasty. This research unit is a 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 Biomedical Research Unit will not receive further funding past 2012 but the research undertaken will continue to be used to inform clinical advancements.



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. During 2011, the CVBRU was involved in a range of research projects exploring different aspects of cardiovascular disease and pulmonary hypertension.

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.

The Biomedical Research Unit will not receive further NIHR funding past 2012 but the research undertaken will continue to be used to inform clinical advancements.

Training the healthcare professionals of the future

The Trust continues to deliver a high quality training and teaching environment as measured by student and junior doctor feedback as well as robust GMC and Deanery formal assessment.

The emergence of new statutory bodies for England and Wales, which includes Health Education England, will drive a fundamental change in the processes associated with Quality Assurance of training in the UK through the establishment of Local Education Training Boards. The Trust is ready to respond to the associated changes through continued improvements in facilities and standards of teaching and training. This will be achieved by:

- Optimising training opportunities by enhancing further the Trust's completed clinical skills facilities which will provide high quality procedural skills training across a broad range of professions
- Collaboration with the Yorkshire and Humber Deanery in promoting the use of an "Induction Passport" which will allow seamless transfer of health care professionals from post to post within the region.
- Developing new ways of working that enhance training and teaching opportunity in the out of hours periods. This will include developing where possible a coordinated approach to care as seen in the Hospital at Night concept.
- Working closely with Sheffield Universities and the reconfigured Deanery to ensure curriculum development and its delivery is fit for purpose.
- Providing final year student doctors with high quality assistantships and shadowing placements to enhance their experiences prior to the start of the clinical careers.

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.

Staff Engagement

The Trust recognises the importance of staff engagement to both productivity and good patient care. During 2011 a Staff Engagement Steering Group chaired by the Chief Executive was established to oversee the implementation of the staff engagement strategy. This included monitoring progress on the three workstreams which are integral to effective staff engagement:

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

In addition 'Lets talk' events started on a Trust wide basis during 2009, have been held in some directorates and work is ongoing to address the issues raised via these and the staff survey.

Staff Journey

A group was actively involved in the development of the simplified appraisal system introduced in the Trust in June 2011, which has resulted in more staff having an annual appraisal. The group has also sought views on what make staff feel valued as this is a key component of staff engagement.

A values and behaviourally based appraisal system is being introduced in the Trust in 2012, initially for senior leaders. All staff were asked for their feedback on the potential values to be adopted via an electronic survey. Almost 3,000 staff responded.

Staff involvement

A consultation exercise was undertaken with over 600 consultants in the Trust to identify how the Trust could improve communication and engagement with Consultants particularly with a view to increased participation in corporate issues and service transformation. A number of suggestions has been acted upon including regular meetings between Consultants, the Chief Executive and Medical Director. The Chief Executive has also held "Chat with the Chief Executive" roadshows across the Trust during 2011. All staff were invited to attend to provide feedback on the new draft corporate strategy - "Making a difference'. An internal communications survey was carried out in the Spring to seek staff views on how to improve communications in the Trust. Just over 3,100 staff responded and the insight gained has informed the new Trust communications and engagement strategy.

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.

Health and Wellbeing

The inaugural Health and Wellbeing festival was held during the summer of 2011 which gave staff the opportunity to access a variety of information and advice to help improve their health and wellbeing. This was much appreciated by staff and was followed by a 'Shortest Day' festival in December.

Feedback has been sought from staff to identify what health and wellbeing support they would like to see provided. As a result of this more exercise classes are now available on site and weight management classes will be commencing shortly. Plans are in place for a 'Longest day' festival in June.

A joint Sheffield Hallam University/Sheffield Teaching Hospitals research study for providing staff health checks is currently being piloted which was nominated for an award in the annual 2012 BMJ awards.

A fast track musculoskeletal service for staff is being piloted in the Jessop Wing during 2012 with a view to rolling this out to all staff within the Trust during 2013/14.

This work is being complemented, in collaboration with colleagues from the Health & Social Care Trust, by a review of interventions for staff who have been diagnosed with a range of mental health related conditions such as stress, anxiety and depression. The intention will eventually be to provide a similar fast track service to these staff also.

Whilst these two initiatives are still in their early stages, it is believed that combined, the two fast track pathways would have a considerable impact on staff health & wellbeing, reducing sickness absence, improving productivity and thereby improving the overall patient experience.

The Trust is considering a staff lottery where the profits will be ploughed back into staff Health & Wellbeing initiatives.

It is also planned to develop, with Leeds Metropolitan University, a Staff Health & Wellbeing website providing support, advice and guidance on a range of issues and signposting staff to a range of internal and externally provided resources. In addition, the Trust now has a mediation service and it has funded 25 staff to complete a mediation training package, aimed at supporting the Health & Wellbeing of staff by achieving mediated resolution of differences/grievances among staff thereby reducing the need for following formal procedures. Research has shown that 80% of all cases that enter mediation are settled. The scheme came on line on 2nd April 2012

2011 Staff Survey Results

The Trust's progress on staff engagement is measured every year via the annual NHS staff survey. The 2011/12 results show a general improvement which is reflected in the Trust's overall staff engagement score.

Some key results for the 2011/12 staff survey are shown below.

	STH 2010	NHS 2010	STH 2011	NHS 2011
Response rates	49%	52%	50%	53%

Top four ranking scores

Key Finding	2010 STH	2010 NHS	2011 STH	2011 NHS	Improvement/ deterioration
Staff experiencing physical violence from staff in last 12 months (%)	1	1	0	1	Improvement
Staff working unpaid extra hours (%)	57	59	55	65	Improvement
Staff experiencing harassment/bullying/abuse from staff (%)	14	15	12	16	Improvement
Staff intending to leave jobs	2.38	2.53	2.45	2.59	Deterioration

Bottom four ranking scores

Key Finding	2010 STH	2010 NHS	2011 STH	2011 NHS	Improvement/ deterioration
Able to contribute to improvements at work (%)	50	62	52	61	improvement
Appraised in last 12 months (%)	53	78	67	81	improvement
Staff having well structured appraisals in last 12 months (%)	22	33	26	34	improvement
Staff appraised with a personal development plan (%)	42	66	55	68	improvement

Most Improved

Key Finding	2010 STH	2011 STH
Effective team working	3.49	3.63
Staff appraised in last 12 months (%)	53	67
Staff appraised with personal development plan (%)	42	55
Having equality training in last 12 months (%)	25	34

It is clear that the uncertainty due to the forthcoming changes in the NHS are continuing to impact on how staff feel. However it is pleasing to note that 79% of staff are satisfied with the quality of work and patient care they are able to deliver which compares well with the average for acute trusts (74%).

Leadership and Management Development.

Leadership Development is one of the three enabling strategies which underpin the vision and supports delivery of our aims in the 2008-2012 corporate strategy called "Excellence as Standard."

Over the next 4 years Sheffield Teaching Hospitals arguably faces its biggest challenges to date; it has to remain economically viable in the face of major public spending reductions and respond to significant change across the NHS. 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 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 aim has been 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 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 also have the option to attend a University accredited Work Based Learning Leadership Development Programme run in partnership with Hallam University.

The programme was launched in Spring 2011 and 4 groups of staff have started.

There has been an average of 23 people per group, who undertake the Insights personality assessment, the Leadership Framework 360 feedback process and attend a work based learning module at Sheffield Hallam University.

Our first Institute of Leadership and Management (ILM) level 3 programme commenced in September 2011. Cohort 2 commenced in April 2012, with cohort 3 due to start in August . These programmes have proved popular and have been oversubscribed.

The Effective Management series started in January 2012 covering a management topic every month; these are usually attended by 30 - 40 people. This is a non - accredited rolling programme, featuring topic experts from around the Trust.

This is all supplemented by the guest lecture series which takes place several times a year and a range of e- learning packages.

A Medical Leadership programme for doctors was also developed and proved highly successful.

Staff can access information about all the opportunities available to them via the Leadership and Management Development intranet site, which was launched in autumn 2011.

Future initiatives during 2012 include developing coaching and mentoring capacity within the Trust.

A Good Corporate Citizen

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."

Caring for the environment

The Trust continues to make good progress in increasing its rating as a Good Corporate Citizen. The following provides of summary of the key achievements in 2011/12.

Sustainable Development Action Plan

The Board of Directors approved a Sustainable Development Action Plan for the Trust in October 2011. The Action Plan will assist the Trust in becoming a Good Corporate Citizen and by doing so it will be using resources to make a significant contribution to the health and sustainability of the communities it serves.

The Action Plan is a 'living document' which will be subject to review and adaptation in response to new challenges.

Approval of the Action Plan is a key milestone achievement and sets out objectives for Trust Directors.

There are 42 objectives which fall into the following 13 categories:

- Learning from best practice
- Creating a culture of sustainable development
- Ensuring sustainability is embedded into systems and processes
- Meeting the NHS CO2 reduction targets in energy and water
- Discovering the CO2 footprint of our procured items
- Ensuring efficient use of resources in our practices
- Encouraging suppliers and business partners to innovate
- Meeting the NHS CO2 reduction targets in waste
- Aiming to contribute to reductions in congestion and air pollution
- Meeting the NHS CO2 reduction targets in travel
- Helping employees, patients and the community to live a sustainable life
- Aiming for an increase in employees' awareness and motivation
- Maintaining and, where relevant, protecting natural vegetation on the campuses

Several objectives are aimed at gathering more information and creating individual business cases for approval/funding/implementation. This will ensure that all prospective projects are properly evaluated and progressed. Each individual business case will include the likely carbon savings, cost savings and other qualitative benefits where relevant. Progress will be monitored by the Trust's Sustainable Development Manager.

BeGreen Awards

For the second year a "BeGreen Award" was presented at the Trust's "Thank You" awards ceremony held in November 2011. The winner of this year's award went to Peter Tanker for establishing a recycling project.

The winner planted a fruit tree on the central campus as a lasting token of their work. GrowSheffield provided the tree under the Abundance project which promotes the growing and harvesting of fruit.

BeGreen Representatives.

Training of 'BeGreen Representatives' (BGRs) continues. There are currently 189 Trained BGRs and further 274 have expressed a potential interest in training. 129 BGRs have been accompanied by the Sustainable Development Manager to identify potential improvements in their work area. This work will continue.

Carbon Modelling Project

The Carbon Modelling Project with Sheffield University's School of Health and Related Research (ScHARR) is moving forward. Key metrics have been collated and potential projects to investigate have been identified. The aim of this project is to investigate ways to reduce NHS carbon emissions by modelling the relationship between financial, carbon, healthcare and operational considerations linked to the patient-pathway.

Cystic Fibrosis Unit at the NGH

The Cystic Fibrosis unit has been provided with a hybrid vehicle used to provide outpatient services in the community. The plan is to replace this vehicle with an electric vehicle within the next 1- 2 years when electric cars have become commercially viable. In preparation for this and also to capture the feed in tariff incentive, solar panels have been installed on the roof of the Cystic Fibrosis building. The objective is to demonstrate how low carbon patient pathways can be achieved. The solar panels will provide renewable fuel for the electric car. These will reduce costs and emissions.

NGH New Laboratory Building

A new state of the art Laboratory Centre is planned to be operational in June 2012. The building will have solar panels, a green roof, bicycle parking and is expected to achieve BREEAM Excellence 'A' rating for best practice in sustainable building design, construction and operation. This rating has become the most comprehensive and widely recognised measure of a building's environmental performance. The measures used represent a broad range of categories and criteria from energy to ecology. They include aspects related to energy and water use, the internal environment (health and well-being), pollution, transport, materials, waste, ecology and management processes.

Partnership working

The Trust continues to be an active member of the following working groups:

- Low Carbon Working Group with Sheffield City Council
- Health and Wellbeing Group
- Sustainable Travel Group
- Climate Change Management Group Yorkshire and Humber NHS
- Sheffield Health Planet
- Sheffield University's School of Health and Related Research

Sustainable travel

Our Travel Plan outlines possible options to assist patients, visitors and staff to travel in more environmentally efficient ways when coming to Trust premises with key emphasis on the encouragement of public transport, car sharing, cycling and walking.

Key achievements 2011/12

- The Trust continues to work in partnership with South Yorkshire Passenger Transport Executive (SYPTE), the University of Sheffield, Sheffield Hallam University, Sheffield City Council and Sheffield Children's Hospital to achieve sustainable travel in the wider Sheffield area.

- Car sharing allows the flexibility of car travel, whilst reducing the associated problems of carbon emissions, congestion and the oversubscription of parking spaces. Recently the Trust has provided some designated parking spaces for those members of staff who prefer to share cars and not queues.

- The H1 Hospital Shuttle bus remains a very popular service and usage of it continues to increase. The number of staff using the bus continues to rise and there has also been an increase in use of the service by the general public, thus the H1 is an added benefit to the local community. The existing diesel powered bus is to be replaced with an electric bus funded by the League of Friends.

- All new members of staff are given information about sustainable transport options as part of the Central Induction Programme and are offered free Personalised Journey Planners (PJPs).

- The Trust's salary sacrifice scheme (i-Choose) continues to increase in numbers with well over 600 members of staff acquiring a bike to date.

- During Walk To Work Week 2011 the Trust teamed up, once again, with the Ramblers to promote 'Get Walking Keep Walking', generating another very successful uptake from Trust staff.

Energy

Comparing 2010/11 against 2011/12, electricity consumed by the Trust has been reduced by 6.14%. Gas consumption has been reduced by 22.58%. This equates to a reduction of 7,533 tCO2 or a 13% reduction in emissions.

Total Emissions attributable to the Trust's gas and electricity consumption for 2010/2011 were 56,665 tCO2.

Total Emissions attributable to the Trust's gas and electricity consumption for 2011/2012 were 49,132 tCO2.

Savings = 7,533 tCO2 or a 13% reduction.

Enough gas to fill 7,500 hot air balloons.
Or
The emissions equivalent to travelling 750 times around the world in an averaged sized car.
Or
The weight of 75 blue whales.

This has been achieved by:

- The partial decentralisation of the steam distribution system at the Northern General Hospital via the installation of gas fired installations serving peripheral buildings.
- The installation of a summertime heating system at the Royal Hallamshire Hospital designed to serve critical areas and processes which still require heat during summertime. This enables the larger distribution system to be switched off during the Summer reducing heat losses the energy required to cool the building during Summer.

Work will continue into 2012/13 and beyond to provide further reductions in energy and carbon emissions.

In summary, the Trust is on course to achieve its 2015 carbon reduction target.

Waste

Our Waste Management Strategy is to ensure statutory compliance within healthcare waste management legislation and fulfilling our duty of care in ensuring compliant segregation of healthcare wastes. Performance against the required NHS Carbon reduction strategy targets have again been high. Continual progress has been made towards the reduction of our Carbon footprint.

Household waste is the largest volume of waste produced from Sheffield Teaching Hospitals with 89% of this waste being sent for recycling and recovery. The remainder is segregated for landfill disposal.

Reductions in the volumes of hazardous waste produced at the trust have been achieved, annual reductions in hazardous healthcare wastes have occurred despite high levels of seasonal flu within the South Yorkshire area.

Significant progress has been achieved in the on site segregation of recyclable materials.

Waste type	2010 - 2011 Tonnes	2011 - 2012 Tonnes
Household (Recovery)	2043.307	2053.820
Household (Landfill)	360.584	360.090
Clinical (HTI)	122.168	141.556
Clinical (Non burn)	1477.785	1382.924
Recycling	135.967	738.335
Household waste spend	£278,260.00	£267,068.00
Clinical waste spend	£950,122.21	£790,681.00
Recycling waste spend	£11,478.00	£23,560.00
Hazardous waste spend	£14,447.75	£7,978.00
Total spend	£1,249,942.00	£1,096,104.00
Percentage of Household waste Recycled / Recovered	85.80 %	88.58 %
Percentage of household waste Landfilled	14.20 %	11.42 %

Everyone Counts

Sheffield Teaching Hospitals is committed to eliminating discrimination, promoting equal opportunity and to fostering good relations with the diverse community the Trust serves and within our staff teams, taking account of gender, race, colour, ethnicity, ethnic or national origin, citizenship, religions and beliefs, disability, age, domestic circumstances, social class, sexual orientation and marriage or civil partnership. Everyone who comes into contact with our organisation can expect to be treated with respect and dignity and to have proper account taken of their personal needs.

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 an identified 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 2011 /12 the Trust focussed on responding to changes in equality legislation. Staff information published in the Annual Equality and Human Rights report was updated in January 2012 and published on the Trust internet site alongside information about people who use the Trust's services. The Trust also started to focus equalities work around a new framework known as the NHS Equality Delivery System (EDS). The EDS has four goals for the NHS as a whole:

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

The EDS grading system was used to inform development of the Trusts Equality Objectives.

The Equality Act 2010 includes a new duty known as the Public Sector Equality Duty which applies to this Trust and to other public organisations. The duty is to have due regard in all the Trust does to:

- Eliminate Discrimination, Harassment and Victimisation
- Advance Equality of Opportunity between people protected by the Equality Act and others
- Foster Good Relations between people protected by the Equality Act and others

In 2011/12 the Trust undertook a number of actions to meet this duty including:

Eliminating Discrimination, Harassment and Victimisation

The Trust worked with organisations that specialise in Dementia to understand the needs of people in this group. Some of the Trusts quality improvement work focused on the care received by older people using Trust services.

Advancing Equality of Opportunity for Protected Groups

A pictorial communication guide was produced to support patient care for non English speakers. A web site was launched for staff which provides information about providing good quality services to people with Learning Disabilities. The Trust also worked in partnership with 'Photo Symbols Ltd' to produce a wider range of photosymbols for people with learning disabilities who might use hospital services.

Fostering Good Relations Between People in Protected Groups and Others

The Trust continued to work with other NHS organisations in its engagement events and activities looking at the new equality legislation and the NHS Equality Delivery System. Membership of Stonewall continued and a 'Mindful Employer' group was established. Four staff network groups were started; these are a Black and Minority Ethnic (BME) group, an overseas staff group, a Disability group and Lesbian Gay Bisexual and Transgender (LGBT) group. The Trust had a stall at Sheffield's 2011 LGBT Pride event. We promoted information about Stonewall's survey of men's health and other relevant information.

Full details of what the Trust did to meet this duty can be found in the Trusts Annual Equality and Human Rights Report which was published in July 2011. Information about people who work in the Trust, people who use the Trusts services and annual reports can now be found on the Trusts website at http://www.sth.nhs.uk/about-us/equality-and-diversity.

In 2011 we renewed our 'two ticks' standard and also maintained our action plan to support the Trust as a Mindful Employer.

Information about the Diversity of Trust staff and Trust Members

Diversity of Trust Staff

Age of Staff in Post	%
Under 20	1.11%
20 to 29	17.74%
30 to 39	24.58%
40 to 49	28.76%
50 to 54	13.42%
55 to 59	9.11%
60 to 64	4.22%
65+	1.06%

Gender of Staff in Post	%
Female	77.42%
Male	22.58%

Ethnicity	%
White British	81.98%
White Irish	0.68%
Any other White background	3.52%
White and Black Caribbean	0.36%
White and Black African	0.33%
White and Asian	0.37%
Any other mixed background	0.49%
Indian	2.53%
Pakistani	1.56%
Bangladeshi	0.13%
Any other Asian background	1.12%
Caribbean	0.87%
African	3.13%
Any other Black background	0.19%
Chinese	0.53%
Any other ethnic group	0.78%
Not stated	1.44%

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 Care Quality Commission (CQC) is responsible for ensuring 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. 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 processes have 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 2011/12. The Trust has received no improvement notices this year.

Clinical Audit

Approximately 580 clinical audit and service review projects were registered within the Trust Clinical Effectiveness Unit during 2011/12. 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 214 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 2012.

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), was introduced in 2011. 'The Dr Foster Good Hospital Guide 2011 rated the Trust's HSMR value as 'significantly low'. The Trust was also delighted to receive acknowledge of this achievement through the award of Dr Foster Hospital of the Year (North).

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.

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	6,787
Patient Constituency	3,842
Staff	15,278

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.

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 with the Governors.

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.

Nominations Committee

The Nominations Committee is a formal committee of the Governors' Council and is responsible for the appointment, appraisal and remuneration of the Chairman and Non-Executive Directors.

When the appointment, appraisal and remuneration of the Chairman is being considered the Chairman will withdraw from the meeting and the Vice Chairman of the Committee assumes the Chair. The Committee is supported and administered by the Trust Secretary. The Director of Human Resources and Chief Executive is invited to attend as required.

Attendances at Nominations Committee Meetings

Name	31 May 2011	15 Aug 2011	7 Oct 2011	24 Oct 2011	25 Jan 2012
David Stone (Chair until 31 Dec 2011)	✓	✓	Not present*	Not present	
Tony Pedder (Chair from 1 January 2012)					✓
George Clarke	✓	✓	✓	✓	Apol
John Holden (Vice Chair)	✓	✓	✓	✓	✓
John Laxton	✓	✓	✓	✓	✓
Andrew Manasse	✓	✓	✓	✓	✓
Viv Stevens	✓	✓	Apol	✓	✓
Jeremy Wight	✓	✓	✓	✓	Apol
Mark Hattersley	Apol	✓	✓	✓	Apol

*Chairman not present when main purpose of the meeting was to discuss the recruitment and selection of a new chair

The Appointments Panel of the Nominations Committee met on 27 May 2011 and 15 November 2011 to discuss the recruitment and selection of a new Chairman and a new Non Executive Director.

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 Governors appoint the Trust's non-executive directors, including the chair, and determine their remuneration. The Council also approves the appointment or removal of the Trust's auditors following a recommendation from the Trust's Audit Committee.

