Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report & Accounts

2009-10

Excellence as standard

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 2009-10

Contents

Welcome

High quality care for all

As one of the largest and most consistently high performing NHS foundation trusts in the country, the Trust 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; the Northern General, the Royal Hallamshire, Weston Park, Jessop wing and Charles Clifford Dental hospital.

Among the largest employers in the region, Sheffield Teaching Hospitals employs around 13,500 talented and dedicated people who continually strive to enhance the patient experience and improve clinical outcomes to meet the needs of the local, regional and national population that we serve.

During this year the Trust has performed over 260,000 inpatient episodes and day cases and around 940,000 outpatient appointments totalling over a million patient episodes. Each year we build on our vision and priorities to ensure we provide high quality health services to our patients and create an environment where staff are empowered to explore new, creative ways of working for the benefit of patients.

Introduction

Once again it has been a successful year which culminated in services being further improved in the areas which really matter to patients including safety, quality of care, waiting times, cleanliness of the hospitals, prevention of hospital acquired infections such as MRSA and how responsive a trust is to its patients.

This was reflected in the Trust being awarded the highest possible rating of excellent for receiving both the quality of our services and financial management by the Care Quality Commission. We were one of only a handful of Trusts nationally to achieve a double rating of excellent for 3 consecutive years. The results of the 2009/10 national NHS Patient Survey also placed STHFT in the top 20% of NHS Trusts for patient satisfaction.

This was achieved, not least, through the dedication and determination of all our staff to improve patient services, whilst at the same time working hard to ensure that the services offered constitute value for money.

These two achievements are based on delivering what we know all patients want from their health services and so our priorities during the year have continued to be rigorous infection control, low waiting times, quality clinical care, a good patient experience, research and innovation.

During the year we have driven down waiting times to an all time low albeit the national target of 18 weeks from referral to treatment has been challenging. National research has also shown that in 2009/10 we have gone a step further and a high proportion of our patients were treated within 6-8 weeks.

Infection prevention and control continued to be one of our highest priorities during the year, which is reflected in a continued excellent performance in this area. For the past four years we have been one of the most successful teaching trusts in the country to prevent healthcare associated infections like MRSA and Clostridium Difficile.

THE NHS
CONSTITUTION
the NHS belongs to us all

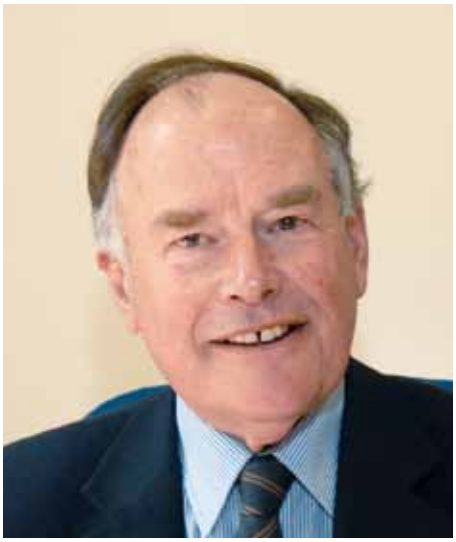
Despite sustained pressure particularly around the number of emergency admissions, the Trust has continued to produce an impressive array of developments and achievements within an environment of testing financial demands. The Year to View chapter gives a snapshot of how patients are benefiting from these new developments.

Sheffield has always had a role to play in helping shape the direction of NHS services and last year was no different. We are also proud to have been involved in the shaping of the NHS Constitution which provides our patients and staff with a legal right to quality care and treatment. This is also the guiding principle in our own corporate strategy.

Finally we are very proud of all our staff and volunteers for their tremendous achievements, which are the basis for this organisation's success and for the excellent quality of care provided to patients. All 13,500 of our staff work above and beyond the call of duty to ensure that the needs of our patients are at the core of everything we do

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

Our foundation status enabled us to work even closer with our local community throughout the year through our membership and Governors' Council. We have increasing numbers of people attracted to foundation trust membership and we have been excited and encouraged to see more younger people joining us as members. The work of the Governors is making a positive impact on services with representation on many of our committees and boards.



And finally we look forward to the coming year when we will continue to implement our 'Excellence as standard' corporate strategy. The strategy has a drive for quality at the heart of everything we do and builds on a history of improvement and innovation.

Key areas