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 Group. 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 with their employing organisation. At 31st March 2012, membership of the full Governors' Council was as shown overleaf:

Membership of Governors' Council at 31st March 2012

Constituency	Governer	Expiration of term of office
Patient	Richard Barrass	30-06-14
	Roz Davies	30-06-14
	John Holden	30-06-12
	Caroline Irving	30-06-13
	Shirley Lindley	30-06-12
	Graham Thompson	30-06-14
	Michael Warner	30-06-12
Public North	Georgina Bishop	30-06-14
	George Clark	30-06-14
	Kaye Meegan	30-06 13
Public South West	John Laxton	30-06-14
	Andrew Manasse	30-06-12
	Susan Wilson	30-06-13
Public West	Anne Eckford	30-06-13
	John Warner	30-06-14
	Vacant	
Public South East	Yvonne Challans	30-06-12
	Hetta Phipps	30-06-13
	Danny Roberts	30-06-12
Staff		
Allied Health Professionals, Scientists & Technicians	Vivien Stevens	30-06-12
Ancillary, Works & Maintenance	Vacant	
Managerial, Administration & Clerical	Mark Hattersley	Retired March 2012
Medical & Dental	Frank Edenborough	30-06-12
Nursing & Midwifery	Vacant	
Partner Organisation	**Governor**	
NHS Sheffield	Jeremy Wight / Ilyes Tabani	From 01-02-12
Sheffield City Council	Mary Lea / Richard Webb	N/A
University of Sheffield	Vacant	N/A
Sheffield Hallam University	Vacant	N/A
Sheffield College	Heather MacDonald	N/A
South Yorkshire Police	Simon Torr	N/A
Sheffield Health & Social Care NHS FT	Michael Rooney	N/A
Sheffield First Partnership	Vacant	N/A
Voluntary Action Sheffield	Maggie Rowlands	N/A
NHS Yorkshire & the Humber	Vacant	N/A
Non-Sheffield PCT	Vacant	N/A

Governors' Council members and attendance at meetings

NAME	07-06-11	13-09-11	17-11-11	21-02-12
Public/Patient Governor				
R Barrass from July 2011		✓	✓	✓
G Bishop	✓	Apols	✓	✓
Y Challans	✓	✓	✓	✓
G Clark	✓	✓	✓	Apols
R Davies from July 2011		✓	✓	✓
A Eckford	✓	✓	✓	✓
F Edenborough	✓	✓	✓	✓
M Hattersley	Apols	✓	✓	✓
J Holden	✓	✓	✓	✓
C Irving	✓	✓	Apols	✓
J Laxton	✓	✓	✓	✓
S Lindley	✓	✓	✓	Apols
A Manasse	✓	✓	✓	✓
K Meegan	✓	Apols	Apols	✓
H Phipps	✓	✓	✓	✓
D Roberts	✓	✓	✓	✓
V Stevens	✓	✓	✓	✓
G Thompson	✓	Apols	✓	✓
J Warner	✓	Apols	✓	✓
M Warner	✓	✓	✓	✓
S Wilson	✓	✓	✓	✓
Partner Governor				
S Torr	Apols	X	X	X
R Webb	X	✓	Apols	Apols
M Rooney	X	X	Apols	X
H MacDonald	X	Apols	Apols	✓
M Lea	✓	Apols	X	✓
J Wight	✓	✓	✓	✓

Attendance at Governors' Council meetings

NAME	07-06-11	13-09-11	17-11-11	21-02-12
Exec/Non-Executive Director				
T Pedder from Jan 2011				✓
D Stone to December 2011	✓	✓	✓	
A Cash	✓	Apols	✓	✓
H Chapman	✓	✓	Deputy	Deputy
M Gwilliam	✓	✓	✓	✓
K Major	Apols	✓	✓	✓
N Priestley	✓	✓	✓	✓
M Richmond	✓	Deputy	✓	✓
N Riley	✓	✓	✓	✓

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, 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.

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 Director of Finance. Mr Vic Powell was subsequently appointed in April 2007 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 2011/12 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, were held privately with only the Board of Directors, associated employees, and employees of the Trust making presentations to the Board, in attendance. In anticipation of the Health and Social Care Act, the Board has resolved to hold its meetings in public from May 2012.

Audit Committee

The Audit Committee (AC) is appointed by the Board of Directors and consists of four non-executive directors of the Trust. The Chair of the Healthcare Governance Committee is an ex-officio member . 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 Pay and Remuneration Committee.

Governance Code

The Board has considered the Monitor Code of Governance and is compliant. The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors, and members of the Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

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. By maintaining fraud levels at an absolute minimum the Trust ensures that more funds are available to provide better patient care and services.

Sir Andrew Cash OBE
Chief Executive
24 May 2012

Members of the Board during 2011-12

The Chairman

David Stone CBE - retired December 2011

David was 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.

Tony Pedder - from January 2012

Tony joined the Trust as Chairman in January 2012. He was previously Chairman of NHS Sheffield and also the Chairman of South Yorkshire and Bassetlaw Cluster of NHS Primary Care Trusts.

As well as his NHS experience, Tony brings extensive management and operational experience in a variety of business organisations and markets. He was previously Chief Executive of Corus plc.

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 status in July 2004.

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

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 Human Resources at Central Manchester and Manchester Children's University Hospital.

Professor Hilary Chapman CBE

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.

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.

Kirsten Major

Director of Service Development

Kirsten joined the Trust in February 2011. Before her current post she was the Executive Director of Health System Reform at NHS North West Strategic Health Authority.

Kirsten is a health economist by background beginning her career at the Greater Glasgow Health Board and has worked at Ayrshire and Arran Health Board before moving to the North West in 2007.

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 term of office expired April 2012

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 after 8 years as commander of North Sheffield.

Vickie Ferres

Vickie Ferres is Chief Executive of Age UK 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 term of office expired June 2011

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.

Professor Rhiannon Billingsley from July 2011

Professor Rhiannon Billingsley is the Pro Vice-Chancellor for the portfolio of Regional and Public Health Development at Sheffield Hallam University.

Rhiannon's academic background is in social sciences, and she followed an early career in management in social work. She was previously at Salford University as director of social work and community studies. She is also a member of the Institute for Learning and Teaching in Higher Education.

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.

Andrew Riley

Director of Corporate Development

Andrew has worked for the NHS for over 30 years. Before joining the Trust he was managing director of the National Institute for Health Research clinical research networks.

During his career, Andrew has been chief executive of three NHS hospitals. He is a qualified executive coach and a life member of the Institute of Directors.

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 Neil 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.

Chair and Non Executive Director terms of office

Name	Position	Term of Office Commenced		Term of Office Ends
David Stone	Chairman	Reappointment commenced	01-07-08	Retired 31-12-11
Tony Pedder	Chairman	Appointment commenced	01-01-12	31-12-16
Rhiannon Billingsley	Non-Executive Director	Appointment commenced	01-07-11	30-06-15
John Donnelly	Non-Executive Director	Reappointment commenced	01-07-10	30-06-14
Vickie Ferres	Non-Executive Director	Reappointment commenced	01-07-09	30-06-13
Shirley Harrison	Non-Executive Director	Appointment commenced	01-11-07	31-10-11 Extended to 30/06/12
Jane Norbron	Non-Executive Director	Appointment commenced	01-07-07	30-06-11
Vic Powell	Non-Executive Director	Reappointment commenced	01-07-11	30-06-15
Iain Thompson	Non-Executive Director	Appointment commenced	01-05-08	30-04-12
Anthony Weetman	Non-Executive Director	Reappointment commenced	01-07-09	30-06-13

Attendances at Board of Directors Meetings and Associated Sub Committees - 2011/2012

Date of Meeting	Tony Pedder (WEF 1.1.12)	David Stone* (Retired 31.12.11)	Andrew Cash	John Donnelly	Vickie Ferres	Mark Gwilliam	Shirley Harrison	Kirsten Major	Jane Norbron** (Left 30/06/11)	Julie Phelan	Vic Powell	Neil Priestley	Mike Richmond	Andy Riley	Neil Riley	Prof Hilary Chapman	Iain Thompson	Prof A Weetman	Rhiannon Billingsley (WEF 1.7.11)
20/04/11		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
18/05/11		✓	✓	✓	APOL	✓	APOL	✓	✓	✓	✓	✓	✓	✓	✓	✓	APOL	✓	
15/6/11		✓	✓	✓	✓	✓	✓	✓	APOL	APOL	✓	✓	✓	✓	✓	✓	✓	✓	
20/07/11		✓	✓	✓	✓	✓	APOL	✓		APOL	✓	✓	DEP	✓	✓	✓	✓	✓	✓
17/08/11		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	DEP	✓	✓	✓	✓	✓	✓
21/09/11		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	APOL	✓	✓	✓	APOL	APOL
19/10/11		APOL	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	DEP	✓	✓	✓	✓
16/11/11		✓	✓	✓	✓	DEP	✓	✓		✓	✓	✓	DEP	✓	✓	✓	✓	✓	APOL
21/12/11		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
19/01/12	✓	RET.	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
21/02/12	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
21/03/12	✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	APOL	✓	✓	✓	✓	✓

DEP - Deputy Attended
*David Stone retired on 31st December 2011
**Jane Norbron left the Trust at the end of June 2011

Audit Committee

Date of Meeting	John Donnelly (Chair)	Shirley Harrison	Vic Powell	Prof A Weetman
12/4/2011 Business	✓	✓	✓part	✓
12/04/2011 Private	✓	✓	✓	✓
26/05/2011	APOL	APOL	✓	✓
5/7/2011 Business	✓	✓	✓	APOL
5/7/2011 Private	✓	✓	✓	APOL
01/11/2011 Business	✓	✓	✓	✓
01/11/2011 - Private	✓	✓	✓	✓
10/01/2012	✓	✓	✓	✓
13/03/2012	✓	✓	✓	✓

Finance Committee

Date of Meeting	Vic Powell (Chair)	Andrew Cash	John Donnelly	Mark Gwilliam	Kirsten Major	Neil Priestley	Prof Hilary Chapman	David Stone (Retired 31/12/11)	Tony Pedder (WEF 01/01/12)
11/04/2011	✓	✓	✓	✓	✓	✓	APOL	✓	
09/05/2011	APOL	✓	APOL	✓	✓	✓	✓	✓	
06/06/2011	✓	APOL	✓	DEP	DEP	✓	✓	✓	
11/07/2011	✓	✓	APOL	DEP	✓	✓	DEP	✓	
08/08/2011	✓	APOL	✓	DEP	✓	✓	✓	APOL	
12/09/2011	✓	APOL	✓	✓	✓	✓	✓	✓	
10/10/2011	✓	✓	✓	✓	DEP	✓	DEP	APOL	
07/11/2011	✓	✓	✓	✓	✓	✓	✓	✓	
12/12/2011	✓	✓	✓	DEP	✓	✓	✓	APOL	
09/01/2012	✓	✓	✓	✓	DEP	✓	✓	RETIRED	✓
06/02/2012	✓	✓	✓	✓	✓	✓	✓		APOL
12/03/2012	✓	✓	✓	✓	✓	✓	✓		✓

Human Resources Committee

Date of Meeting	Jane Norbron (Chair until 30 June 2011)	Mark Gwilliam	Shirley Harrison	Rhiannon Billingsley (Chair from 1 July 2012)
23/05/2011	✓	DEP	APOL	
18/07/2011		✓	APOL	✓
19/09/2011		✓	✓	APOL
21/11/2011		✓	APOL	✓
19/01/2012		✓	✓	✓
19/03/2012		✓	✓	✓

Healthcare Governance Committee

Date of Meeting	Vickie Ferres (Chair)	Prof Hilary Chapman	Mark Gwilliam	Kirsten Major	Prof Mike Richmond	Neil Riley	Prof A Weetman
18/04/2011	✓	✓	DEP	✓	✓	✓	✓
16/05/2011	APOL	✓	✓	✓	✓	✓	✓Chair
20/06/2011	✓	✓	DEP	APOL	✓	✓	✓
25/07/2011	✓	✓	APOL	✓	✓	✓	✓
26/09/2011	✓	✓	✓	APOL	✓	✓	✓
24/10/2011	✓	✓	✓	✓	✓	✓	✓
28/11/2011	✓	APOL	✓	✓	✓	✓	✓
19/12/2011	✓	✓	✓	APOL	✓	✓	✓
23/01/2012	✓	✓	✓	✓	✓	✓	APOL
27/02/2012	✓	DEP	✓	✓	✓	✓	APOL
27/03/2012	✓	DEP	APOL	✓	✓	APOL	✓

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

Board of Directors' Declaration of Interests 1 April 2011 to 31 March 2012.

NAME	JOB TITLE	INTERESTS
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 UK Armed Forces Champion and Co Chair UK MOD/DH Partnership Board. Director of Unique Health Solutions Brother - Northern Regional Chairman of Building Design Partnership

NAME	JOB TITLE	INTERESTS
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
Mr. John Donnelly	Non Executive Director	Trustee - Sheffield Hospitals Charitable Trust Chair - General Medical Council Fitness to Practice Panels
Ms. Vickie Ferres	Non Executive Director	Chief Executive - Age UK Doncaster Member - Weston Park Hospital Cancer Trust Husband - Non Executive Director, Sheffield Care Trust
Ms. Shirley Harrison	Non Executive Director	Board Member, Governance Board, Stratified Medicine Project Board Member, National Cancer Research Institute Lay Member, Cancer Research UK Clinical Trials Awards Advisory Committee Lay reviewer: NETSSC Health Technology Assessment (Clinical Evaluation and Trials) Member, North Trent Consumer Research Panel (unpaid)
Ms Kirsten Major	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) Member of Health Economists' Study Group Member of Unite
Ms. Jane Norbron (Left employment 30/06/2011)	Non Executive Director	Company Director of Jane Norbron Limited – Acts as Business Consultant and Performance Coach Involved with 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)

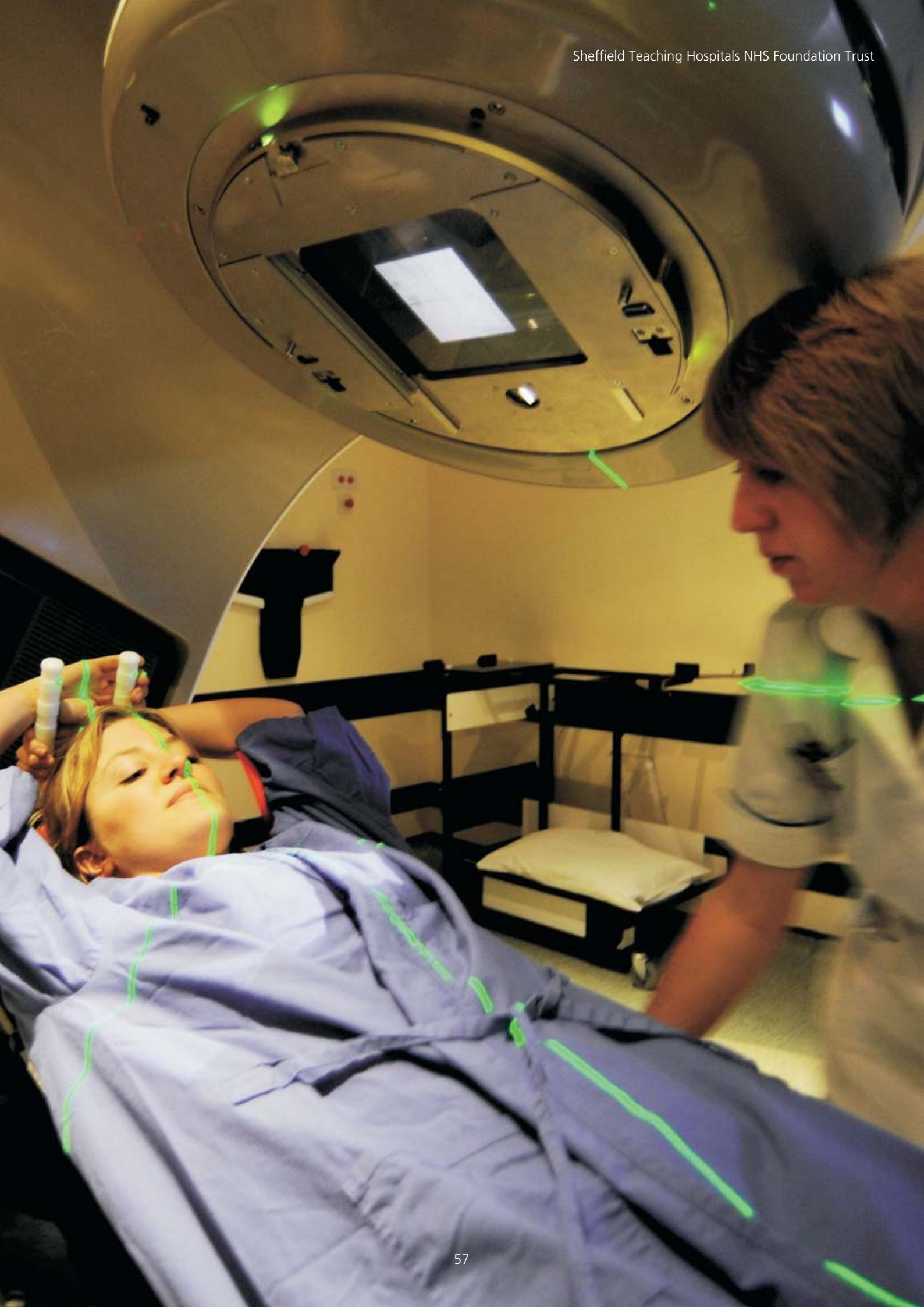
NAME	JOB TITLE	INTERESTS
Mr. Tony Pedder (wef 01/01/2012)	Chairman	Director, Sheffield Forgemasters International Ltd Director, Yorkshire and Humber IDB Ltd Director, Metalysis Ltd Director EEF Ltd Director, JSW Ltd (India) Member of Council, Sheffield University Trustee, Sheffield Theatres Trustee, Whirlow Hall Farm Trust
Mr. Vic Powell	Non Executive Director	Member of DoH Foundation Trust Finance Facility
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
Mr. Neil Riley	Trust Secretary	Visiting Professor, Faculty of Health and WellBeing, Sheffield Hallam University
Mr. David Stone (Retired - 31/12/2011)	Chairman	Trustee of Freshgate Foundation Trustee of Sheffield Botanical Gardens Trust Honorary Consul, Republic of Finland Chairman, Cutlers Hall Preservation Trust
Professor Anthony Weetman	University Representative	Chair, Medical Schools Council Chair, UK Healthcare Education Advisory Committee Board member, UK Clinical Aptitude Test Member, Health and Education National Strategic Exchange Member, Joint Medical Consultative Committee Member, Health Education England Steering Group

Nil returns

NAME	JOB TITLE
Mr. Neil Priestley	Director of Finance
Mrs. Julie Phelan	Communications Director
Mr. Iain Thompson	Non Executive Director
Mr. Mark Gwilliam	Director of Human Resources
Mr. Andrew Riley	Director of Corporate Development

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.



Director of Finance Report

The 2011/12 financial year has ultimately been a very successful one, albeit an immensely challenging one as we enter a period of very constrained funding for public services. The Accounts show a year-end surplus from continuing operations of £7.98m which is just over 0.9% of turnover. This is marginally better than the Trust's 2011/12 Financial Plan which was for a surplus of £6.7m. The funds generated from this surplus will be entirely reinvested in supporting the Trust's Capital programme. Overall, therefore, the results represent a very satisfactory position with continued financial stability for the Trust and enhanced investment, alongside its significant service achievements.

The Trust's income position for 2011/12 was as below:-

	£M	% increase over 2010/11
Income from patient services	717.0	8.9
Other operating income	144.7	(1.8)
Total Income	861.7	6.9

The significant level of growth in income from patient services is due to the transfer of Community services from NHS Sheffield to the Trust from 1 April 2011. This accounted for just over £53m of the £58.5m growth. The outturn activity position was slightly ahead of plan in overall terms with the main over performance on elective activity reflecting the drive to improve waiting times. The reduction in other operating income is largely due to a reduction in "charitable and other contributions" from a relatively high level in 2010/11, although Education and Training funding also reduced by 2%.

The Trust again faced a major efficiency requirement of just over £25m, bringing the cumulative requirement for the 6 years up to and including 2011/12 to nearly £180m. The Trust virtually delivered this savings requirement. However, this fell short of the Trust's plan which was to deliver further efficiency savings to offset underlying pressures in Directorate budgets and prepare for the challenges ahead.

Neil Priestley
Director of Finance

Pay Costs rose by over 8% in the year which again reflects the transfer of the staff providing community services to the Trust from 1 April 2011. If the impact of the new community staff is adjusted for, then staff numbers reduced significantly in the year as driven by efficiency plans. Drug costs rose by 5.7% and clinical supplies and services by 6.6%. The purchase of healthcare from non-NHS bodies was virtually unchanged at £12.8m. Clinical negligence costs increased by a further 9.5% to just over £12m. Depreciation and financing costs increased by 9.6%, largely due to new investments and accelerated depreciation charges on resulting surplus buildings.

The Trust's Capital Programme was underspent by £7.8m in 2011/12 due to slippage on planned schemes. The unspent resources are carried forward into 2012/13 and will be used to complete the relevant planned schemes. Total programmed capital expenditure for the year was £41.0m which represents a further major investment in the Trust's facilities and equipment in order to improve the service to patients. This expenditure is analysed below and demonstrates a significant investment in new service developments whilst maintaining investment in existing infrastructure, information technology, medical equipment and statutory and regulatory needs.

	£,000	£,000
Service Development	**23,875**	
Laboratory Medicine Facilities (NGH)		10,708
RHH Critical Care		4,082
NGH Ultrasound Reconfiguration		1,281
NGH Car Parks		1,078
2nd Gamma Knife Building Works		970
Clinical Skills Facilities		788
Office Accommodation NGH		734
Medical Education Facilities		659
Orthopaedic Reconfiguration		638
Single Switchboard		558
Brearley Outpatients Department		550
Other smaller schemes		1,829
Medical Equipment **sub total**	**11,677**	
Equipment Replacement Programmes e.g., Patient Monitors, Ultrasounds, Stack Systems & Orthopaedic Power Tools		5,442
3T MRI Scanner		2,097
Linear Accelerator		1,527
Replacement Catheter Lab		1,017
Urology Lithotripter		499
Other		1,095
Infrastructure **sub total**	**3,573**	
Ward Refurbishments		687
Catering Infrastructure		594
Rivermead Heating System		341
NGH Electrical Cabling		314
Steam Distribution		310
Lifts		250
Other		1,077
Information Technology **sub total**	**1,595**	
Single Patient Administration System		363
Ophthalmology Information System		244
Renal Information System		111
GU Medicine Information System		105
Other		772
Statutory Compliance **sub total**	**312**	
Moving & Handling Equipment		168
Fire Safety		74
Other (e.g. Security, Road Safety, DDA compliance etc)		70
Total Expenditure	**41,032**	

Total capital income available to the Trust for the year was £48.8m. This can be analysed as follows:-

	£,000
Resources available from the Department of Health/Internally Generated	47,807
Sale of 26 Northumberland Road	300
Other Donations/External Income	708
Total Income	**48,815**

In addition to the above, the Trust invested £4.4m in a second Gamma Knife but this was funded by means of a finance lease.

The Trust's net assets employed at 31 March 2012 were £376.2m compared with £366.1m at the previous year-end. Net current assets at 31 March 2012 were £16.1m, although this position is inflated by the high level of cash balances referred to below. Outstanding "borrowings" relating to Foundation Trust Financing Facility loans, a PFI contract and the new Finance Lease for the second Gamma Knife totalled £56.5m at the year-end.

Cash balances were £65.1m at the year-end, barely changed over the year. Of the £65.1m, around £19m relates to resources committed to capital schemes in 2012/13 and around £20m relates to R&D, provisions and other commitments. This leaves an uncommitted balance of around £25m which reflects the Trust's strategy of gradually improving its working capital position in order to provide a degree of financial security in the difficult years ahead. The position has been improved by a major focus on reducing outstanding debts with other NHS organisations.

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 comfortably achieved a risk rating of three. 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 2011/12 financial results are very 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 at least the next three years and almost certainly, based on public expenditure plans announced in the 2012 Budget, a further 2 years. Further major national efficiency targets are therefore inevitable as appear to be cuts to Education and Training funding following the Department of Health's MPET Review. In addition to this, commissioners will continue to seek savings through reduced use of hospital services and national contracts/business rules may become even more challenging for providers given the overall NHS financial position. The Trust remains committed to delivering high quality services and to achieving real efficiency savings to address the future financial pressures and to protect and invest in our services. However, the size of the financial challenge over several years ahead is clear.

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 committee sets the pay and conditions of the Executive Directors.

The membership of the committee comprises the non-executive directors of the Board including the Chairman. The Chief Executive (except where matters relating to the Chief Executive are under discussion), the Director of Finance and the Director of Human Resources are in attendance at all meetings to advise the committee. The committee is supported by the Trust Secretary to ensure that an appropriate record of proceedings is kept.

The Pay and Remuneration Committee met once during 2011/12. Attendance is as shown below:

	Meeting on 15 December 2011
David Stone (Chair)	Yes
John Donnelly	Yes
Vickie Ferres	Yes
Tony Weetman	Apologies
Rhiannon Billingsley	Yes
Vic Powell	Yes
Shirley Harrison	Yes
Ian Thompson	Yes

Remuneration of Chairman and non-executive directors

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

The committee comprises seven 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 Nominations 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 Executive Directors' remuneration data from comparative Teaching Hospitals.

Hutton Report Disclosure

The Hutton Report on Fair Pay in the Public Sector, published in March 2011, made a number of recommendations regarding the establishment of a framework for fairness in public sector pay.

In January 2012, the Financial Reporting Advisory Board formally approved and adopted one recommendation of the Hutton report namely the requirement to disclosure the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The disclosure is intended to hold the Trust to account for remuneration policy, and in particular, the remuneration of the highest paid director compared with the median remuneration of staff.

The banded remuneration of the highest-paid director in the Trust in the financial year 2011-12 was £217.5k (2010-11, £217.5k). This was 8.46 times (2010-11 8.98 times) the median remuneration of the workforce, which was £25,505.75 (2010-11, £24,031.09).

These figures are shown in tabular format below:

Pay Multiple Statement

	2011/12	2010/11
Highest paid Director Total Remuneration (mid point banded remuneration in multiples of £5k)	£217.5k	£217.5k
Median Total Remuneration	£25,505.75	£24,031.09
Ratio	8.46	8.98

In calculating the above pay multiples the full time equivalent total annualised remuneration of the workforce is used to ensure that the above ratios are not distorted which would be the case if staff were not represented as whole units.

Remuneration includes all taxable earnings, but excludes employer pension contributions and Cash Equivalent Transfer Values. Agency Workers are excluded from the calculations, however temporary, fixed term employees are included.

In calculating the above ratios, pay figures have been annualised to their full year effect as a reliable proxy for total yearly earnings.

Pay Multiples 2011/12 and 2010/11

2011/12 has been an extremely demanding and challenging year for the Sheffield Teaching Hospital NHS Foundation Trust, with significant organisational change in the form of the integration of the former Community Services from NHS Sheffield being one significant area of work.

In common with the rest of the Public Sector and large sectors of Private Industry, the Trust Board and Remuneration Committee, ever mindful of the wider economic climate, have decided that pay increases are 'frozen' during such an unprecedented period of austerity. This is of course set against the backdrop of the ever more challenging targets that are present in managing such a large, complex organisation. The remuneration of the highest-paid Director remains at the same level in 2011/12 as it did in 2010/11.

The total median remuneration of the Organisation has increased in 2011/12 owing to pay rises for members of staff on certain Agenda for Change pay grades, and the change in the profile of the workforce following the integration of Community Services staff on 1 April 2011.

The increase in total median pay in 2011/12, and the 'freeze' in the pay of the highest paid Director serves to explain the decrease in the multiple from 2010/11 in the above table.

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.

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.

The Chairman and 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 01-07-08	Retired 31-12-11
Tony Pedder	Chairman	Appointment commenced 01-01-12	31-12-16
Rhiannon Billingsley	Non Executive Director	Appointment commenced 01-07-11	30-06-15
John Donnelly	Non Executive Director	Reappointment commenced 01-07-10	30-06-14
Vickie Ferres	Non Executive Director	Reappointment commenced 01-07-09	30-06-13
Shirley Harrison	Non Executive Director	Appointment commenced 01-11-07	31-10-11 Extended to 30-06-12
Jane Norbron	Non Executive Director	Appointment commenced 01-07-07	30-06-11
Vic Powell	Non Executive Director	Reappointment commenced 01-07-11	30-06-15
Iain Thompson	Non Executive Director	Appointment commenced 01-05-08	30-04-12
Anthony Weetman	Non Executive Director	Reappointment commenced 01-07-09	30-06-13

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 2011/12 Accounts contained on pages 90 to 91 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Changes in Pension at age 60 during 2011/12
- Value of the cash equivalent transfer value at the beginning of the year
- Changes in the cash equivalent transfer value during 2011/12

Sir Andrew Cash OBE
Chief Executive
24 May 2012

Annual Governance Statement 2011-12

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 2012 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 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 of the Board are chaired by a non-executive director 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 (TEG) 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 Policy within their own areas.

The Risk Management 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 department of Patient and Healthcare Governance provides support and expert advice and guidance.

Incidents, claims and feedback from patients and visitors are systematically reviewed, using root cause analysis as appropriate, and reported in accordance with the relevant policies and procedures.

Serious incidents are escalated to the Serious Untoward Incident (SUI) Group which meets weekly. Facilitated by department of Patient and Healthcare Governance, membership of the group includes the Medical Director, Chief Nurse/Chief Operating Officer, Trust Secretary and Head of Patient and Healthcare Governance. The SUI Group review and classify serious incidents to determine which must be reported to the PCT as a SUI and which may not meet the commissioners' SUI criteria but are deemed serious enough to be similarly investigated and managed. The SUI Group request the relevant directorate to undertake an investigation using root cause analysis techniques and to make recommendations to mitigate the risk of recurrence. Once the group is satisfied with the investigation report and action plan it is signed off. Implementation of the action plan is monitored by the department of Patient and Healthcare Governance with external oversight by the PCT (where appropriate). Lessons learned are shared via appropriate forums at directorate and Trust-wide level. The Healthcare Governance Committee and the Safety and Risk Management Board receive a monthly verbal update on SUIs and a quarterly written report. Work is underway developing a Trust policy which will formalise the systems and processes for managing a SUI.

The Trust has an annual programme of Clinical Audit (reflecting national, regional and local priorities) providing assurance of quality improvement. The multi-disciplinary programme covers all clinical directorates and is delivered with the support of the Clinical Effectiveness Unit in accordance with best practice policies and procedures. Audits are reported at appropriate forums and practice re-audited as necessary. Implementation of the programme is monitored by the Clinical Effectiveness Committee, which reports to the Healthcare Governance Committee, and our local commissioner. Formal reporting is done via the Clinical Effectiveness Annual Report.

The results of national surveys and external agency visits, inspections and accreditation reports are also routinely reviewed and reported. Action plans to address recommendations are closely monitored. Issues raised by such reviews are used to ensure lessons are learnt and to improve practice.

The risk and control framework

At the July 2011 meeting, the Board approved a proposal to undertake an in-depth review of quality governance arrangements to ensure it was in a position to submit a revised Board Statement by Q2 as stipulated in the Monitor 2011/12 Compliance Framework. The review was overseen by a Quality Governance Steering Group which was established as a task and finish committee of the Board. The group was chaired by the Senior Independent Director and membership included the Medical Director, the Chief Nurse / Chief Operating Officer, the Director of Service Development and the Trust Secretary. It reported to the TEG, the Audit Committee and the Board.

Key staff were co-opted to operationally manage the review process using an analysis tool which was an adaptation of Monitor's Quality Governance Framework. The Steering Group made a summative assessment of collated documented evidence of the Trust's practice against best practice examples and assigned a risk rating and score using Monitor's rating scale. The scope of the review included adult community services that the Trust had taken responsibility for from April 2011.

The Steering Group assessed the Trust's quality governance arrangements as satisfactory and fit for purpose (i.e. would not have caused Monitor to refuse authorisation). However, the review did identify a number of areas for future development that would strengthen quality governance. An action plan was developed and the key recommendations were fed into work underway to refresh the corporate strategy and a complementary quality strategy. The review findings were shared with the Governors.

At their October meeting, the Board approved the Steering Group's assessment of the Trust's quality governance and action plan. The revised Board statement was submitted to Monitor.

The Risk Management 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.

The 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.

The policy 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.

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, Risk Validation Group, 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.

All new risks logged on to the Trust's Risk Register and existing risks that are scheduled for review by the risk owner in the previous month are reviewed and validated by the Risk Validation Group (RVG). The RVG is a sub committee of the Safety and Risk Management Board. As from January 2012, the RVG sends a monthly report to the TEG summarising the risks it has considered and highlighting those risks that it assesses as warranting detailed consideration by TEG. The RVG may escalate risks to TEG for a number of reasons such as severity, potential for aggregation (i.e. risks which are separately identified by more than one directorate but are common to a number of directorates or are Trust-wide), operational risks that have strategic risk implications, potential for significant reputational damage and risks that require executive leadership to mitigate the risk.

The major risks facing the Trust are:

In-year Risks:

- Failure to maintain financial balance 2011/12. This risk has been successfully managed and mitigated by detailed annual planning; an efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- Impact of a failure to meet C.Difficile target. The Trust struggled to meet this challenging target in the early part of the year. During this time an action plan was put in place (externally reviewed by an expert panel) and supported by strengthened oversight by the Board of Directors and the Healthcare Governance Committee. However, the target was breached in November and the Trust informed Monitor. Monitor reviewed the Trust's action plan and was content that it would significantly improve performance without the need for regulatory action. Although the national target was not met, the Trust managed to reduce the number of C.Difficile cases compared to 2010/11.

Future Risks:

- Failure to maintain financial balance in future years (2012/13 onwards) which will be managed and mitigated by detailed annual planning; an efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- Infection Prevention and Control which will be managed and mitigated by continued investment and 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. The Trust faces a considerable challenge in meeting reduced target cases for MRSA and C. Difficile for 2012-13.

- Failure to meet 18-week waiting time at every specialty level 2012/13 which will be managed and mitigated by the 18-week operational plan to increase capacity, (complemented by enabling elements of the Trust's Emergency Care Plan) and led by the Chief Nurse /Chief Operating Officer. The Trust has the support of its commissioners but anticipates particular challenge in meeting the target in certain specialities i.e. neurosurgery and orthopaedics.
- Realise the benefits of adult community services integrated into the Trust from April 2011. The Trust is a partner in a city-wide initiative to re-design the way patients receive their care based on a guiding principle of "right care, at the right time, in the right place and by the right person". The partnership involves primary and social care colleagues, including commissioners. Key elements for the Trust include the development of new models of care to improve patient flow by avoiding unnecessary admissions by placing greater reliance on community and social care provision and ensuring more efficient and timely discharge from hospital. Delivery will be managed by implementation of the Emergency Care Plan which is led by a Programme Director reporting to a Project Board and the Transforming Sheffield Health Steering Group.
- Managing the implementation of the Health and Social Care Act 2012 as it affects the Foundation Trust and the wider health economy. The Trust will work closely with its partners, particularly the Sheffield NHS Commissioning Group, to understand and mitigate the risks associated with implementation of the Act.

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 TEG 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).

The Assurance Framework identifies the Trust's principal objectives and the high level risks that threaten 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 TEG 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 TEG on key strategic risks and allow 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.

The Board of Directors receive a monthly Performance Report which includes performance against national targets, CQUIN standards, the Trust's KPIs and inpatient and outpatient activity. The Board is assured of the quality of information included in the performance report via a number of sources including routine internal quality assurance systems that support the Performance Management Framework; relevant internal audit reports (e.g. CQUIN audit which this year tested the quality of indicator data; Data Quality audit which tested A&E target data; eCAT audit which tested submitted data); external audit reports (notably the Limited Assurance report on the Quality Report); and the Clinical Coding audit undertaken by independent auditors.

Over the past year, the Trust has developed a new strategy Making a Difference and supporting strategies for 2012-17. The Trust plans to rebuild its Assurance Framework using the new corporate objectives.

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 2011/12 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. In response to the changing use of social network sites, the Internet - Acceptable Use Policy and the Confidentiality - Staff Code of Conduct have been reviewed and updated to strengthen information governance arrangements.

All Trust laptops are now encrypted and encrypted USB sticks issued to staff. The introduction of port control and an approved list for removable media is planned to be introduced shortly as part of the Trust's New Corporate Desktop programme.

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. However, in March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from a MRI diagnostic scanner. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DoH). The incident has been notified to the Information Commissioners Office (ICO) and the joint view of the DoH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.

There are well established and effective arrangements in place for working with public stakeholders across the local health economy:

- NHS Sheffield [Sheffield NHS Commissioning Group - in shadow form]
- Yorkshire and the Humber Strategic Health Authority [NHS North of England from 01/04/12]
- NHS South Yorkshire and Bassetlaw Cluster
- Yorkshire and the Humber Specialised Commissioning Group
- East Midlands Specialised Commissioning Group
- 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 Executive 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 registration requirements of the Care Quality Commission (CQC). 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 approved a Compliance Framework which describes how the CQC Compliance Review Group will oversee the development and systematic periodic evaluation of each of the essential standards as evidence of ongoing compliance. The Healthcare Governance Committee receives a monthly update report on compliance with CQC standards.

During the year, the CQC made three unannounced visits to the Trust (i.e. a responsive review of the Jessop Wing, a themed inspection of A&E and a themed review of Termination of Pregnancy at the Royal Hallamshire Hospital). CQC found the Trust to be compliant with standards and legislation and no concerns were raised.

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 is committed to eliminating discrimination, promoting equal opportunity and to fostering good relations in relation to the diverse community it serves and its staff, taking account of characteristics protected by the Equality Act 2010.

It has an established Equality and Human Rights Steering Group (reporting to TEG and the Healthcare Governance Committee and chaired by the Trust Secretary) and an Operational Leads Group (reporting to the steering group and includes representatives from each care group) which ensures good practice in equality and diversity is identified and shared across the organisation. An Equality and Human Rights Annual Report is published on the Trust's website.

Over the past year, the Trust has focused its work to meet the statutory requirements of the 2010 Equality Act ensuring ongoing regulatory compliance with the Equality and Human Rights Commission and the Care Quality Commission. It has adopted the NHS Equality Delivery System as a framework to develop its Equality Objectives.

The 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 an established Sustainable Development Strategy Group, (reporting to TEG and the Board of Directors and chaired by me) and a Sustainable Development Partnership Group (reporting to the strategy group and to the Healthcare Governance Committee and chaired by the Director of Estates). The Sustainable Development Manager provides the operational lead or input on a number of projects delivering energy efficiency, sustainable development, improved waste management and travel, as detailed in the Trust's Sustainable Development Action Plan, which are delivered as part of a Trust-wide campaign called Be Green. Be Green is now firmly embedded within the organisation with its own intranet site (including news and guidance for staff and updated energy and emissions data), supported by a network of trained Be Green representatives who promote sustainability and undertake sustainability audits within their own areas.

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 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 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 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 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 efficiency gains. The development of information and performance management systems has also been a key element 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 (SLR) 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 SLR information is now informing performance management and budget-setting 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 of the above is underpinned by the Trust Scheme of Reservation and Delegation of Powers, 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 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has an established process for preparing the Quality Report. Overall responsibility for the report rests with the Medical Director but the Head of Patient and Healthcare Governance is operationally responsible. The Quality Report Steering Group oversees the design, production, publication and review of the report. The group is accountable to TEG and membership includes managers, clinicians and Governors. This year the group has benefitted with input from Patient Partnership and Service Improvement to strengthen alignment with the Trust's quality priorities and representation from colleagues from newly integrated community services.

The Steering Group has reviewed progress against 2009-10 and 2010-11 quality priorities and agreed five priorities for 2012-13 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.

The group has responded to the recommendations in the External Assurance Report on last years Quality Report, in particular by developing additional outcome measure for priority areas and including a summary analysis of complaints.

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 issues 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, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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 has 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. It also reviews the Annual Report and Accounts including the Trust-wide governance arrangements as described. The Vice-chair has recent and relevant financial experience which supports expert and rigorous challenge on financial reports received by the committee, an understanding of Monitor's Financial Risk Rating and sound accounting policies and practices.

The preparation 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:

- Quality Governance Framework Review
- Opinion and reports by Internal Audit (Assure) who work to a risk-based annual plan approved by TEG and the Audit Committee 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 (KPMG) and specifically their Annual Governance Report.
- Quarterly Financial and Governance Risk Ratings 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.
- Other external Visits, Inspections and Accreditations
- Governors' Council reports.
- Clinical Audit reports.

Conclusion

No significant internal control issues have been identified.

Sir Andrew Cash OBE
Chief Executive
24 May 2012

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: 24 May 2012

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

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2012. 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 applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Governors of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Sheffield Teaching Hospitals NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

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

Chartered Accountants
St James' Square
Manchester
24 May 2012

Financial statements

Sheffield Teaching Hospitals NHS Foundation Trust Foreword to the accounts

These accounts for the year ended 31 March 2012 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.

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

Signed

Sir Andrew Cash, OBE,
Chief Executive
24 May 2012

Statement of Comprehensive Income for the year ending 31 March 2012

	NOTE	2011/12 £000	2010/11 £000
Operating Income from continuing operations	3.1	861,716	805,830
Operating Expenses from continuing operations	4.1	(840,900)	(789,332)
OPERATING SURPLUS		**20,816**	**16,498**
FINANCE COSTS			
Finance income	7.1	380	408
Finance expense- financial liabilities	7.2	(3,430)	(2,663)
Finance expense-unwinding of discount on provisions		(71)	(59)
Public Dividend Capital Dividends payable		(9,716)	(9,759)
Net finance costs		**(12,837)**	**(12,073)**
SURPLUS FROM CONTINUING OPERATIONS		**7,979**	**4,425**
Other comprehensive income			
Impairment		(14)	(1,726)
Revaluation		2,058	171
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**10,023**	**2,870**

The notes on pages 78 to 109 form part of these accounts.

All income and expenditure is derived from continuing operations.

On 1st April 2011 the Trust took over the provision of a number of Community Services for the residents of Sheffield from NHS Sheffield for the benefit and improvement of patient care. The transfer included 31 types of service, including District Nursing, Intermediate Care, Muskuloskeletal Care, Contraception, Sexual Health and GP Collaborative Services. Operating income and expenditure on these services during 2011/12 was around £53m, and involved around 1,100 Whole Time Equivalent Staff. In line with the exemption from full merger accounting for such transfers during 2011/12, 2010/11 comparatives have not been restated.

Statement Of Financial Position 31 March 2012

	NOTE	31 March 2012 £000	31 March 2011 £000	1 April 2010 £000
Non-current assets				
Intangible assets	8.1	947	1,139	1,169
Property, plant and equipment	9.1	410,702	389,628	386,885
Investments	11.0	0	0	0
Trade and other receivables	13.1	5,489	5,243	4,522
Total non-current assets		**417,138**	**396,010**	**392,576**
Current assets				
Inventories	12.1	13,674	12,179	12,059
Trade and other receivables	13.1	27,465	29,939	32,185
Cash	22	65,133	64,895	42,072
Total current assets		**106,272**	**107,013**	**86,316**
Current liabilities				
Trade and other payables	15.1	(73,032)	(63,366)	(58,593)
Borrowings	17	(2,415)	(2,033)	(1,345)
Provisions due within one year	20	(2,531)	(4,489)	(1,678)
Other liabilities	16	(12,238)	(11,499)	(10,596)
Total current liabilities		**(90,216)**	**(81,387)**	**(72,212)**
Total assets less current liabilities		**433,194**	**421,636**	**406,680**
Non current liabilities				
Borrowings	17	(54,055)	(52,465)	(38,497)
Provisions due after one year	20	(2,035)	(2,308)	(2,498)
Other liabilities	16	(951)	(733)	(2,475)
Total non-current liabilities		**(57,041)**	**(55,506)**	**(43,470)**
Total assets employed		**376,153**	**366,130**	**363,210**
FINANCED BY:				
Taxpayers' equity				
Public Dividend Capital		324,657	324,657	324,607
Revaluation reserve	21	27,733	27,182	30,089
Income and expenditure reserve		23,763	14,291	8,514
Total Taxpayers' equity		**376,153**	**366,130**	**363,210**

The financial statements on pages 74 to 109 were approved by the Board on 24 May 2012 and were signed on behalf of the Board by

Sir Andrew Cash, OBE,
Chief Executive
24 May 2012

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 2011	**366,130**	**324,657**	**27,182**	**-**	**14,291**
Surplus for the year	7,979				7,979
Revaluation gains on property, plant and equipment	2,058		2,058		
Impairments	(14)		(14)		
Other recognised gains and losses	-		(1,493)		1,493
Taxpayers' Equity at 31 March 2012	**376,153**	**324,657**	**27,733**	**-**	**23,763**
Taxpayers' Equity at 1 April 2010 (As previously stated)	**360,967**	**324,607**	**27,346**	**28,914**	**(19,900)**
Prior period adjustment	2,243	-	2,743	(28,914)	28,414
Taxpayers' Equity at 1 April 2010 - restated	**363,210**	**324,607**	**30,089**	**-**	**8,514**
Surplus for the year	4,425				4,425
Revaluation gains on property, plant and equipment	171		171		
Impairments	(1726)		(1726)		
Other recognised gains and losses	-		(1352)		1,352
Public Dividend Capital received	50	50			
Taxpayers' Equity at 31 March 2011	**366,130**	**324,657**	**27,182**	**-**	**14,291**

The prior period adjustment reflects the changed treatment for donated and government granted assets as directed by HM Treasury's interpretation of International Accounting Standard 20.

Statement Of Cash Flows 31 March 2012

	NOTE	2011/12 £000	2010/11 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus from continuing operations		20,816	16,498
Non-cash income and expenditure			
Depreciation and amortisation		27,288	24,525
Impairments		692	11,031
Reversals of impairments		(1,593)	(684)
Decrease in Trade and Other Receivables		2,133	2,654
(Increase) in Inventories		(1,495)	(120)
Increase in Trade and other Payables		7,039	2,050
Increase / (Decrease) in Other Liabilities		958	(9)
(Decrease) / Increase in Provisions		(2,302)	2,564
Other operating cashflows		(300)	(2,686)
NET CASH GENERATED FROM OPERATIONS		**53,236**	**55,823**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		373	397
Purchase of intangible assets		(66)	(242)
Purchase of Property, Plant and Equipment		(40,073)	(36,199)
Sales of Property, Plant and Equipment		300	0
Net cash used in investing activities		**(39,466)**	**(36,044)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		0	50
Loans received		0	16,000
Loans repaid		(1,445)	(780)
Capital element of finance lease rental payments		(366)	0
Capital element of Private Finance Initiative Obligations		(588)	(565)
Interest paid		(1,463)	(881)
Interest element of finance lease		(113)	0
Interest element of Private Finance Initiative obligations		(1,849)	(1,758)
PDC Dividend paid		(9,084)	(10,426)
Cash flows from other financing activities		1,376	1,404
Net cash (used in) / generated from financing activities		**(13,532)**	**3,044**
Increase in cash and cash equivalents		**238**	**22,823**
Cash and Cash equivalents at 1 April	22	64,895	42,072
Cash and Cash equivalents at 31 March		**65,133**	**64,895**

Notes to the Accounts

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 (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 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 Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012 is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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-Statement of Financial Position 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 FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of i) the impairment charged to operating expenses and ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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 are 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 and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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 Revenue, government and other grants

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

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 is 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 2.8% (2010/11 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 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 activities.

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 expenditure 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.

1.18 Critical Accounting Estimate and Judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and assumptions are based on historical experience and other factors that are considered to be reasonable and relevant under all the circumstances. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Management do not consider that there are any estimates which create a significant risk of causing a material uncertainty. However, the following are areas of estimation or judgement which have a major effect on the amounts recognised in the financial statements:

- Plant, Property and Equipment Valuations - see paragraph 1.4 & note 9
- Income Estimates - see paragraph 1.1. Included in the income figure is an estimate for partially completed spells, i.e. treatment for admitted patients which is ongoing at the close of 31 March each year. This income is estimated based on the average specialty tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.
- Provision for Impairment of Receivables - see paragraph 1.8 & note 13.2
- Expenditure Accruals - see paragraph 1.3 & note 15.1
- Provisions - see paragraph 1.10 & note 20

1.19 Accounting Standards which have been issued but which have not yet been adopted

The Treasury Financial Reporting Manual does not require the following Standards to be applied in 2011/12:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 Income Taxes (amendment) - effective 2012/13 but not yet adopted by the EU
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 Financial Instruments: Disclosures (annual improvements) - effective 2012/13 but not yet adopted by the EU
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation

The application of the Standards as revised would not have a material impact on the accounts of the Trust for 2011/12, were they applied in that year.

2. SEGMENTAL ANALYSIS

The Trust has determined that the Chief Operating decision maker (as defined by IFRS8: Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

The Board review the operating and financial results of the Trust on a monthly basis and consider the position of the Trust as a whole in their decision making process, rather than as individual components which comprise the total, in terms of allocating resources. Consequently the Board of Directors considers that all the Trust's activities fall under the single segment of provision of healthcare, and no further segmental analysis is therefore required.

3. Income

3.1 Income from Activities

	2011/12 £'000	2010/11 £'000
Elective income	153,888	152,435
Non Elective income	170,984	174,857
Outpatient income	113,969	112,584
A&E Income	12,869	11,713
Other NHS Clinical income	207,993	202,834
Income re Community Services	53,081	0
Private Patient Income	4,194	4,028
Total income from activities	**716,978**	**658,451**
Other operating income		
Research and development	14,253	13,338
Education and training	66,150	67,514
Charitable and other contributions to expenditure	682	4,923
Non-patient care services to other bodies	47,641	46,980
Other	14,419	13,940
Reversal of impairments of property, plant & equipment	1,593	684
Total other operating income	**144,738**	**147,379**
TOTAL OPERATING INCOME	**861,716**	**805,830**

3.2 Private patient income

	2011/12 £'000	2010/11 £'000	Base year (2002-03) £'000
Private Patient Income	4,291	4,150	2,919
Total patient related income	717,075	658,574	367,927
Proportion (as percentage)	0.60%	0.63%	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).

3.3 Operating lease income

	2011/12 £'000	2010/11 £'000
Rents recognised as income in the period	266	280
Contingent rents recognised as income in the period	10	16
	276	**296**
Future minimum lease payments due		
- not later than one year;	12	16
- later than one year and not later than five years;	648	346
- later than five years.	1701	1442
TOTAL	**2,361**	**1,804**

3.4 Operating Income (by type)

	2011/12 £'000	2010/11 £'000
Foundation Trusts	0	20
NHS Trusts	0	2
Strategic Health Authorities	3,480	3,285
Primary Care Trusts	704,081	646,795
Local Authorities	333	41
NHS Other	1,295	1,398
Non NHS: Private patients	3,161	2,940
Non NHS: Overseas patients (non-reciprocal)	1,033	1,088
NHS injury scheme (formerly The Road Traffic Act Scheme)	3,450	2,744
Non NHS: Other*	145	138
Total Income from activities	**716,978**	**658,451**

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

Other Operating Income		
Research and Development	14,253	13,338
Education and Training	66,150	67,514
Charitable and other contributions to expenditure	682	4,923
Non patient care services to other bodies	47,641	46,980
Reversal of impairments of property, plant & equipment	1,593	684
Other **	14,419	13,940
Total Other income	**144,738**	**147,379**

**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.

4.1 Operating expenses comprise:

	2011/12 £'000	2010/11 £'000
Services from other NHS Foundation Trusts	8,823	5,969
Services from other NHS Trusts	23	34
Services from PCT's	448	1,339
Services from other NHS bodies	6,240	6,007
Purchase of healthcare from non NHS bodies	12,750	12,268
Executive Directors' costs	1,217	1,220
Non-Executive Directors' costs	185	185
Staff costs	541,738	499,947
Drugs costs	84,528	79,970
Supplies and services - clinical	81,290	76,231
Supplies and services - general	7,991	7,517
Establishment	8,855	7,344
Research and Development	4,555	3,664
Transport	634	943
Premises	32,291	27,389
Increase / (decrease) in bad debt provision	743	(107)
Depreciation on property, plant and equipment	26,863	24,162
Amortisation on intangible assets	425	363
Impairments of property, plant and equipment	691	11,030
Impairments of intangible assets	1	1
Audit services - statutory audit	54	58
Further audit assurance services	2	8
Clinical negligence	12,031	10,989
Legal fees	1,378	1,393
Consultancy costs	1,508	2,998
Training, courses and conferences	1,896	1,826
Redundancy	(93)	1,465
Insurance	719	775
Losses, ex gratia & special payments	231	137
Other	2,883	4,207
TOTAL	**840,900**	**789,332**

	£'000	£'000
Limitation on Auditors' liability	**1,000**	**Unlimited**

4.2 Arrangements containing an operating lease

	2011/12 £'000	2010/11 £'000
Minimum lease payments	1,865	1,508
Contingent rents	0	0
Less sublease payments received	0	0
TOTAL	**1,865**	**1,508**

4.3 Arrangements containing an operating lease

	2011/12 £'000	2010/11 £'000
Future minimum lease payments due:		
Within 1 year	412	49
Between 1 and 5 years	2,888	3,491
After 5 years	1,254	1,516
TOTAL	**4,554**	**5,056**

4.4 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	To 31 March 2012		To 31 March 2011	
	Salary	**Employee Short term benefits - Employer's National Insurance**	Salary	Employee Short term benefits - Employer's National Insurance
	(bands of £5000) £000	**Rounded to the nearest £100**	(bands of £5000) £000	Rounded to the nearest £100
Sir A J Cash, OBE, Chief Executive	215-220	27,500	215-220	25,600
Mr N Priestley, Director of Finance	150-155	18,400	150-155	17,200
Professor M Richmond, Medical Director	165-170	23,900	165-170	22,300
Professor H Chapman, Chief Nurse/Chief Operating Officer	170-175	21,900	170-175	20,400
Ms K Major, Director of Service Development (from 1 April 2011)	125-130	15,100		
Mr C C Linacre, Director of Service Development (retired 31 March 2011)			140-145	16,400
Mr M Gwilliam, Director of Human Resources	125-130	15,000	115-120	12,900
Mr I Thompson, Non-Executive Director (Term of office expired 30 April 2012)	15-20	1,200	15-20	1,300
Mr J P Donnelly, Non-Executive Director	15-20	1,200	15-20	1,300
Ms V R Ferres, Non-Executive Director	15-20	1,200	15-20	1,300
Mr V G W Powell, Non-Executive Director	15-20	1,500	15-20	1,600
Mrs J Norbron, Non-Executive Director (until 30 June 2011)	0-5	300	15-20	1,300
Professor R Billingsley (from 1 July 2011)	10-15	1,000		
Ms S Harrison, Non-Executive Director	15-20	1,200	15-20	1,300
Professor A P Weetman, Non-Executive Director	15-20	1,200	15-20	1,300
Mr D Stone, Chairman (retired 31 December 2011)	40-45	5,300	55-60	6,700
Mr A Pedder, Chairman (from 1 January 2012)	10-15	1,800		

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 2012	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	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	-0-2.5	370-372.5	1,984	1,838	84	30,200
Mr N Priestley, Director of Finance	0-2.5	212.5-215	957	838	90	21,000
Professor M Richmond, Medical Director	0-2.5	227.5-230	1,191	1,084	70	26,600
Professor H Chapman, Chief Nurse/Chief Operating Officer	0-2.5	282.5-285	1,198	1,016	147	24,500
Mr M Gwilliam, Director of Human Resources	7.5-10	50-52.5	217	154	57	17,500
Ms K Major, Director of Service Development	35-37.5	105-107.5	361	183	172	17,600

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.

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

	2011/12 Total £'000	Permanent	Other	2010/11 Total £'000	Permanent	Other
Salaries and wages	450,910	445,411	5,499	416,294	410,778	5,516
Social Security Costs	31,631	31,631	0	29,084	29,084	0
Employer contributions to NHSPA	49,846	49,846	0	45,853	45,853	0
Other pension costs	34	34	0	(7)	(7)	0
Termination Benefits	(93)	(93)	0	1,465	1,465	0
Agency / contract staff	10,534	0	10,534	9,943	0	9,943
TOTAL	**542,862**	**526,829**	**16,033**	**502,632**	**487,173**	**15,459**

The above figure of £542,862k is net of the amount of £1,680k (2010/11 £1,952k) in respect of capitalised salary costs included in fixed asset additions (note 9.1).

5.2 Average number of persons employed (Whole Time Equivalent basis)

	2011/12 Total Number	Permanent	Other	2010/11 Total Number	Permanent	Other
Medical and dental	1,714	1,595	119	1,709	1,581	128
Administration and estates	2,704	2,593	111	2,500	2,409	91
Healthcare assistants and other support staff	1,468	1,400	68	1,437	1,374	63
Nursing, midwifery and health visiting staff	5,528	5,285	243	5,135	4,887	248
Scientific, therapeutic and technical staff	2,306	2,280	26	2,047	2,035	12
Total	**13,720**	**13,153**	**567**	**12,828**	**12,286**	**542**

5.3 Employee benefits

	2011/12 £000	2010/11 £000
Benefits	0	0
	0	0

5.4 Staff Exit Packages

2011/12 Exit package cost band	Number of Compulsory redundancies	Number of other departures agreed	Total Number of Exit packages by cost band
<£10,000	0	14	14
£10,000 - £25,000	0	8	8
£25,001 - £50,000	1	14	15
£50,001 - £100,000	1	2	3
£100,001 - £150,000	0	0	0
Total Number of Exit Packages by type	**2**	**38**	**40**
Total Cost	**118**	**853**	**971**

2010/11 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		**2,010**	**2,010**

5.5 Early Retirements Due to Ill Health

	2011/12 £'000	2011/12 Number	2010/11 £'000	2010/11 Number
Number of early retirements agreed on the grounds of ill health		14		13
Cost of early retirements agreed on grounds of ill health	1,219		901	

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:

	2011/12	2010/11
Number of non NHS invoices paid	161,347	158,146
Number of non NHS invoices paid within 30 days	155,183	150,868
Percentage of invoices paid within 30 days	96.18%	95.40%
	£'000	£'000
Value of non NHS invoices paid	294,594	274,955
Value of non NHS invoices paid within 30 days	278,885	259,332
Percentage of invoices paid within 30 days	94.67%	94.32%
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

	2011/12 £000	2010/11 £000
Bank account interest	380	408
	380	**408**

7.2. Finance costs - interest expense

	2011/12 £000	2010/11 £000
Loans from the Foundation Trust Financing Facility	1,469	905
Finance Lease interest	113	0
Finance Costs in PFI obligations		
Main Finance Costs	1,390	1,425
Contingent Finance Costs	458	333
TOTAL	**3,430**	**2,663**

7.3 Impairment of assets

	2011/12 £000	2010/11 £000
Loss or damage from normal operations	328	729
Abandonment of assets in course of construction	217	570
Changes in market price	161	11,458
Impairments charged to expenses	**706**	**12,757**
Reversal of impairments credited to income	(1,593)	(684)
TOTAL	**(887)**	**12,073**

8.1 Intangible fixed assets 2011/12

	Total £'000	Software licences £'000
Gross Cost at 1 April 2011	**2,703**	**2,703**
Reclassifications	130	130
Additions - purchased	68	68
Additions -donated	36	36
Disposals	(31)	(31)
Gross cost at 31 March 2012	**2,906**	**2,906**
Amortisation at 1 April 2011	1,564	1,564
Provided during the year	425	425
Impairments	1	1
Disposals	(31)	(31)
Amortisation at 31 March 2012	**1,959**	**1,959**
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**
Net book value		
- Purchased at 31 March 2012	913	913
- Donated at 31 March 2012	34	34
Total at 31 March 2012	**947**	**947**

8.2 Intangible fixed assets 2010/11

	£'000	£'000
Gross cost at 1 April 2010 as previously stated	2,480	2,480
Prior period adjustment	0	0
Gross cost at 1 April 2010 restated	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 as previously stated	1,311	1,311
Prior period adjustment	0	0
Amortisation at 1 April 2010 restated	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**

Note 8.3 Intangible assets acquired by government grants

	2011 /12 £,000
Initial fair value	0
Carrying amount at 31 March 2011	0
Carrying amount at 31 March 2012	0

Note 8.4 Economic life of intangible assets

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

9. Property, Plant and Equipment

9.1 Property, Plant and Equipment 2011/12	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 2011	508,539	16,743	312,703	2,226	14,835	113,869	946	22,970	24,247
Additions - purchased	43,704	0	2,557	0	29,677	11,019	143	226	82
Additions - donated	646	0	287	0	223	121	0	0	15
Additions - government granted	1,071				1,071				
Impairments	(14)	0	(1)	0	0	(13)	0	0	0
Reclassifications	(130)	0	10,652	0	(16,541)	4,526	0	1,034	199
Other Revaluations	(44)	50	30	0	(216)	92	0	0	0
Disposals	(7,632)	(100)	(202)	0	0	(7,054)	(107)	(159)	(10)
Cost or valuation at 31 March 2012	**546,140**	**16,693**	**326,026**	**2,226**	**29,049**	**122,560**	**982**	**24,071**	**24,533**
Accumulated Depreciation at 1 April 2011	118,911	0	11,090	112	0	71,976	628	17,076	18,029
Provided during the year	26,863	0	14,089	111	0	8,800	85	2,663	1,115
Impairments recognised in operating expenses	691	0	128	0	217	342	0	0	4
Reversal of impairments	(1,593)	0	(1,593)	0	0	0	0	0	0
Reclassifications	0	0	2	0	0	0	0	0	(2)
Other Revaluations	(2,102)	0	(1,977)	0	(217)	92	0	0	0
Disposals	(7,332)	0	(2)	0	0	(7,054)	(107)	(159)	(10)
Depreciation at 31 March 2012	**135,438**	**0**	**21,737**	**223**	**0**	**74,156**	**606**	**19,580**	**19,136**
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**
Net book value									
- Purchased at 31 March 2012	360,039	15,808	262,503	1,844	28,982	41,220	366	4,411	4,905
- Finance Leases at 31 March 2012	4,123	0	0	0	0	4,123	0	0	0
- PFI at 31 March 2012	14,817	0	14,817	0	0	0	0	0	0
- Government granted assets at 31 March 2012	3,914	0	3,117	0	0	729	0	24	44
- Donated at 31 March 2012	27,809	885	23,852	159	67	2,332	10	56	448
Total at 31 March 2012	**410,702**	**16,693**	**304,289**	**2,003**	**29,049**	**48,404**	**376**	**4,491**	**5,397**

9.2 Analysis of Property, Plant and Equipment									
Net book value									
- Protected assets at 31 March 2012	322,985	16,693	304,289	2,003					
- Unprotected assets at 31 March 2012	87,717				29,049	48,404	376	4,491	5,397
Total at 31 March 2012	**410,702**	**16,693**	**304,289**	**2,003**	**29,049**	**48,404**	**376**	**4,491**	**5,397**

9.3 Property, Plant and Equipment 2010/11

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under constr & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2010 as previously stated	489,587	16,738	296,946	2,226	12,967	114,135	1,022	22,449	23,104
Prior Period adjustment	0	0	0	0	0	0	0	0	0
Cost or valuation at 1 April 2010 restated	**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	(1,726)	0	(1,726)	0	0	0	0	0	0
Reclassifications	(290)	0	20,234	0	(24,359)	2,152	12	760	911
Other Revaluations	(10,495)	5	(10,821)	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
Prior Period adjustment	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 1 April 2010 restated	**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	11,030	0	10,467	0	0	491	0	68	4
Reversal of impairments	(684)	0	(684)	0	0	0	0	0	0
Reclassifications	0	0	270	0	0	(270)	0	0	0
Other Revaluations	(10,666)	0	(10,988)	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 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
- Government grant assets at 31 March 2011	0	0	0	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

9.4 Analysis of Property, Plant and Equipment

Net book value									
- Protected assets at 31 March 2011	320,470	16,743	301,613	2,114	0	0	0	0	0
- Unprotected assets at 31 March 2011	69,158	0	0	0	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**

9.5 Economic life of Property, Plant and Equipment

	Min Life Years	Max Life Years
Land	0	0
Buildings excluding dwellings	5	45
Dwellings	15	25
Assets under Construction & Payments on Account	0	0
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & 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 historic cost basis (as a proxy for fair value for short life assets)	48,404	376	4,491	5,397
	48,404	**376**	**4,491**	**5,397**

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)	16,693	304,289	2,003
Modern Equivalent Asset (Alternative Site)	0	0	0
Other Professional Valuations	0	0	0
Total	**16,693**	**304,289**	**2,003**

10.1 Non-current assets for sale and assets in disposal groups 2011/12

There were no non-current assets for sale and assets in disposal groups in 2011/12 and 2010/11

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 2012 and 31 March 2011).

The Trust owns 45.95% (45.95% 31 March 2011) of the share capital of Epaq, and 21.89% (22.22%, 31 March 2011) of the share capital of Zilico.

12.1. Inventories

	31 March 2012 £'000	31 March 2011 £'000
Drugs	5,907	5,088
Energy	368	329
Other	7,399	6,762
TOTAL	**13,674**	**12,179**

12.2 Inventories recognised in expenses

	2011/12 £'000	2010/11 £'000
Inventories recognised in expenses	94,606	86,319
Write down of inventories recognised as an expense	50	210
Total Inventories recognised in expenses	**94,656**	**86,529**

13.1. Trade receivables and other receivables

	31 March 2012 Total £'000	31 March 2011 Total £'000
Amounts falling due within one year:		
NHS receivables	11,952	14,504
Other receivables with related parties	4,309	5,323
Provision for impaired receivables	(5,135)	(4,690)
Prepayments	1,896	1,463
Accrued income	4,492	4,913
Interest receivable	31	24
PDC dividend receivable	105	737
VAT receivable	1,479	393
Other receivables	8,336	7,272
Total due within one year	27,465	29,939
Amounts falling due after more than one year:		
Accrued receivables	207	250
Other receivables	5,282	4,993
Total due after more than one year	5,489	5,243
TOTAL	**32,954**	**35,182**

13.2 Provision for impairment of receivables

	2011/12 £'000	2010/11 £'000
At 1 April	4,690	5,911
Increase in provision	2,818	1,897
Utilised	(299)	(1,114)
Unused amounts reversed	(2,074)	(2,004)
At 31 March	**5,135**	**4,690**

13.3 Analysis of impaired receivables

Ageing of impaired receivables	£'000	£'000
0-30 days	27	45
30-60 days	29	30
60-90 Days	32	48
90-180 days	237	331
over 180 days	4,810	4,236
Total	**5,135**	**4,690**
Ageing of non-impaired receivables past their due date		
0-30 days	0	0
30-60 days	1,435	1,560
60-90 Days	362	878
90-180 days	358	1,555
over 180 days	520	2,743
Total	**2,675**	**6,736**

14. Current asset investments

	2011/12 Total £'000	2010/11 Total £'000
Additions	0	0
Disposals	0	0
Cost or valuation at 31 March	**0**	**0**

15. Payables

15.1 Trade and other payables

	31 March 2012 Total £'000	31 March 2011 Total £'000
Amounts falling due within one year:		
NHS payables	6,992	7,747
Amounts due to other related parties	4,712	5,902
Trade payables - capital	10,416	9,191
Other trade payables	16,220	12,485
Other payables	6,768	6,086
Accruals	17,063	11,973
Social Security and other taxes	10,861	9,982
Total current trade and other payables	**73,032**	**63,366**

	31 March 2012 Total £'000	31 March 2011 Total £'000
Amounts falling due after one year:	0	0
Total non-current trade and other payables	**0**	**0**

15.2 - early retirements detail included in payables above

	31 March 2012 Total £'000	Number	31 March 2011 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	6,138		5,704	

16 Other liabilities

Current	31 March 2012 £'000	31 March 2011 £'000
Deferred Income	12,238	11,499
Total Other Current liabilities	**12,238**	**11,499**
Non-current		
Deferred Income	951	733
Total Other Non-current Liabilities	**951**	**733**

17 Borrowings

	31 March 2012 £'000	31 March 2011 £'000
Current		
Loans from Foundation Trust Financing Facility	1,445	1,445
Obligations under finance leases	368	0
Obligations under Private Finance Initiative contracts	602	588
Total Current Borrowings	**2,415**	**2,033**
Non- current		
Loans from Foundation Trust Financing Facility	29,071	30,516
Obligations under finance leases	3,637	0
Obligations under Private Finance Initiative contracts	21,347	21,949
Total Non Current Borrowings	**54,055**	**52,465**

18 Prudential Borrowing Limit

	2011/12 £'000	2010/11 £'000
Total long term borrowing limit set by Monitor	175,700	166,700
Working capital facility agreed by Monitor	60,000	60,000
Contracted working capital facility	60,000	60,000
TOTAL PRUDENTIAL BORROWING LIMIT	**235,700**	**226,700**
Long term borrowing at 1 April 2011	54,498	39,841
Net actual long term borrowing/repayment in year	1,972	14,657
Long term borrowing at 31 March 2012	**56,470**	**54,498**
Working capital facility at 1 April 2011	0	0
Net actual borrowing / repayment in year	0	0
Net Working capital facility at 31 March 2012	**0**	**0**

	2011/12		**2010/11**	
	Limit	actual	Limit	actual
Minimum Dividend Cover	>1	4.81	>1	4.99
Minimum Interest Cover	>3	13.76	>3	18.42
Minimum Debt Service Cover	>2	8.10	>2	12.88
Maximum Debt Service to Revenue	<3%	0.68%	<3%	0.50%

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 2011/12 (2010/11) 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 2012 £000	31 March 2011 £000
Gross lease liabilities	**4826**	**0**
of which liabilities are due		
- not later than one year;	535	0
- later than one year and not later than five years;	2142	0
- later than five years.	2149	0
Finance charges allocated to future periods	(821)	0
Net lease liabilities	**4,005**	**0**
- not later than one year;	379	0
- later than one year and not later than five years;	1675	0
- later than five years.	1951	0

19.2 Private Finance Initiative (PFI) Obligations (On Statement of Financial Position)

	31 March 2012 £'000	31 March 2011 £'000
Gross PFI liabilities	**42,757**	**44,735**
of which liabilities are due		
- not later than one year;	1,954	1,977
- later than one year and not later than five years;	7,445	7,614
- later than five years.	33,358	35,144
Finance charges allocated to future periods	(20,808)	(22,198)
Net PFI liabilities	**21,949**	**22,537**
- not later than one year;	602	588
- later than one year and not later than five years;	2,410	2,430
- later than five years.	18,937	19,519

19.3 Amounts included in operating expenses in respect of PFI transactions deemed to be in the categories listed below

	2011/12 £000	2010/11 £000
Building Maintenance	294	277
Insurance	136	129
Other management services	95	90
Depreciation	346	356
	871	**852**

19.4 Finance charges in respect of Private Finance Initiative (PFI)

Finance charges in respect of PFI transactions re shown in note 7.2

19.5 PFI Scheme details

Estimated capital value of PFI scheme	£14,813k
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	24.6
Contract end date	December 2036

19.6 The Trust is committed to make the following payments for the total service element for on-SoFP PFI service concessions for each of the following periods

	31 March 2012 Hadfield Block £000	31 March 2011 Hadfield Block £000
Within one year	3,197	3,082
2nd to 5th years (inclusive)	13,606	13,274
Later than 5 years	90,796	90,324

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 2012 £'000	31 March 2011 £'000	31 March 2012 £'000	31 March 2011 £'000
Pensions relating to other staff	168	173	2,035	2,288
Legal claims	681	465	0	20
Agenda For Change	69	149	0	0
Redundancy	780	1,420	0	0
Other	833	2,282	0	0
TOTAL	**2,531**	**4,489**	**2,035**	**2,308**

	Pensions relating to other staff £'000	Legal claims £'000	Agenda For Change £'000	Redundancy £'000	Other £'000	31/03/2012 Total £'000	31/03/2011 Total £'000
At start of period	2,461	485	149	1,420	2,282	6,797	4,176
Change in discount rate	0	0	0	0	0	0	(160)
Arising during the year	100	626	51	608	928	2,313	4,268
Utilised during the year	(164)	(347)	(65)	(487)	(1,940)	(3,003)	(1,046)
Reversed unused	(265)	(83)	(66)	(761)	(437)	(1,612)	(500)
Unwinding of discount	71	0	0	0	0	71	59
At 31 March 2012	**2,203**	**681**	**69**	**780**	**833**	**4,566**	**6,797**
Expected timing of cashflows							
Within one year	168	681	69	780	833	2,531	4,489
Between one and five years	626	0	0	0	0	626	666
After five years	1,409	0	0	0	0	1,409	1,642

Pensions relating to other staff represent the liability relating to staff retiring before April 1995 (£587k) and Injury Benefit Liabilities (£1,616k). 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. The provision for such cases totals £556k.
- A number of other legal cases, not being handled by the NHSLA, are also recorded under this heading. These total £125k.

The 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. Consultation with individual members of staff on this issue is proceeding.

Other provisions and redundancy relate to:-
- Costs likely to be incurred under the trust workforce reduction scheme (£780k).
- Costs likely to be incurred under the Trust's Mutually Agreed Resignation Scheme (£752k)
- Costs likely to be incurred due to Carbon Trading scheme (£52k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (£29k)

The consultation with staff in respect of the pay award and the staff reduction project is continuing.

The actual value of costs incurred under the Carbon Trading Scheme will depend on the actual quantity of CO2 produced.

Of the above total provision and related payments, some £244,302 has been covered by "back-to-back" income arrangements with the Trust's major Purchasers (31.3.11 £269,937).

£62,269,833 is included in the provisions of the NHS Litigation Authority at 31/03/2012 in respect of clinical negligence liabilities of the Trust (31/3/2011 £62,307,909)

21 Revaluation reserve

	Total Revaluation Reserve	Revaluation Reserve - intangibles	Revaluation Reserve -property, plant & equipment
Revaluation reserve at 1 April 2011	27,182	0	27,182
Impairments	(14)	0	(14)
Revaluations	2,058	0	2,058
Other recognised gains and losses	(1,493)	0	(1,493)
Revaluation reserve at 31 March 2012	**27,733**	**0**	**27,733**
Revaluation Reserve at 1 April 2010, as previously stated	27,346	0	27,346
Prior period adjustment	2,743	0	2743
Revaluation reserve at 1 April 2010, restated	**30,089**	**0**	**30,089**
Impairments	(1,726)	0	(1,726)
Revaluations	171	0	171
Other recognised gains and losses	(1,352)	0	(1,352)
Revaluation reserve at 31 March 2011	**27,182**	**0**	**27,182**

22 Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
At 1 April	64,895	42,072
Net change in year	238	22,823
At 31 March	65,133	64,895
Analysed as		
Cash at commercial banks and in hand	243	183
Cash at Government Banking Service	64,890	64,712
Cash and cash equivalents as in Statement of Financial Position	65,133	64,895
Bank overdraft	0	0
Cash and cash equivalents as in SoFP	**65,133**	**64,895**
Third party assets held by the NHS Foundation Trust		
At 1 April	30	15
Gross inflows	106	159
Gross outflows	(132)	(144)
At 31 March	4	30

23. Capital Commitments

Commitments under capital expenditure contracts at the Balance Sheet Date were £9.1m (31 March 2011, £15.9m). The major components of these commitments are as follows:

	Property, Plant & Equipment Scheme 31 March 2012 Amount £'000
Northern General Hospital Laboratory Medicine Reconfiguration	2039
Medical Equipment	1998
Chest Clinic / Respiratory Outpatients	1821
Royal Hallamshire Hospital (RHH) Ward Refurbishment Programme	1224
RHH Critical Care	1181
RHH Endoscopy / Decontamination Scheme	221
Renal Lifts	208
Jessop Hospital for Women Medical Air & Vacuum Upgrade	161
Firth Lift Refurbishment	108
Other Schemes	114
Total	**9,075**

24. Events after the reporting period

There were no material events after the reporting period.

25. Contingencies

	2011/12 £000	2010/11 £000
Gross value	270	256
Amounts recoverable	0	0
Net contingent liability	270	256

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 54 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. The main entities with whom the Trust has transacted are listed below:

	2011/12		2010/11	
	Income £'000	Expenditure £'000	Income £'000	Expenditure £'000
Sheffield PCT	388,308	4,055	335,545	1,739
Bassetlaw PCT	7,554		7,595	
Derby County PCT	27,752		27,823	
Barnsley PCT	182,441		180,733	
Rotherham PCT	23,794		23,877	
Doncaster PCT	15,208		15,408	
Leicestershire County and Rutland PCT	35,968		32,660	
Yorkshire and The Humber Strategic Health Authority	65,546		68,351	
NHS Litigation Authority		12,571		11,483
National Blood Authority		5,975		7,714
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	6,614	6,761	6,793	7,345
Sheffield Health and Social Care NHS Foundation trust	1,470	3,254	1,304	1,060
Sheffield Children's NHS Foundation Trust	7,367	4,074	6,868	4,040
Barnsley Hospital NHS Foundation Trust	5,016	2,255	4,722	2,202
Chesterfield Royal NHS Foundation Trust	3,430	2,051	3,381	2,098
The Rotherham NHS Foundation Trust	4,308	1,879	4,252	1,196

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 and NHS bodies to be related parties, as they and the Trust are under the common control of Monitor and the Department of Health. During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non support services. Of the Trust's total receivables of £32,954k at 31 March 2012, (£35,182k at 31 March 2011, note 13.1) £16,651k (£19,667k at 31 March 2011) 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. The remainder of the balance comprises monies owed from NHS Trusts in respect of clinical support services provided. £3,587k was receivable from the University of Sheffield at 31 March 2012, (31 March 2011, £4,148k) in respect of clinical and estates support services provided. Professor A P Weetman has clinical commitments at Thornbury Private Hospital, which is sited in Sheffield. During the year the Trust purchased healthcare from this hospital in the sum of £1,910k (2010/2011 £3,159k.)

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at Thornbury and Claremont private hospitals. This amounted to £7,972k (2010/2011 £10,660k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Payables falling due within one year of £73,032k (31 March 2011, £63,366k, note 15.1) include £6,992k owing to NHS bodies (31 March 2011, £7,747k). This sum includes monies owing to other NHS Trusts and Foundation Trusts for clinical support services received.

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 £1.0m (2010/11, £1.0m). 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
NHS Trade and other receivables excluding non financial assets	16,651	-	-	-	16,651
Non-NHS Trade and other receivables excluding non financial assets	5,281				5,281
Cash and cash equivalents at bank and in hand	65,133				65,133
Total at 31 March 2012	**87,065**	**-**	**-**	**-**	**87,065**
NHS Trade and other receivables excluding non financial assets	19,667	-	-	-	19,667
Non NHS Trade and other receivables excluding non financial assets	6,126				6,126
Cash and cash equivalents at bank and in hand	64,895				64,895
Total at 31 March 2011	**90,688**	**-**	**-**	**-**	**90,688**

* SoCI - Statement of Comprehensive Income Page 74

27.2 Financial liabilities by category

Liabilities as per Statement of Financial Position	Other financial liabilities	Liabilities at fair value through the SoCI*	Total
	£000	£000	£000
Borrowings excluding Finance lease and PFI liabilities	30,515	0	30,515
Finance lease obligations	4,005	0	4,005
Obligations under Private Finance Initiative contracts	21,949	0	21,949
NHS Trade and other payables excluding non financial assets	6,992	0	6,992
Non-NHS Trade and other payables excluding non financial assets	48,411		48,411
Provisions under contract	4,566	0	4,566
Total at 31 March 2012	**116,438**	**0**	**116,438**
Borrowings excluding Finance lease and PFI liabilities	31,961	0	31,961
Obligations under Private Finance Initiative contracts	22,537	0	22,537
NHS Trade and other payables excluding non financial assets	7,747	0	7,747
Non-NHS Trade and other payables excluding non financial assets	39,551		39,551
Provisions under contract	6,797	0	6,797
Total at 31 March 2011	**108,593**	**0**	**108,593**

* SoCI - Statement of Comprehensive Income Page 74

27.3 Fair values of financial assets at 31 March 2012

	Book Value £000	Fair value £000
Non current trade and other receivables excluding non financial assets	0	0
Other Investments	0	0
Other	226	226
Total	**226**	**226**

27.4 Fair values of financial liabilities at 31 March 2012

	Book Value £000	Fair value £000
Provisions under contract	4,566	4,566
Loans	30,516	30,516
Other	0	0
Total	**35,082**	**35,082**

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 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 at 31 March 2012 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 £3,521 (31 March 2011, £30,329) at bank and in hand at 31 March 2012, which related 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 1,300 (590 in the year to 31 March 2011) cases of losses and special payments totalling £321k (12 months to 31 March 2011, £432k) approved during the financial year.

There was one case of an individual loss exceeding £100,000 (2010/11 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 £9,716k (2010/11 £9,759k) bear to the average net relevant assets during the twelve month period of £275,631k (2010/11 £279,187k), that is 3.5% (2010/11 - 3.5%).

This is calculated as follows:

	31 March 2012 £'000	31 March 2011 (Pre-restatement) £'000
Total Capital and Reserves	**376,153**	**361,325**
Less - Donated Assets / Lottery grant assets	(28,138)	(28,477)
Less - Cash held at Government Banking Service	(64,890)	(64,712)
Net Relevant Assets	283,125	268,136
Average Net Relevant Assets	**275,631**	**279,187**
Dividend paid per Cash Flow statement	9,084	10,426
Dividend Debtor movement	632	(667)
Total Dividend paid and payable per Statement of Comprehensive Income	9,716	9,759
Percentage	**3.5%**	**3.5%**

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Quality Report 2011/2012

Incorporating the Department of Health requirements for the Quality Account

Contents

Foreword

This Quality Report details the quality improvement priorities taken forward during 2011/12 and describes the quality improvement priorities for the year ahead.

It also reviews the quality of services provided by the Trust, and includes comments from our main Commissioners (NHS Sheffield), Sheffield Local Involvement Network (LINk), Trust Governors, and the Sheffield Health and Community Care Scrutiny Committee for 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.

This year the Trust will produce a summary version of this document to make the report content more accessible for a wider audience. This will be available on the Trust website or from Sandi Carman (details below), and will be published in the Autumn.

It is hoped that this Quality Report tells you what you want to know about services provided by Sheffield Teaching Hospitals NHS Foundation Trust. We believe it will be of interest and value to patients and the public as well as to those who commission our services.

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
0114 2266489

PART 1

1.1 Statement on quality from the Chief Executive

I am delighted to introduce the Sheffield Teaching Hospitals NHS Foundation Trust Quality Report 2011-2012. This has been a significant year for the Trust as we became the provider organisation for Adult Community Services in the Sheffield area. This initiative complements the overall strategic direction of the Trust to bring about an integrated pathway of care for patients.

We have made significant progress over the year against our quality improvement priorities. Our successes include exceptionally low levels of MRSA blood stream infection, continued improvement in Stroke Care Services, and improvement in the diagnosis and treatment of venous thromboembolism.

I am also pleased to report we were awarded the Dr Foster Trust of the Year (North) in recognition of our record in delivering excellent clinical outcomes in a safe environment.

Despite the many successes during the year, there have been disappointments in some areas. Most notably we have had more cases in 2011/2012 of Clostridium Difficile than our challenging target. But we have been working hard to understand the nature of these infections to inform future actions and have seen a marked improvement in our Clostridium Difficile rates towards the end of the financial year.

During 2011/2012 we have worked hard to find new and better ways to involve front line clinical staff in improving services for patients. This Quality Report describes just some of these successes.

2012/2013 will continue to see a significant period of transition and challenge for the organisation. The Government has set out a National programme of financial reform for the NHS known as the Quality, Innovation, Productivity and Prevention (QIPP) initiative. This centres around developing new and innovative ways to provide the same service but with less resource whilst maintaining quality. Like all other NHS Trusts, Sheffield Teaching Hospital is now in the process of developing plans to address these challenges. Our Efficiency Programme will seek to minimise the impact on patients and staff. These are challenging times and we will work hard, through our efficiency programme, to fully engage our staff, patients, carers and the wider health and social care community to ensure that any changes have minimal impact on patients and staff and maintain the quality of our services.

As well as taking forward the quality improvement priorities detailed in this Quality Report, 2012 will see the launch of our new Corporate Strategy which sets the direction for the organisation for the next five years. The quality of our services over this period is paramount and therefore we have developed a supporting Quality Strategy to ensure that quality remains our top priority.

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

Sir Andrew Cash OBE
Chief Executive

1.2 Introduction from the Medical Director

This is the third year that the Trust has published a report about the quality of its service.

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of the care patients received during 2011/2012. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report we present here will give you confidence in our ability to deliver safe, effective and high quality care.

We have consulted widely on which quality improvement priorities we should adopt for 2012/2013 and hope that changes made to the report this year make it more informative and useful to the reader.

As with previous Quality Reports we have developed the quality improvement priorities in collaboration with representatives from NHS Sheffield, the Local Involvement Network (LINk) and Sheffield Health and Community Care Scrutiny Committee. This year the Trust has held five meetings with LINks representatives (Helen Rowe and Tony Whiting) from December 2011 - May 2012. This partnership approach has enabled feedback from LINks to be considered in the production of this Quality Report.

This work is overseen by the Quality Report Steering Group, whose membership includes Trust staff including managers and clinicians and Trust Governor representatives. To recognise the recent addition of Community Services the membership was reviewed to include a Community and Primary Care Services representative. All of the improvement priorities proposed apply equally to community and hospital based services.

The remit of the Steering Group is to decide on the content of the Quality Report and ensure the Trust's quality improvement priorities are practical and achievable and address key elements of quality including patient safety, the effectiveness of clinical treatment and the patient experience. Meeting the regulatory standards set out by the Department of Health and Monitor, the Independent Regulator for Foundation Trusts, also forms part of this Group's remit.

In the production of this report we have also taken into account the comments and opinions from internal and external parties on the 2010/2011 Quality Report. The proposed quality improvement priorities for 2012/2013 were agreed by the Trust Board of Directors on 24 May 2012. The final draft of the Quality Report was sent to external partner organisations for comments in April 2012 in readiness for the publishing deadline of the 31 May 2012.

Professor Mike Richmond
Medical Director

PART 2 Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

2.1.1 Priorities for Improvement 2011/2012 - Overview

Last year we set five priorities for improvement. Our focus on these priorities has delivered many improvements; these are summarised below and are explained further in this section

	Achieved	Almost Achieved	Behind Schedule
Priority 1 - Improving the Care Received by Older People Using Our Services			
Improve nutritional assessment and treatment			✗
Reduce pressure ulcers	✓		
Implement the dementia care pathway	✓		
Priority 2 - Improving the Diagnosis and Treatment of Venous Thromboembolism			
95% of patients who have been identified as being at risk of thromboembolism (VTE) to receive appropriate preventative treatment.		✓	
Priority 3 - Reducing Hospital Acquired Infection			
Monitor Methicillin Sensitive Staphylococcus Aureus (MSSA)	✓		
Reduce Methicillin-Resistant Staphylococcus Aureus (MRSA)	✓		
Reduce Clostridium Difficile cases			✗
Priority 4 - Continued Improvement in Stroke Care Services			
Appropriate treatment on Stroke Unit	✓		
Priority 5 - To Improve the Patient Experience by Reducing the Number of Operations Cancelled for Non-Clinical Reasons			
Reducing the number of operations cancelled for non clinical reasons			✗

2.1.2 Priority 1 - Improving the Care Received by Older People Using Our Services

Nutritional Assessment

Target

70% of patients aged 65 or over to be screened using the Malnutrition Universal Screening Tool (MUST) and 60% of those who are identified as being at risk to then receive a subsequent nutritional assessment (In-patient measure).

Outcome

40% of patients aged 65 or over received a Malnutrition Universal Screening Tool (MUST) screen on admission (Audit data: February 2012).

Of those aged 65 or over and identified as being at risk i.e. a MUST score of 2 or more, 67% went on to receive an appropriate care plan.

This unfortunately is a deterioration on the historical achievements for nutritional assessment, despite a focus on improvement.

The MUST screening tool is currently embedded in different places within the nursing documentation. This has recently been streamlined and can now only be found on the patients weight chart. The weight chart now encourages a review of the trend of weight as well as the MUST score and is easier to locate in the new core screening booklet. The core screening booklet is for all inpatients and contains all the necessary charts required for admission rather than individual pieces of paper. It was noted during analysis of the data that wards who piloted this new weight chart had higher completion rates for MUST.

The core screening booklet is currently being reviewed by the Nurse Directors for sign off prior to launch. Nurse Directors will also receive their audit results per directorate to disseminate to their clinical areas to encourage improvements. This audit will be repeated in the coming year.

This priority will continue to be monitored through the Trust's internal processes and improvement work undertaken until satisfactory performance is achieved.

Pressure Ulcers

Target

10% reduction in Grade 2 or above hospital acquired pressure ulcers.

Outcome

Having achieved a reduction in the number of hospital acquired Grade 2 or above pressure ulcers during 2011/12, the Trust will continue to take forward work in this area. Firstly, the Safety Thermometer, a safety measurement tool, which is being introduced nationally, will allow us to monitor the prevalence of pressure ulcers in our services as well as the incidence. Secondly, building on the integration of services following the merger with Community services the focus will broaden from those pressure ulcers which develop in hospital to those pressure ulcers which develop whilst patients are in the care of the Trust irrespective of the setting.

Hospital acquired pressure ulcers (Grade 2 or above)
2010/11 - 320 cases
2011/12 - 282 cases

Dementia Care Pathway

Target

Design and implement a new multi professional care pathway for patients with dementia and implement a dedicated training programme.

Outcome

During 2011 we produced an integrated multi professional care pathway for patients suffering with both dementia and delirium. The pathway incorporates best practice as published by the National Institute for Health and Clinical Excellence and is easily accessible to staff through the Trust intranet site. Implementation of the pathway commenced in December 2011 and will be implemented across the Trust over the coming year.

The pathway is supported by a dedicated training programme in dementia. The development of the programme has included collaboration with the University of Sheffield in order to run bespoke workshops for staff to enhance skills specific to their roles.

Over 150 front line staff have already accessed this course since January 2012 and more courses are planned.

Feedback from attendees has been very positive:

"This course enhanced my professional practice by encouraging me to consider my own practice when caring for patients with dementia; informing me of the care pathway for patients with dementia and also the assessment of delirium" (attendee January 2012).

"This course enhanced my professional practice by …. Making me see people with DEMENTIA as PEOPLE with dementia and helped me feel calmer about caring for patients and how to communicate more effectively and provide better care for them and their families" (attendee February 2012).

2.1.3 Priority 2 - Improving the Diagnosis and Treatment of Venous Thromboembolism (VTE)

Target
95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment.

Outcome
The Trust has made good progress in this area but did not quite achieve the target of 95% of patients as being at risk of venous thromboembolism (VTE) receiving appropriate preventative treatment.

The national Commissioning for Quality and Innovation (CQUIN) target for VTE risk assessment requires that at least 90% (93.4% achievements) of patients identified are assessed on admission to hospital for their risk of VTE. STHFT has achieved this target since February 2011.

A local VTE CQUIN target was agreed that audited a sample from four high-risk surgical areas (general/colorectal, orthopaedics, gynaecology and urology). To achieve the target, patients had to be risk assessed and receive appropriate preventative treatment. The target was 75% in October to December 2011 (Quarter 3), and 90% in January to April (Quarter 4). STHFT achieved both these of targets, with 78.25% and 90.25% overall respectively.

During July to December 2011 (Quarters 2 & 3) a Trust-wide audit was carried out of the NICE Quality Standards for VTE. Data was collected on 656 patients from over 50 wards. 534 patients (81%) were assessed to be at increased risk of VTE and 93.4% of those patients received appropriate preventative treatment. Action plans are currently being drawn up to improve compliance levels in those specialities that failed to meet the target. Future monitoring will be through the CQUIN target which will continue into 2012/13, and the Safety Thermometer (a safety measurement tool) which will assess whether at-risk patients are managed correctly.

Hospital acquired thrombosis (HAT) is defined as VTE occurring during a hospital admission or within 90 days of discharge. We are now undertaking root cause analysis (detailed investigation) of HAT to identify the lessons that can be learned and ways to further improve the care we provide to patients. An intranet website is also being developed so that staff can access all the information about VTE prevention and treatment in one central place.

This priority will continue to be monitored through the Trust's internal processes and improvement work undertaken until satisfactory performance is achieved.

2.1.4 Priority 3 - Reducing Hospital Acquired Infection

Methicillin Sensitive Staphylococcus Aureus (MSSA)

Target
To collect information on cases of Trust attributable MSSA bloodstream infections. Examine the information, devise methods of reducing the number of cases.

Outcome
Having collected data for just over a year the Trust is beginning to understand both the prevalence of MSSA bloodstream infections and the specialties with which these infections are most commonly associated. In the coming year work will be undertaken with these specialties aimed at reducing the incidence of MSSA bloodstream infections. The focus will vary depending on the specialty but there will be a particular focus on improving the care of intravenous lines which sit in a vein and reducing the potential for infections in surgical wounds.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

Target
To maintain or reduce the number of MRSA Trust attributable bloodstream infections when compared with 2010/2011 figures.

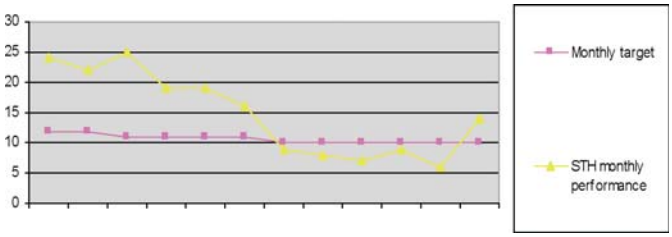
Outcome
The Trust has continued to reduce the numbers of MRSA bloodstream infections to a point where they are virtually eliminated. The challenge going into 2012/13 will be to maintain MRSA bloodstream infections at this low level. To achieve this, the focus will remain on screening and decolonising those patients who are found to be colonised with MRSA (have it on their skin).

MRSA Bloodstream Infections
2010/11 - 9 cases
2011/12 - 2 cases

Clostridium Difficile

Target
To achieve a year on year reduction in a number of cases for Trust attributable Clostridium Difficile.

Outcome
Although the Trust has achieved a year on year reduction in the number of cases of C.difficile, it was very disappointing not to have achieved the national target set by the Department of Health of 134 cases. In particular in the first half of the year the number of cases was higher than in previous years. The implementation of a comprehensive action plan with a particular focus on the deep cleaning of wards, supported by further investment helped to achieve a significant reduction in the number of cases of C.difficile the Trust recorded each month.



Based on the performance that has been achieved in the second half of the year, 53 cases of C.difficile, the Trust is confident that the target of 134 will be achieved in 2012/13, by continuing to implement the strategies which have proved to be successful during 2011/12.

2.1.5 Priority 4 - Continued Improvement in Stroke Care Services

Target
To ensure that over 80% of patients spend at least 90% of their time on the Stroke Unit and that high risk Transient Ischaemic Attacks (TIAs) are assessed and investigated within 24 hours.

Outcome
91% of patients spent at least 90% of their time on the stroke unit. 100% of high risk TIAs were assessed and investigated within 24 hours.

2.1.6 Priority 5 - To Improve the Patient Experience by Reducing the Number of Operations Cancelled for Non-Clinical Reasons

Target
768 cancellations or fewer in 2011/2012

Outcome
During 2011/12 the Trust cancelled 1106 operations on the day of surgery.

Unfortunately we have not met the target this year as a result of the pressures from emergency admissions. Emergency workload is unpredictable and the number of beds which are available each morning can change very quickly.

This may mean that late cancellations then take place if the bed is required for an emergency admission.

At very busy times this maximises the number of patients who have their procedure as planned and patients are advised that this may be the case. To ensure that the number of on day cancellation is reduced in January 2012 we transferred 28 orthopaedic elective beds to the Royal Hallamshire site as this site is not as significantly affected by emergency workloads. We will continue to monitor this through the Trust's Performance Management systems.

This priority will continue to be monitored through the Trust's internal processes and improvement work undertaken until satisfactory performance is achieved

Year	Cancelled Operations
2008/2009	879
2009/2010	690
2010/2011	768
2011/2012	1106

2.1.7 Priorities for Improvement 2012/2013

This section describes the Quality Improvement Priorities that have been adopted for 2012/2013. These have been agreed by the Quality Report Steering Group after discussion with patients, clinicians, Trust Governors, LINk representatives, Overview and Scrutiny Committee and our Commissioners. These were approved by the Trust Board of Directors on 24 May 2012. The Trust has compared hospital and community service priorities for the coming year choosing five areas to focus on which span the domains of clinical effectiveness, patient experience, patient safety and quality: holistic care.

These local priorities reflect issues high on the national agenda. In addition to these priorities for improvement there are many quality improvement proposals in the new Quality Strategy and the CQUIN Programme.

Priorities for 2012/2013 Quality Report are:

Clinical Effectiveness - reduced length of stay

1. **Optimise Length of stay**
   Through a systematic process of review identify areas for improvement in length of stay across the organisation. Establish improvement plans to achieve necessary reductions in length of stay compared to national benchmarks (Dr Foster Benchmark comparators).

Patient Experience - communicate better

2. **Discharge Letters for GPs**
   Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by improvement activities at Directorate and Trust level.

Patient Experience - Listening to Patients

3. **Giving patients a voice - Make it easier to communicate with the organisation**
   Making what we've got work well - to improve the response rate by 20% for frequent feedback forms and 50% comments cards. By promoting the processes and demonstrating effectiveness, for example through case studies and actively communicating feedback (e.g. you said - we did).

Safety - deliver harm free care

4. **Review Mortality rates at the weekend**
   Review in detail the Trust's position with regards to Mortality at the weekend and identify any significant differences, review causes and implement improvements as required.

Quality: Holistic Care - to promote a good experience for patients who have dementia

5. **Improve Dementia Awareness**
   Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Link to the Kings Fund Environmental Assessment Tool and ward essential maintenance programme).

2.1.8 Detailed Objectives Linked to Improvement Priorities

Priority 1
Clinical Effectiveness – optimising length of stay

<table>
<tr><td>Our Aim</td><td>Through a systematic process of review identify areas for improvement in length of stay across the organisation. Establish improvement plans to achieve necessary reductions in length of stay compared to national benchmarks (Dr Foster Benchmark comparators)</td></tr>
<tr><td>Past Performance</td><td>It is not in the best interest for patients to spend longer in hospital than necessary, especially for older people as they may be more prone to infection and loss of mobility and independence. It is also important that the Trust makes the most efficient use of its beds and other resources to ensure we can meet the needs of the sickest patients.

Measurement of length of stay can be undertaken in a number of different ways. We will review the most appropriate measurement tools over the duration of this project.

For the purpose of this report we have used 'spells' to measure performance. A 'spell' can be classed as an episode of inpatient care but may involve different clinical teams and treating consultants.

Although average length of stay is decreasing, we are aware that this can hide local variation in performance, this project aims to reduce this variation.

<table><tr><th>Financial Year</th><th>Average Spell LOS</th></tr><tr><td>2009/10</td><td>3.2 days</td></tr><tr><td>2010/11</td><td>3.1 days</td></tr><tr><td>2011/12</td><td>2.9 days</td></tr></table></td></tr>
<tr><td>Key Objectives</td><td>To provide on a regular basis timely information to each clinical area to help understand length of stay at a speciality level and support the speciality teams to identify opportunities for improvement.

Provide speciality level benchmark information to support performance improvement.

As required identify areas for improvement and put in place clear, measurable improvement plans.

Review lessons learnt from the ongoing Geriatric Stroke Medicine improvement work on patient flow and length of stay to assess the degree to which the learning can be spread to help improve other areas of the organisation.

Implement speciality specific projects such as enhanced recovery in surgery.

Through the ‘Right First Time’ improvement initiatives continue to work jointly with Trust partners to ensure effective discharge planning for patients.</td></tr>
<tr><td>Measurement and Reporting</td><td>Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2012/13</td></tr>
<tr><td>Board Sponsor</td><td>Professor Mike Richmond, Medical Director</td></tr>
<tr><td>Implementation lead</td><td>Dr Tom Downes, Clinical Lead for Quality Improvement, and Suzie Bailey, Service Improvement Director</td></tr>
</table>

Priority 2
Patient Experience - communicate better

Our Aim	**Improve the quality of immediate discharge letters sent to GPs by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by improvement activities at Directorate and Trust level.**
Past Performance	The quality of immediate discharge notes is variable, and has been a cause for complaints from some General Practitioners. No formal audit of the quality of these documents has previously been made across the Trust. Some areas of the Trust have progressed to electronic discharge summaries. This has assisted in improving the quality, however this is not consistent across the whole organisation.
Key Objectives	To formally audit the proportion of discharge notes sent to General Practitioners which: 1. Are clearly legible 2. State a clear diagnosis 3. Identify the Consultant responsible for the patient's care 4. Set out follow-up arrangements and clearly explain any actions required by the General Practitioner after discharge 5. Include a complete, legible and accurate drug list 6. Completed by an appropriate clinician And where necessary to draw up an action plan to address areas of poor performance identified by the audit.
Measurement and Reporting	An audit, in each clinical directorate will take place during April - June 2012, followed by the drawing up of action plans to address areas of poor performance in July - September. Performance will be re-audited in October - December (Quarter three) and January - March (Quarter four). Final outcomes will be reported in the Quality Report 2012/13.
Board Sponsor	Professor Mike Richmond, Medical Director
Implementation lead	Dr David Throssell, Deputy Medical Director

Priority 3
Patient Experience - Listening to patients

<table>
<tr><td>Our Aim</td><td>Making what we've got work well. To improve the response rate by 20% for frequent feedback forms and 50% for comments cards. By promoting the processes and demonstrating effectiveness. For example through case studies and actively communicating feedback (e.g. you said we did).</td></tr>
<tr><td>Past Performance</td><td>The following table summarises recent responses to requests for feedback
<table>
<tr><th></th><th>2010/11</th><th>2011/12</th></tr>
<tr><td>Comment cards</td><td>434</td><td>575</td></tr>
<tr><td>Website comments</td><td>170</td><td>185</td></tr>
<tr><td>Picker patient survey responses</td><td>Not available</td><td>2480</td></tr>
</table>
However, these are relatively small numbers considering the volume of activity undertaken by the Trust.</td></tr>
<tr><td>Key Objectives</td><td>To offer a broad range of methods to capture patient feedback e.g. surveys, complaints and websites.

To provide directorates with rich and meaningful patient experience data at ward and department level.

To identify trends and themes in patient feedback.

To make service improvements based on feedback from patients.</td></tr>
<tr><td>Measurement and Reporting</td><td>Monthly complaints and feedback reports.

Monthly update reports on Picker Frequent Feedback results.

Quarterly Trust Wide Patient Experience Reports.

Final outcomes will be reported in the Quality Report 2012/13.</td></tr>
<tr><td>Board Sponsor</td><td>Professor Hilary Chapman, Chief Nurse/Chief Operating Officer</td></tr>
<tr><td>Implementation lead</td><td>Chris Morley, Deputy Chief Nurse.</td></tr>
</table>

Priority 4
Safety - deliver harm free care

<table>
<tr><td>Our Aim</td><td>Review in detail the Trust's position with regards to Mortality at the weekend and identify any significant differences, review causes and implement improvements as required</td></tr>
<tr><td>Past Performance</td><td>The Trust's mortality rates are good and we have recently introduced Hospital at Night to further improve care out of hours. However, this is an important area of interest for our patients and their families and therefore is a priority this year.

<table><tr><th></th><th>2010/11</th><th>2011/12</th></tr><tr><td>Hospitals Standardised Mortality Ratio</td><td>91</td><td>98</td></tr><tr><td>Standardised Hospital Mortality Indicator</td><td>86</td><td>87</td></tr><tr><td>National average</td><td>100</td><td>100</td></tr></table>
Although the Trust has historically very good performance in this area it is important to understand any variation linked to weekend activity.</td></tr>
<tr><td>Key Objectives</td><td>The Trust will establish four projects linked to reducing mortality and morbidity

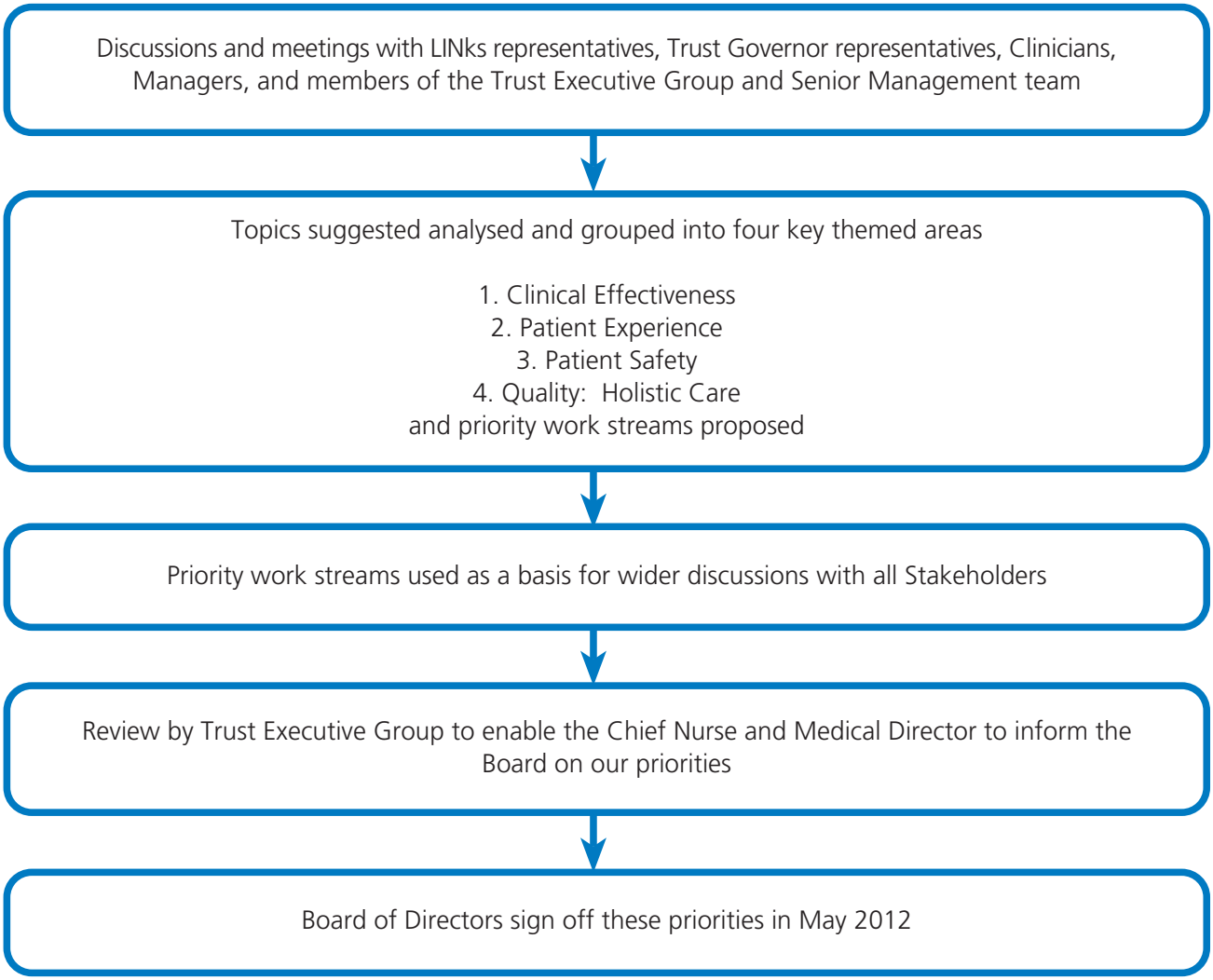
1. Enhancing 24/7 services
2. Review systems for measurements
3. Reducing harm
4. Promoting excellence in End of Life Care

Throughout this work the Trust will look specifically at mortality rates for weekend admissions and discharges to identify and address any areas for improvement.</td></tr>
<tr><td>Measurement and Reporting</td><td>Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2012/13</td></tr>
<tr><td>Board Sponsor</td><td>Professor Mike Richmond, Medical Director</td></tr>
<tr><td>Implementation lead</td><td>Dr Andrew Gibson, Deputy Medical Director and Dr Des Breen, Associate Medical Director</td></tr>
</table>

Priority 5
Quality - promoting a good experience for patients who have dementia

Our Aim	**Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Linked to the Kings Fund Environmental Assessment Tool and the ward essential maintenance programme)**
Past Performance	Historically the Trust has not specifically considered the needs of Dementia Patients when undertaking refurbishment plans.
Key Objectives	When undertaking essential maintenance or ward development schemes ensure the work is influenced by best practice identified from the Kings Fund Dementia environmental audit. Develop a model ward (Brearley 7). This will be used as an exemplar of good practice for other sites. Actively promote attendance on the Dementia Care training courses. Continue to embed the roll out of the dementia care pathway and review compliance across the Trust.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2012/13
Board Sponsor	Professor Mike Richmond, Medical Director
Implementation lead	Dr Rob Ghosh, Dementia Lead and Consultant Physician and Geriatrician and Chris Morley, Deputy Chief Nurse

2.1.9 How did we choose these priorities?



Equality Diversity and Human Rights

The Trust considers equality, diversity and human rights in every aspect of what it does and regards the components of equality, diversity and human rights as essential when considering delivery of high quality service.

Under Equality legislation the Trust must develop Equality Objectives; these have recently been published by the Trust. The Quality Report priorities complement these Equality Objectives and also support the Trust's aim to promote equal access and experience for all patients.

Reducing length of stay is informed by the Trust Equality Objectives, one of which is to consider information about length of stay and examine if length of stay is influenced by aspects such as age, sex or ethnicity.

When implementing priority three, listening to patients, it will be important to consider the diversity of the communities in Sheffield and surrounding areas and to ensure that patient feedback reflects this diversity. It will also be important to ensure that patients have equal access to the systems the Trust uses to gain feedback.

Priority five, promoting a good experience for those with dementia, directly supports the principle of ensuring equal access to Trust services and considering the experience of services which patients who have disabilities associated with dementia. Again this priority supports the Trusts overall intention to promote equality and to celebrate and respond to diversity.

2.2 Statements of Assurance from the Board

This section contains formal statements from the following services delivered by Sheffield Teaching Hospitals NHS Foundation Trust.

a) Services provided
b) Clinical Audit
c) Clinical Research
d) CQUINs framework
e) Care Quality Commission
f) Data Quality
g) Patient Safety Alerts
h) Annual Staff Survey
i) Annual Patient Survey (in-patient and outpatient)
j) Complaints
k) Eliminating mixed sex accommodation
l) Coroners Rule 43 letter

For the first six sections (a - f) the wording of these statements and the information required are set by Monitor and the Department of Health. This enables the reader to make a direct comparison between different Trusts for these particular services and standards.

a. SERVICES PROVIDED

During 2011/12 Sheffield Teaching Hospitals NHS Foundation Trust provided both core and sub-contracted general hospital services locally, tertiary services regionally and specialist services nationally. Sheffield Teaching Hospitals 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 2011/2012 represents 100% of the total income generated from the provision of NHS services by Sheffield Teaching Hospitals for 2011/12.

b. CLINICAL AUDIT

During 2011/12, 40 national clinical audits and 2 national confidential enquiries covered NHS services that Sheffield Teaching Hospitals provides. During that period Sheffield Teaching Hospitals participated in 37 (93%) national clinical audits and 2 (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 2011/12 are shown in Table 1 as follows:

Audits & Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Perinatal mortality and Neonatal (CMACE)	Yes	100% (89/89)
Neonatal intensive and special care (NNAP)	Yes	100% (864/864)
Children		
British Thoracic Society: Paediatric pneumonia	N/A	
British Thoracic Society: Paediatric asthma	N/A	
College of Emergency Medicine: Paediatric fever	N/A	
RCHP Childhood epilepsy	N/A	
PICANet: Paediatric intensive care	N/A	
Congenital Heart Disease: paediatric cardiac surgery (adult)	Yes	100% (30/30)*
RCPH: Diabetes	N/A	
Acute Care		
British Thoracic Society: emergency use of oxygen	Yes	100% (47/47)
British Thoracic Society: Adult community acquired pneumonia	Yes	100% (27/27)
British Thoracic Society: Non invasive ventilation (NIV) - adults	Yes	100% (30/30)
British Thoracic Society: pleural procedures	Yes	100% (55/51)
ICNARC NCAA: Cardiac Arrest	No	See statement
College of Emergency Medicine: Severe Sepsis & Septic Shock	Yes	100% (30/30)
ICNARC CMPD: Adult critical care units	Yes	100% (1400/1400)
NHS Blood & Transplant: potential donor audit	Yes	100% (298/298)
National Audit of Seizure Management	No	See statement
Long Term Conditions		
Diabetes: National Diabetes Audit	Yes	97% (5285/5424)
National Inflammatory Bowel Disease: Ulcerative Colitis & Crohns Diseases	Yes	100% (40/40)
Parkinson's UK: National Parkinson's Audit	Yes	100% (41/40)
British Thoracic Society: adult asthma	Yes	100% (39/20)
British Thoracic Society: Bronchiectasis	Yes	100% (36/20)
Elective Procedures		
NJR: hip and knee replacements	Yes	77% (1125/1467)*
NHS Blood & Transplant: intra-thoracic transplants	Yes	100% (95/95)
Liver Transplant (NHSBT UK Transplant Registry)	N/A	
NIAP: Adult cardiac interventions: coronary angioplasty	Yes	100% (1550/1550)*
National Vascular Database: peripheral vascular surgery	Yes	48% (215/446)*
Carotid interventions	Yes	86% (63/73)*
Adult cardiac surgery: CABG and valvular surgery	Yes	100% (875/875)*

Audits & Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Cardiovascular Disease		
MINAP : AMI & other ACS	Yes	100% (1450/1450)*
Heart Failure Audit	Yes	63% (475/760)*
Pulmonary Hypertension Audit	Yes	100% (1140/1140)*
SINAP: acute stroke	Yes	91% (898/989)
Cardiac Rhythm Management	Yes	100% (1000/1000)*
Renal disease		
Renal Registry: renal replacement therapy	Yes	100% (646/646)
NHSBT UK registry: Renal Transplant	Yes	100% (57/57)
Cancer		
NLCA: lung cancer	Yes	93% (444/480)
NBOCAP: bowel cancer	Yes	98% (315/320)*
DAHNO: head and neck cancer	Yes	(143)**
NOGCA: Oesophago-gastric cancer audit	Yes	70% (128/184)
Trauma		
NHFD: hip fracture	Yes	87% (584/670)
TARN: severe trauma	Yes	42% (256/612)*
Psychological conditions		
POMH: Prescribing in mental health services	N/A	
NAS: National Audit of Schizophrenia	N/A	
Blood transfusion		
National Comparative Audit of Blood Transfusion: Bedside Transfusion	Yes	100% (130/130)*
National Comparative Audit of Blood Transfusion: Medical Use of Blood	Yes	100% (163/163)*
Health Promotion		
National Health Promotion in Hospitals Audit: Risk Factors	No	See statement
End of Life		
NCDAH: Care of dying in hospital	Yes	98% (59/60)
NCEPOD	Yes	91% (29/32)

Please note the following:

Data for projects marked with an asterisk requires 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.

**DAHNO: NHS Information Centre is unable to provide information on numbers of eligible patients until publication of the Report in June 2012.

Supporting Statements:

ICNARC NCAA: Cardiac Arrest:
The Trust did not participate in the National Cardiac Arrest Audit because the Trust Resuscitation Committee decided that, although it would be desirable to contribute to the national audit, resources were already allocated to other resuscitation priorities. The Trust is currently considering the implications of involvement in the audit for 2012/13.

National Health Promotion in Hospitals Audit: Risk Factors:
The Trust did not participate in the National Health Promotion in Hospitals Audit: Risk Factors due to resources at the time of recruitment (February 2011). The Trust is currently considering the implications of involvement in the audit for 2012/13.

National Audit of Seizure Management:
The Trust did not participate in the National Audit of Seizure Management due to resources at the period of time for measurement

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals participated in, and for which data collection was completed during 2011/12, are listed above in Table 1 alongside the number of cases submitted to each audit or enquiry at a percentage of a number of registered cases required by the terms of that audit or enquiry.

The reports of 35 national clinical audits were reviewed by the Trust in 2011/12, 13 of these reports were reviewed by Committees of the Board and 35 reviewed by Senior Teams in clinical areas. Sheffield Teaching Hospitals intends to take a number of actions to improve the quality of healthcare provided, some the examples of which are included below.

The reports of 57 local clinical audits were reviewed by the provider in 2011/12 and Sheffield Teaching Hospitals intends to take a number of actions to address the outcomes, examples of which are included below

MINAP (Myocardial Ischaemia National Audit Project)
A myocardial infarction (MI), or heart attack, occurs when a coronary artery suddenly becomes blocked or at least partially blocked by a blood clot, causing some of the heart muscle being supplied by that artery to become infarcted (that is, to die). Heart attacks are divided into two types, according to their severity and associated Echo-Cardiograph (ECG) changes, non-ST elevation MI (NSTEMI) and ST elevation MI (STEMI). The latter is usually the more severe type.

Centres were initially invited to participate in MINAP on a voluntary basis and STH were in the first cohort of participants. It then became incorporated into the National Service Framework for Coronary Heart Disease, issued in 2000 and participation / performance measured against national targets.

For the last 10 years MINAP has presented a report for the general public on the performance of hospitals, ambulance services and cardiac networks in England and Wales on the care of patients with myocardial infarction (heart attack).

The Tenth Report, published on 1 September 2011 included analyses of performance for Sheffield Teaching Hospitals (NGH site) between April 2010 and March 2011 as compared against nationally and internationally agreed standards.

The aim of MINAP is to provide comparative data to help clinicians and managers monitor and improve the quality and outcomes of their local services so that they match the best in the World.

Data is collected on all eligible patients and entered electronically into the Central Cardiac Audit Database (CCAD). Reports can be generated internally by authorised users to assess data completeness and performance against targets. This is a continuous audit i.e. data collection is on an ongoing basis. A data validation study is carried out by MINAP each January to test data quality and the results of this plus data

completeness and performance are reported to the Care Quality Commission and shown in the Quality and Risk Profile for the Trust.

Our results show that we are achieving the national target of 75% for Primary Percutaneous Coronary Intervention (pPCI) within 150 minutes of calling for help. This is a surgical procedure used for the treatment of Myocardial Infarction. There are no other specific targets, though we are close to the national average for all other criteria measured. STHFT also performs well on prescribing of secondary prevention discharge medication to reduce the risk of death and further heart attack at approximately 99% compared with a national target of 90%.

National Hip Fracture Database

The National Hip Fracture Database is a clinically led web based audit of hip fracture care and secondary prevention. The key standards measured in the audit are based on the Blue Book (British Orthopaedic Association: The care of patients with fragility fracture) and includes prompt admission to orthopaedic care; surgery within 48 hours; nursing care aimed at minimising the development of pressure ulcers; routine access to ortho-geriatric medical care; assessment and appropriate treatment to promote bone health; and falls assessment.

A minimum data set is routinely entered for patients admitted to the trust with a fractured neck of femur with data analysis provided by the national team. The 2011 National Report was based on patients admitted from the 1 April 2010 to 31 March 2011.

The results show that for the majority of standards we are in line with or above the national average e.g. the Trust is 10th in the country (176 hospitals meeting case threshold of 100) for surgery within 36 hours, 96% have surgery within 48 hours (national average 86%).

To continue to improve care for this group of patients a dedicated hip fracture ward was opened in November 2011 and a specialist nurse will be appointed in April 2012 to further improve practice in line with key standards, including minimising the risk of developing pressure ulcers.

National Lung Cancer Audit (NLCA)

The purpose of this national audit is to improve outcomes for people diagnosed with lung cancer and mesothelioma. This is achieved by attaining a better understanding of care delivered during referral, diagnosis and care.

Data is collected continuously with national reports published annually. The 2011 report covers patients first seen in the calendar year 2010.

As part of the governments commitment to transparency and open data (July 2011), clinical audit data, will be available on the data.gov.uk website from national audits included in the National Clinical Audit and Patient Outcomes Programme, for reports published from April 2012. The NLCA was a pilot for this type of data release in December 2011.

A variety of data was published including case mix adjusted results for four key outcome measures for patients diagnosed with lung cancer:

- proportion of patients receiving active treatment (surgery, chemotherapy or radiotherapy)
- proportion of patients with histologically confirmed non small cell lung cancer receiving surgery,
- proportion of patients with small cell lung cancer receiving chemotherapy
- median survival for patients diagnosed with lung cancer.

Sheffield Teaching Hospital's performance was better than comparator trusts for small cell lung cancer receiving chemotherapy and in line with comparator trusts for the other three measures.

The other notable result is that Sheffield Teaching Hospitals now delivers a median survival that is not statistically different from comparator trusts which represents a major improvement over the last 12 years.

Respiratory Mental Health: Referrer Satisfaction

The Respiratory Mental Health Team (RMHT) offers assessment and treatment for people who are experiencing co-existing mental health problems (mainly anxiety and depression) and chronic respiratory illness.

The team consists of mental health nurses and occupational therapists, who work within primary care in order to reduce psychological distress, improve self-management, maximise quality of life and reduce the number of unplanned hospital admissions.

The audit was undertaken to identify whether the team is meeting quality of service standards. It was also an opportunity to collate qualitative information about the service.

Recommendations

The following recommendations are made as a result of the audit:

Recommendation	Action
1. Communication improvements:	1.1. All referrers without access to SystmOne will receive a letter confirming that their referral has been received and processed. 1.2. All involved Healthcare Professionals (HCPs) without access to SystmOne will receive a summary of the RMHT assessment and a brief summary of the plan of care. 1.3. All involved HCPs will receive a discharge summary. 1.4. A member of the RMHT will attend the respiratory team meetings held within primary and secondary care to improve communication and collaborative working across the respiratory services. 1.5. Members of the RMHT will attend Case Management meetings at regular intervals in order to improve communication. 1.6. The RMHT will "advertise" its services to GP practices.
2. The RMHT will offer training to referrers. Including: identifying mental health problems, standardised assessments, and how to provide basic self-help material.	
3. The team will continue to discuss service needs with senior management and the business case for expanding the team to meet demand	
4. A brief summary of this audit has been produced and made available to all HCPs referring to the service and to GP practices across Sheffield to raise awareness.	

Conclusion

The audit has identified that the main area for improvement is communication. From September 2011 the RMHT is using SystmOne (Primary Care and Community patient record system) and therefore some areas where improved communication is needed will be addressed. A significant number of recommendations are being made to improve communication and partnership working.

Audit compliance with NICE TA 133 Omalizumab for severe persistent allergic asthma

The aim of the audit is to assist Sheffield Teaching Hospitals Foundation Trust (STHFT) to determine whether the service is implementing, and is in compliance with, the NICE technology appraisal Omalizumab for severe persistent allergic asthma.

Recommendation	Action
Improve documentation, in particular: drug history, smoking history and drug compliance	Production of an Omalizumab prescription protocol sheet to allow for clear documentation of all NICE criteria in patients' notes
Improve communication between treating clinicians.	A checklist for this will be incorporated into the above protocol sheet.

Conclusion

The severe asthma service within the Sheffield Teaching Hospitals is compliant with the most recent NICE guidance for Omalizumab, as interpreted locally. Areas for improvement involve clearer documentation of previous drug history and compliance, for which a specific protocol sheet will be designed. A re-audit is recommended in 1-3 years.

The Diagnosis and Management of DKA

Diabetic ketoacidosis (DKA) is a life-threatening but easily manageable condition if detected and treated quickly and appropriately.

Sheffield Teaching Hospitals has developed an evidence based guideline for the management of DKA. This requires a proforma to be filled in which details management such as fluid, insulin and electrolyte initiation and provides guidance criteria for referral to critical care.

The aim of the audit was to review the care provided to patients who have diabetic ketoacidosis.

Recommendation	Action
Patient education about diabetes and DKA	Production and distribution of patient information leaflet to the patient's home.
GP notification of DKA event	Automatic letter to GP advising appointment for diabetes education with recommendations about 'sick day rules' - when to contact healthcare professionals, Blood Glucose (BG) goals and use of supplemental short-acting insulin during illness, means to suppress fever and treat infection, initiation of liquid diet containing carbohydrates and salt, continue insulin medication.
Early nurse review, urgent doctor review	Nurse review should incorporate BG and urinalysis, if positive, urgent review by doctor.
Appropriate critical care referral	Ensure patients that meet HDU/ITU criteria are referred/reviewed.
Record of biochemical markers with fluid prescription	Document last BG and potassium result next to each prescription of fluid on the sliding scale.
Appropriate monitoring of biochemical markers after initiating treatment	Ensure urea and electrolytes (UE) results two hours post-initiation of treatment are handed over and documented.
Modification of existing proforma	Incorporate a checklist of the above into the DKA proforma.
Ensure adherence to standards is improving	Re-audit in one year.

Conclusion

DKA is a life-threatening condition which needs swift treatment to avoid mortality. We recommend better patient education, early nursing review of key parameters followed by urgent review by doctors, appropriate referral to critical care, careful monitoring of biochemical parameters after initiation of treatment, and a re-audit in one year.

c. CLINICAL RESEARCH

The number of patients receiving NHS services provided or sub-contracted by Sheffield Teaching Hospitals in 2011/2012 that were recruited during that period to participate in research approved by a Research Ethics Committee was 6646 (2010/11 – 8865)

d. CQUIN FRAMEWORK

A proportion of Sheffield Teaching Hospitals income in 2011/2012 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/2012 and for the following 12 month period are available on line at link or from the contact details at the beginning of this report.

In 2011/12 1.5% of our contractual income (£10.1 million) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield.

e. CARE QUALITY COMMISSION

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 2011 - 31 March 2012. Sheffield Teaching Hospitals has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12.

i. Jessop Wing responsive visit

The CQC undertook a responsive review on 25 October 2011 to follow up various improvements identified by the Trust in our response to previous maternity outlier alerts issued by the CQC surveillance team. The maternity outlier alerts related to emergency caesarean section and neonatal readmissions rates. The inspection was undertaken as the CQC wished to review the Trust's compliance with:

- Outcome 4: Care and welfare of people who use services
- Outcome 14: Supporting staff
- Outcome 16: Assessing and monitoring the quality of service provision
- Outcome 21: Records

No gaps in assurance or areas of concern were identified during the assessment.

ii. Accident and Emergency review visit

The CQC carried out an unannounced Themed Inspection at A & E on 5 January 2012. The inspection focused on Outcome 13 (Staffing) and Outcome 4 (Care and welfare of people who use services). The Inspector found the Trust to be compliant with the standards and no areas of concern were identified.

iii. Termination of Pregnancy visit

CQC conducted an unannounced Themed Review of the Termination of Pregnancy regulated activity at the Royal Hallamshire Hospital on 21 March 2012. No concerns were raised.

Sheffield Teaching Hospitals has implemented a Compliance Framework designed to provide a mechanism to monitor compliance with the 16 Essential Standards of quality and safety defined by the Care Quality Commission.

f. DATA QUALITY

Sheffield Teaching Hospitals submitted records during 2011/2012 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which were included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was

99.8% for admitted patient care
99.7% for outpatient care
98.3% for Accident and Emergency care

(This position remains similar to last years performance, which compares well to national benchmarking).

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

100% for admitted patient care
100% for outpatient care
100% Accident and Emergency care

Sheffield Teaching Hospitals Information Governance Assessment Report overall score 2011/2012 was 71% and was graded green.

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

1. Continue to feedback to directorates errors for incorrect GPs noted in medical records.
2. Explore establishing a process for updating the master index with information on the patient's GP's taken from the National Summary Care Record
3. Hold individual meetings with directorates to reinforce/clarify the correct recording of activity
4. Run directorate specific training sessions on recording of the 18 week pathway information
5. Review all local policies for clinical coding to ensure these comply with national guidance
6. Formalise the audit programme for clinical coding
7. Re issue guidance on the recording of outpatient activity following agreements reached with NHS Sheffield.

The Data Quality Group has become well established during 2011/12 and has instituted a number of changes to the management of data quality issues. The majority of data error reports are now provided electronically on the Information Services Website and can be easily accessed by users.

The responsibility for correcting errors has been passed to directorates with the data quality leads for each area having an overview of the issues and responsibility for ensuring that errors are corrected. A series of training sessions had been held with individual groups of staff to resolve any issues they have. This is an on going process and will continue in 2012/13. Also, the clinical audit department now has an auditor who is carrying out a rolling programme of audits across all the specialties. The department also now has a qualified clinical coding trainer who is carrying out refresher training.

Sheffield Teaching Hospitals was subject to a payment by results clinical coding audit during the reporting period by the Audit Commission and the error rate reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

14.0% primary diagnosis incorrect
6.9% secondary diagnosis incorrect
7.0% primary procedures incorrect
6.3% secondary procedure incorrect

(This position has improved since last year, national data is not yet available for comparison).

The results should not be extrapolated further than the actual sample audited. Areas audited were Cardiology, General Surgery, Chest Medicine, Obstetrics, Plastics, Ophthalmology, Gastroenterology, Gynaecology and Rheumatology.

The following paragraphs and information are included as a response to feedback from LINk's representatives, the Trust's External Auditors and senior staff suggestions.

g. PATIENT SAFETY ALERTS

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this data to produce alerts aimed at improving patient safety. Tables 1 and 2 below detail the Alerts and Rapid Response Reports which have been received and acted upon during the year 2011/12.

TABLE 1: Alerts completed and closed during 2011/12

NPSA Ref	National Patient Safety Authority - Alert Title
2010/PSA014	Reducing treatment dose errors with low molecular weight heparins
2010/PSA001	Safer use of intravenous gentamicin for neonates
2010/RRR009	Reducing harm from omitted and delayed medicines in hospital
2010/RRR015	Prevention of over infusion of intravenous fluid and medicines in neonates.
2010/RRR016	Laparoscopic surgery: Failure to recognise post-operative deterioration
2010/RRR017	The Transfusion of blood and Blood Components in an Emergency
2010/RRR018	Preventing fatalities from Medication Loading Doses
2010/RRR019	Safer ambulatory syringe drivers
2011/RRR001	Essential care After an Inpatient Fall
2011/PSA002	Reducing the Harm Caused by Misplaced Nasogastric Feeding Tubes
2011/RRR002	Keeping newborn babies with a family history of Medium Chain Acyl Dehydrogenase Deficiency (MCADD) safe in the first few hours and days of its life.

TABLE 2: Outstanding alerts to be completed during 2012/13

NPSA Ref	NPSA Title	NPSA Deadline
2009/PSA004A + 2011/PSA001 (updated alert)	Safer spinal (intrathecal), epidural and regional devices Action: Trials are currently taking place with equipment which fulfils the requirements of the alert prior to order being placed and the alert being closed	1/4/12 31/3/12
2011/RRR003	Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors This alert has arisen following the implementation of 2009/PSA004A (above) in other Trusts. The approach taken at STH will ensure that this type of incident does not arise as it is being coordinated within the previous alert. In response to NPSA Alert 2011/PSA001 (and 2009/PSA004A) a number of manufacturers placed devices on the market with non luer lock connections to reduce the risk of wrong route errors. In some hospitals equipment has been supplied with incompatible connectors. The approach taken within STHFT is to purchase one connector for use throughout the Trust which will eliminate this risk. Trials of the preferred connector are due to be completed in mid April 2012 for full implementation at the end of the month. Whilst this will eliminate the risk the completed action will be shortly after the deadline. Analysis of the 'Central Alert System' has shown that many other Trusts will not be able to achieve the deadline for similar reasons. In response the NPSA have indicated that the target will remain unchanged but Trusts should add the issue to their Risk Register until compliance is achieved.	

h. ANNUAL STAFF SURVEY

Staff Engagement

The Trust recognises the importance of staff engagement to both productivity and good patient care. During 2011 a Staff Engagement Steering Group chaired by the Chief Executive was established to oversee the implementation of the staff engagement strategy. This included monitoring progress on the three workstreams which are integral to effective staff engagement i.e. Health and Wellbeing, the Staff Journey (experience) and Staff Involvement.

In addition the 'Let's talk?' communication events, started on a Trust wide basis during 2009, have been held in some directorates and work is ongoing to address the issues raised via these and the staff survey.

"a very productive session- everyone given the opportunity to have an input" Obstetrics and Gynaecology Nurse

"good to meet colleagues from other part of the directorate and share views –nice to feel opinion valued" Human Resources staff member

"Good informative session –thought provoking. Will be interesting to see if anything changes" Biomedical Scientist

Health and Wellbeing

The inaugural Health and Wellbeing festival was held during the summer of 2011 which gave staff the opportunity to access a variety of information and advice to help improve their health and wellbeing. This was much appreciated by staff and was followed by a 'Shortest Day' festival in December. Feedback has actively been sought from staff to identify what health and wellbeing support they would like to see provided as a result of this more exercise classes are now available on site and local diet classes will be commencing shortly. Plans are already afoot for another festival for a 'Longest day' in June.

A joint Sheffield Hallam University/STHFT research study for providing staff health checks is currently being piloted which has been nominated for an award in the annual 2012 British Medical Journal awards. A fast track musculoskeletal service for staff is being piloted in the Jessop Wing during 2012 and there are also plans to improve the mental health services available for staff.

Staff experience

This group has sought staff views on what makes staff feel valued and was actively involved in the development of the simplified appraisal system introduced in the Trust in June 2011 which has resulted in more staff having an annual appraisal. A values and behaviourally based appraisal system is being introduced in the Trust in 2012, initially for senior leaders. All staff were asked for their feedback on the potential values to be adopted via an electronic survey. Almost 3,000 staff, approximately 1/5 of the workforce, responded and these views were taken into consideration prior to the adoption.

Staff involvement

A consultation exercise was undertaken with over 600 consultants in the trust to identify how the Trust could improve communication and engagement with Consultants particularly with a view to increased participation in corporate issues and service transformation. A number of suggestions have been acted upon including regular meetings between Consultants, the Chief Executive and Medical Director.

The Chief Executive has also held more 'Chat with the Chief' road shows across the trust during 2011/12 which all staff were invited to attend and which particularly sought feedback on the new draft corporate strategy – 'Making a difference'. An internal communications survey was carried out in the Spring to seek staff views on how to improve communications in the Trust. Just over 3,100 staff responded and the insight gained has informed the Trust communications and engagement strategy.

Leadership and Management Development

The new programme for senior leaders in the trust in collaboration with Sheffield Hallam University was launched in the summer 2011 and 3 cohorts have commenced.

There has been an average of 23 people per cohort, who undertake the Insights personality assessment, the Leadership Framework 360 feedback process and attend a work based learning module at Sheffield Hallam University.

Our first Institute of Leadership Management (ILM) level 3 programme commenced in September, cohort 2 is due to commence in April, The Effective Management series started in January, covering a management topic every month e.g. governance; these are usually attended by 30 – 40 people. This is a rolling programme.

Future initiatives include developing coaching and mentoring capacity within the Trust during 2012.

Staff survey

The Trust's progress on staff engagement is measured every year via the annual staff survey. The results show an improvement across the factors with no significant deterioration in any area, which is reflected in the Trust's overall staff engagement score.

Some key results for the 2011/12 staff survey are shown below.

Top four ranking scores

Key Finding (KF)	2010 STHFT	2010 NHS	2011 STHFT	2011 NHS	Improvement/ deterioration
Staff experiencing physical violence from staff in last 12 months (%)	1	1	0	1	improvement
Staff working unpaid extra hours (%)	57	59	55	65	improvement
Staff experiencing harassment/ bullying/abuse from staff (%)	14	15	12	16	improvement
Staff intending to leave jobs	2.38	2.53	2.45	2.59	deterioration

Bottom four ranking scores

Key Finding (KF)	2010 STHFT	2010 NHS	2011 STHFT	2011 NHS	Improvement/ deterioration
Able to contribute to improvements at work (%)	50	62	52	61	improvement
Appraised in last 12 months (%)	53	78	67	81	improvement
Staff having well structured appraisals in last 12 months (%)	22	33	26	34	improvement
Staff appraised with a personal development plan (%)	42	66	55	68	improvement

Most improved

Key Finding (KF)	2010 STHFT	2011 STHFT
Effective team working	3.49	3.63
Staff appraised in last 12 months (%)	53	67
Staff appraised with personal development plan (%)	42	55
Having equality training in last 12 months (%)	25	34

It is pleasing to note that 79% of staff are satisfied with the quality of work and patient care they are able to deliver which compares well with the average for acute trusts (74%).

i. ANNUAL PATIENT SURVEY (IN-PATIENTS AND OUTPATIENTS)

The Trust undertakes a wide range of activities to find out what patients feel about the services they receive. Survey work during 2011/12 has included participation in the National Survey programme for inpatients, outpatients and cancer services along with an extensive programme of local surveys undertaken using a range of methods including paper based surveys, mystery shopping and the real time frequent feedback system in which views of patients about a wide range of services are gathered by volunteers.

The findings from the National Outpatient Department Survey show that over 96 % of patients who responded rated the outpatient care they received as being excellent, very good or good. Our Trust's results were similar to other Trusts in most areas of outpatient care. The one exception was about patients' experience before their outpatient appointment where Sheffield scored better than most other Trusts with respondents reporting pleasing results about being given a choice of appointment times.

Areas for further attention that have been highlighted through the national outpatient survey include the need to keep patients better informed about waiting times in clinics and the need to ensure that staff provide clear explanations of test results. These issues will be taken forward in the coming year through the outpatient service improvement programme.

Overall results from the latest National Inpatient Survey tell us that over 98% of patients who responded to the survey felt that they were treated with respect and dignity while in hospital, and over 95% of patients felt that the care they received was excellent, very good or good. Our scores were about the same as scores for most other Trusts. We scored better than others on giving patients privacy when being examined or treated, providing emotional support and time taken to answer patient call buttons. We didn't do as well as other Trusts in writing letters to GP's in a way that patients could understand. This area for improvement should therefore be partially addressed through the Quality Report Priority 2 for 2012/13.

Results of the first national cancer survey were received by the Trust in April 2011. Overall results for Sheffield Teaching Hospitals were very good; the Trust was one of only 12 trusts nationally to achieve zero red ratings across the 59 questions in the survey. Many comments were received and were fed back to each cancer team. Most comments were very positive and many named individual members of staff.

j. COMPLAINTS

During 2011/12 the Patient Services Team who are responsible for overseeing the complaints service have focused on improving the process of responding to complainants and improving the information available to staff to follow up and demonstrate that actions have been taken as a result of the things we have learned from complaints.

The experience of making a complaint has been reviewed through a complainant survey. 101 questionnaires were sent out to complainants asking them about how well they felt the Trust responded to their complaint, how easy to understand and how satisfied they were with the overall process. We received a 35% response rate to our survey. 86% of respondents indicated that they felt it was easy to make a complaint and knew what would happen when they had done so. 57% felt that their response was open and honest and 88% knew what to do if they remained unhappy after receiving their response.

The Trust places a high value on complaints as a resource to support service improvement. Agreeing and undertaking actions as a result of complaints investigations where mistakes have been made or services have not been delivered as we might have hoped, is the most important factor in ensuring that we improve services as a result of learning from complaints. During 2011/12 the Patient Services Team has introduced a system for recording, reporting and following up every action that has been agreed as a result of complaint investigations.

In addition to analysis of information obtained through complaints, we routinely review other types of unsolicited feedback including patients' comments on our 'Tell Us What You Think' reply slips and on websites.

As at the end of March we had received 1352 concerns and 564 feedback comments. 1352 is an increase of 55 on the previous year and reflects the fact that the number of complaints received now includes those received by Community Services departments which transferred to the Trust in April 2011.

The top 5 issues raised by complainants based on the DoH subject categories were:

- Complaints about clinical care
- Complaints about attitude of staff
- Complaints about delays or cancellations of inpatient care
- Complaints about delays or cancellations of outpatient appointments
- Complaints about admission, discharge and transfer arrangements.

Further details on the improvements made to the complaints handling process and information on actions taken to improve services are available in the Trust's Annual Complaints report for the period 2011/12.

k. ELIMINATING MIXED SEX ACCOMMODATION

We remain committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall best interest, or reflects their personal choice. We monitor our compliance with this by asking patients throughout the Trust about their experience of sharing sleeping accommodation. Where a number of patients feel that they have been sharing sleeping accommodation inappropriately we have asked feel representatives to visit the area and check compliance. The results of these visits are discussed at the Patient Experience Committee.

l. CORONERS RULE 43 LETTER

In November 2011 we received a Rule 43 letter from the Coroner following an inquest into the death of an older person. These letters are written when the Coroner feels further improvement actions need to be implemented following a death. This letter highlighted concerns regarding the completion of early warning scores and fluid balance charts and the need to ensure that any necessary action is undertaken. In our response to the Coroner we have detailed the changes made to the way we care for patients and we continue to monitor the progress of these actions.

PART 3

3.1 Quality Performance Information 2011/12

Many of the indicators listed below are included to meet the requirements of the Department of Health and Monitor. For ease of reading we have added a Green, Amber and Red rating to identify good, adequate or poor performance.

Patient Safety

Measure of quality performance	2009/10	2010/11	2011/12
Never Events			
Sheffield Teaching Hospital performance	0	2	3
There were 3 Never Events during 2011/12.			
The Trust had previously taken action to comply with the NPSA Rapid Response Report 2010/RRR012: Reducing the risk of retained swabs after vaginal birth and perineal suturing. However there were 2 retained swab incidents reported, post delivery, within 6 weeks. This led to a full scale review of processes within the labour ward and obstetric theatre.	G	R	R
The other incident was also a retained swab during vascular surgery. This case differed as the surgical team were aware that the swab had been retained before the patient's wound was closed. However following the length of time of surgery and their serious condition it was determined that to transfer to the intensive care unit was a higher priority and arrangements would be made for further surgery over the proceeding days.			
Data Source: National Patient Safety Agency			
Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge			
Sheffield Teaching Hospitals performance	98.3%	97.6%	95.6%
National Standard	98.0%	95.0%	95.0%
The Trust continues to work towards the Quality Standards for Accident and Emergency. This performance data is available on the Trust's external website.	G	G	G
Data Source:			
Clostridium difficile year on year reduction			
Sheffield Teaching Hospitals performance	202	184	178
Sheffield Teaching Hospitals Target	375	304	134
Data Source: Health Protection Agency	G	G	R
MRSA blood stream infections			
Sheffield Teaching Hospitals Trust attributable cases	16	9	2
Sheffield Teaching Hospitals target	32	13	10
Data Source: Health Protection Agency	G	G	G

Measure of quality performance	2009/10	2010/11	2011/12
Treating and caring for people in a safe environment			
Number of safety incidents reported	9883	10472	8622
Percentage resulting in severe harm or death	0.2%	0.6%	0.5%
In April 2010 STHFT amended the definitions used for grading the consequence of incidents this increased the number of incidents categorised as 'major'. Data from the National Reporting and Learning System indicates that the percentage of this type of incident across a cluster of similar hospitals is also 0.5%	G	A	G
Data Source: National Patient Safety Authority			

Clinical Effectiveness

Measure of quality performance	2009/10	2010/11	2011/12
Hospital Standardised Mortality Ratio (HSMR)			
Sheffield Teaching Hospitals performance	92.3%	91.0%	98%
National Benchmark	100%	100%	100%
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. (HSMR covers 56 diagnostic categories which comprise about 80% of in-hospital deaths). The baseline for England is set at 100 and 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.	G	G	G
Data Source Hospital Episode Statistics (HES)			
Standardised Hospital Mortality Indicator (SHMI)			
Sheffield Teaching Hospitals performance	0.91	0.86	0.87
National Benchmark	1	1	1
The Summary Hospital-level Mortality Indicator (SHMI) is a new hospital-level indicator for non-specialist acute trusts and is classified as an Official Statistic. It gives an indication of whether the mortality ratio of a provider is "as expected", "higher than expected" or "lower than expected" when compared to the national baseline (England).	G	G	(July 10 - June 11) G
The SHMI is a ratio of all observed deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital.			
The expected number of deaths is calculated from a risk adjusted model developed for each diagnostic group (taking into account age, gender, admission method and co-morbidity (using Charlson Index).			
Data Source: Information Centre			

Measure of quality performance	2009/10	2010/11	2011/12
Emergency readmission to hospital within 28 days of discharge			
Sheffield Teaching Hospitals performance	6.5%	6.5%	6.5%
Certain categories of admission and readmission are excluded from the baseline consistent with the national definitions. In particular, delivery and other obstetric admissions are excluded, as are all patients with a diagnosis of cancer. The Trust is undertaking further analysis of these figures to identify and address areas for improvement.	A	A	A
Data Source: Hospital Episode Statistics			
Percentage of hip replacements we do in the Trust that are revisions			
Sheffield Teaching Hospitals performance	24.6%	22.1%	21.3%
Patients who receive Primary Percutaneous Coronary Intervention within 150 minutes of calling for help			
Sheffield Teaching Hospitals performance	N/A	N/A	75%
National Standard	N/A	N/A	75%
Data Source: Myocardial Ischaemia National Audit Project			G
Patient reported outcome scores for % of patients who reported an increase in general health			
i) Groin hernia surgery (inguinal hernia)		47.7% (50.5%)	
ii) Varicose vein surgery		Not available	
iii) Hip replacement surgery		84.2% (86.8%)	
iv) Knee replacement surgery		75.0% (77.9%)	
National Averages in ( )			
Through the national Patient Reported Outcome Measures (PROMs) programme the NHS now routinely ask patients their views of the outcomes of three of the surgical procedures; groin hernia repair, hip replacement and knee replacements that are undertaken at this Trust. PROMs is the only programme that seeks to measure health outcomes from the perspective of the patient.			
PROMs data is a rich source of information, however analysis is complex, particularly when trying to understand what a change in a patient's PROMs score means clinically. The performance of trusts is measured through 'health gain', which provides a measure of how much patients feel their health status has changed following the procedure.			
The performance information shows that patients in Sheffield feel that their health gain following these procedures is similar to those of patients across England. Our patients undergoing hip replacement surgery report slightly lower health improvement that the average for England. The reasons for this are being investigated by the Orthopaedic Directorate to understand why there is a difference and whether or not any action can be taken to further improve care for hip replacement patients in order to help improve the health gain in line with national levels.			
Data source: Information Centre			

Measure of quality performance	2009/10	2010/11	2011/12
Percentage of admitted patients risk assessed for venous thromboembolism			
Sheffield Teaching Hospitals performance		90%	90%
National Standard		90%	90%
As part of the CQUIN scheme, the Department of Health requires that at least 90% of hospital patients are risk assessed for VTE. We have met this target since February 2011.		G	G
Data Source: Trust monitoring systems			

Patient Experiences

Measure of quality performance		2009/10	2010/11	2011/12
Percentage of patients that would recommend our hospitals to a relative or friend				
Sheffield Hospitals:	yes definitely	69.6%	74.5%	84%
	yes probably	22.6%	16.6%	12%
	Total	92.2%	91.1%	96%
Data Source: Picker frequent feedback survey 2011/12		G	G	G
Patients who require admission who waited less than 18 weeks from referral to hospital treatment				
Sheffield Teaching Hospitals performance		90%	93%	90%
National Standard		90%	90%	90%
Data Source: Patient Administration System (PAS)		G	G	G
Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment				
Sheffield Teaching Hospitals performance		97%	98%	97%
National Standard		95%	95%	95%
Data Source: Patient Administration System (PAS)		G	G	G
Percentage of patients who wait less than 31 days from diagnosis to receiving their treatment for cancer				
Sheffield Teaching Hospitals performance		98%	97%	98%
National Standard		96%	96%	96%
Data Source: Exeter national cancer waiting times database		G	G	G

Measure of quality performance	2009/10	2010/11	2011/12
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Sheffield Teaching Hospitals performance		86%	91%
National Standard		85%	85%
Data Source: Exeter national cancer waiting times database		G	G
Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals performance	93%	93%	95%
National Standard	93%	93%	93%
Data Source: Exeter national cancer waiting times database	G	G	G
Responsiveness to inpatient personal needs			
Sheffield Teaching Hospitals performance	69%	71.9%	72%
The NHS Outcomes Framework for 2012/13 includes an organisation's responsiveness to patients needs as a key indication of the quality of patient experience. This score is based on the average of answers to five questions in the Care Quality Commission (CQC) national inpatient survey: • Were you involved as much as you wanted to be in decisions about your care and treatment? • Did you find someone on the hospital staff to talk to about your worries and fears? • Were you given enough privacy when discussing your condition or treatment? • Did a member of staff tell you about medication side effects to watch for when you went home? • Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	A	G	G
Data Source: CQC Patient Survey			
Percentage of staff who would recommend the provider to friends or family needing care			
Sheffield Teaching Hospitals performance	75%	75%	73%
National average	62%	62%	62%
Data Source: CQC Patient Survey	G	G	G

PART 4

4.1 Response to external partner organisations comments 2010/11

The comments received on the 2010/11 Quality Report.

LINk, NHS Sheffield, Trust Governors and the Sheffield City Council Health and Scrutiny Committee commented in the 2010/11 Quality Report. The following table summarises the Trust's response to those comments.

We would like to thank all individuals involved for taking the time to review our Quality Report and for the helpful feedback provided.

NHS Sheffield Comments

Abridged Comments	Our Response
Care in A & E. A new range of national indicators of clinical performance in A & E services has been introduced for 2011, 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.	The Trust continues to focus on maintaining high performance against the Quality Standards for Accident and Emergency. This has involved specific improvement projects and environment redesign (Capital Scheme)
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.	In recognition of the changes required to improve the patient experience of outpatient services a Trustwide Outpatient Transformation Programme has been established; covering aspects such as environment, patient experience, waiting times and customer service standards.
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.	The Trust has met its requirements under the CQUIN scheme for 2010/11 in relation to communication with GPs. For 2012/13 the trust plans to improve the quality of immediate discharge notes sent to GPs by auditing the content of these documents within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by action planning at Directorate and Trust level.

Sheffield Local Involvement Network Comments

Abridged Comments	Our Response
LINk recommend that in the next Quality Account 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.	Review of place of discharge will be part of the 2012/13 improvement priority relating to reduction in Length of Stay.
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.	For each of the new priorities where this is available we will provide data on performance over time. The Quality Report includes two years of data for each of the Performance Measures. (Part 3).
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.	The Trust supports this proposal and have therefore included this in the performance table in the Quality Report 2011/12
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.	This will be linked to the writing of the Quality Report, although the mandated nature of the Quality Reports prevents full compliance with this request.
In order to present a balanced and representative picture of the quality of services, the Trust should highlight both positive and negative data.	The guidance on the Quality Report has a set of mandated reporting criteria and is included in the report regardless of whether they are positive or negative
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.	Staff views are an important aspect of the organisations development we have therefore included these in the Quality Report 2011/12
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.	Included in the Quality Report 2011/12

Abridged Comments	Our Response
In the dialogue that LINk engaged in prior to the compilation of this Quality Account 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.	This was included in the 2010/11 Quality Report and will be replicated in the 2011/12 Quality Report.
LINk requests that these reports re 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.	Not progressed as well as we would have liked this year. However, the outcomes of all our quality improvement priorities will be publicly available in the 2011/12 Quality Report.

Sheffield Health and Community Care Scrutiny Committee Comments

Abridged Comments	Our Response
We would have found it useful if more comparative information had been included, particularly around priority 5 - reducing the number of cancelled operations.	Where available we have included comparative information relating to the new quality improvement priorities for 2012/13.
In future we would like to see patient public and staff feedback incorporated in the quality account.	To be incorporated into the Report and included in the 2011/12 Quality Report.
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 to the Trust Executive Group available to us and members of the public to help us to do this.	Not progressed as well as we would have liked this year. However, the outcomes of all our quality improvement priorities will be publicly available in the 2011/12 Quality Report. We aim to develop this further during 2012/13.

Trust Governors Involvement

It was noted that Trust Governor representatives were involved throughout the development of the 2010/11 Quality Report and therefore actions and suggestions for inclusion had been responded to during Project Team meetings, this included structural changes, experiential feedback and significant input to the priority setting. Therefore no specific request for actions were included in the comments received.

4.2 Statements from our partners on the quality report 2011/2012

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 continues to achieve good results in national surveys of patient experience, its hospital standardised mortality ratio remains low relative to national averages, and it has achieved significant reductions over time in MRSA levels.

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 are satisfied that the specific priorities for 2012/13 which the Trust has highlighted in this report – reducing length of stay, improving discharge letters to GPs, giving patients a stronger voice, reviewing mortality rates at weekends and improving dementia awareness – are all appropriate areas to target for continued improvement.

Two of these priorities are worthy of specific comment.

- The focus on reducing length of stay in hospital fits well with the wider programme of work under way across the Sheffield health and social care community as a whole, to transform urgent care for patients, investing in stronger community services which will help elderly people in particular to stay healthy in their own homes for longer, minimising avoidable emergency admissions to hospital and ensuring prompt discharge.

- The focus on improved communication with GPs will be particularly welcome to clinical commissioners, and we will look to see significant progress on this issue during 2012/13.

We do, however, note that the Trust made mixed progress during 2011/12 on delivering its agreed improvement priorities, and there are therefore some important outstanding issues for 2012/13. These include:

- Improving the care of older people: achieving real progress on nutritional assessment and treatment and continuing to deliver reductions in the number of Grade 2 pressure sores

- Improving infection control: achieving a significant reduction in the number of Clostridium Difficile infections, in line with the target set by the Department of Health of 134 cases for 2012/13

- Reducing cancelled operations: reversing the increase seen in 2011/12 in the number of planned operations which had to be cancelled for non-clinical reasons

- Improving the patient experience of outpatient care: ensuring that the Trust Outpatient Transformation Programme delivers real improvements for patients, in terms of environment, waiting times and customer service standards and works with clinical commissioners to ensure the right clinical balance of services between hospital clinics and community settings closer to patients' homes

Statement from Sheffield Local Involvement Network (LINk)

This commentary is based on the Quality Report 2011/2012 Version 0.5 dated 30th March 2012

Last year Sheffield LINk developed a closer involvement with Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) during the production of their Quality Report which has led to a better shared understanding of the public's needs and expectations. We felt a Quality Account (QA) was needed which was both understandable to the majority of the Public and yet simultaneously met the format and content requirements placed upon the Trust by Monitor. Joint meetings had been held during the production of the 2010/11 report and it was agreed to continue with this spirit of partnership and engagement and work together in the production of this year's report. As a result, this year's process included four robust and, at times, challenging discussions in the early draft stages of the Report/Account. We feel the overall form of the final, formal report is better as a result of this involvement and we hope this view is shared by the Trust.

Sheffield LINk was pleased to see a significant number of the recommendations made last year were agreed and acknowledged in this year's Account/Report, nevertheless there are issues we would wish to record.

In last year's response to the 2010/2011 STHFT Quality Account, Sheffield LINk commended the Trust on their plan to produce an "easy read" version of the full and formal document and LINk recommended that a draft of this document be provided in the future along with the draft QA so it could be reviewed in conjunction with the "full" QA. It was disappointing that the document was not produced but the reasons were discussed in detail at the joint meetings and this has resulted in a clear commitment from STHFT to produce such a document for 2011/12. We continue to consider an "easy read" format to be invaluable and very important in allowing the public and patients better accessibility to the information. We are seeking to persuade all NHS Trusts in South Yorkshire with whom we have a relationship to produce such a version. We have been assured that an "easy read" version will be produced this year to sit alongside the more formal STHFT Quality Account. Sheffield LINk looks forward to receiving the "easy read" version.

During our joint meetings we were made aware that it is difficult, within the timescale set, to provide all the necessary information and data required to allow LINks and other bodies to comment prior to publication. However an incomplete document, without important and pertinent time sensitive data and statistics, provides challenges to LINk and others in making, worthwhile and accurate responses. We would request therefore that in future STHFT endeavour to provide a full and complete Account/Report in sufficient time for Sheffield LINk to respond within the required period. Sheffield LINk requests that STHFT consider how LINk can be provided with a full and complete version to enable comment within the required timescale.

Last year Sheffield LINk recommended that as part of reporting on "Improving the care received by older people using our services", the place receiving discharged patients should be included in the next report. In its report, STHFT has confirmed that this information will be part of the improvement priority relating to the reduction in Length of Stay. However, Sheffield LINk sees merit in reporting on the place older people were discharged to (own home, intermediate care, permanent care residential/ nursing etc) as well as re-admission data. As it is contextual to the outcomes of 2012/13 Priority 1, Sheffield LINk recommends that information regarding "the place receiving discharged patients" and "re-admission data", both in the context of older people, be collected and a report made in the next QA.

Within the "Agreed priorities for improvement in 2011/12" it states that, "progress on these priorities will be reported to the Trust Executive Group at least four times per year". It would be more transparent and so more accountable if up-dates on the priorities for improvement as identified and reported were available to a wider public on the STHFT website. These reports can then contribute to the recommended "on-going dialogue" with Sheffield LINk and the Sheffield Health and Community Care Scrutiny Committee. Despite asking for access to the

quarterly reports in the year covered by the QA, this did not happen; Sheffield LINk requests greater emphasis be accorded against this action. Sheffield LINk requests that regular reports on priorities for improvement be placed on the STHFT website.

We welcome the recent decision for Board meetings to be held in public.

The priorities identified for the period 2012/13 meet areas identified by the member engagement process of Sheffield LINk in many respects. However significant omissions as far as LINk members are concerned are: the implementation of the "Productive Ward" and the introduction of the "Proactive Rounding". LINk acknowledges that these were discussed at joint meetings and understands that work will be taken forward in both these areas despite not being identified as one of the five priorities. However, both these initiatives support patients' dignity which is seen as extremely high priority by Sheffield LINk members. Sheffield LINk would particularly wish to highlight the "Productive Ward" and "Proactive Rounding as omitted priorities from the STHFT Process and emphasise an expectation that work will continue in these areas.

Sheffield LINk is surprised that other than in the Chief Executive's Statement, the content of the Quality Account contains little mention of the Adult Community Services which became part of the Trust in April 2011. Sheffield LINk had anticipated that this would be included as part of the Trust's report on "the quality of services provided by the Trust" and so to be fully integrated into the report. Sheffield LINk will look forward to a proportionate but detailed report on Adult Community Services in next year's QA.

Sheffield LINk is pleased to note that staff received training especially in Dignity and Dementia, but it would give more reassurance if the proportion of staff compared to the total relevant workforce was always used rather than a single number.

Following the very comprehensive dialogue between Sheffield LINk and STHFT, notwithstanding the comments in this response, Sheffield LINk agrees with and supports the Trust in its areas of priority. Finally we state that Sheffield LINk accepts this QA as an honest account of the services provided by this Trust.

07.05.12
Mike Smith
Chair, on behalf of Sheffield LINk

Sheffield Health and Community Care Scrutiny Committee

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Account for this year.

The Committee feels that the Quality Priorities for 2012/13 reflect the priorities of Sheffield people, and is pleased to see that views were sought from a wide range of stakeholders in their development. The Committee is also pleased that the Quality Account will be published in an easy read format this year, and thanks the Sheffield Local Involvement Network for their work with the Trust on this.

The Committee recognises that the Quality Priorities represent only a small part of the work that the Trust undertakes; and looks forward to engaging with Trust over the coming year both in monitoring progress on the quality priorities, and on wider issues.

In particular, the Committee welcomes the work ongoing to understand the reasons for patients being readmitted to hospital. We look forward to seeing improvement on this performance indicator.

The Committee also recognises the increasingly important role the Trust has as a provider of Community Services, and is keen to see greater emphasis on this area of work in future.

Governor involvement in Quality Steering Group

Four governors attended the Steering Group during the year. We enjoyed our participation in the group and felt heard.

We contributed to deciding the content and the wording of the Quality Report and had some say in the writing of the Quality strategy.

Choosing the priorities for the Quality Report was challenging as many were proposed and those chosen had to be both relevant and meaningful, and also measurable. Outcomes of softer more feeling-centred priorities are more difficult to measure and this may have also limited the choice.

We felt that the final choices for 2012/13 were a good and representative sample that could give meaningful results.

We noted that not all the priorities for 2011/12 were achieved and confirmed that processes should be in place to follow these up and make sure that work continued on them to effect their achievement.

4.3 Statement of directors' responsibility

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 as amended to prepare Quality Accounts for each financial year.

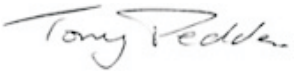
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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 2011-12;
- the content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 1 May 2012
  - Feedback from governors dated 14 May 2012
  - Feedback from LINks dated 7 May 2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012.;
  - The national patient survey (In-patients - published 24 April 2012, Outpatients - published 14 February 2012)
  - The national staff survey published 20 March 2012
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 14 May 2012
  - CQC quality and risk profiles dated April 2011 - March 2012
- 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



Tony Pedder
Chairman

Sir Andrew Cash OBE
Chief Executive

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

We have been engaged by the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA - Number of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia from a positive blood sample test for MRSA on a patient; and
- 62 Day cancer waits - the percentage of patients treated within 62 days of referral from the General Practitioner.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below.

The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to April 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to April 2012;
- Feedback from the Commissioners dated 1 May 2012;
- Feedback from LINKs dated 7 May 2012;
- Feedback from Governors dated 14 May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2011/2012;
- The national outpatient survey, dated 2011 and national inpatient survey dated 2011;
- The national staff survey dated 2011;
- Care Quality Commission quality and risk profiles dated April 2011 to March 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 14 May 2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those sources. Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Governors' Council to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governors' Council as a body and Sheffield Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We 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" ("ISAE 3000") issued by the International Auditing and Assurance Standards Board. Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- 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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

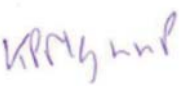
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sheffield Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.



KPMG LLP
Statutory Auditor
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11 June 2012

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
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or write to:

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Sheffield S10 2SB

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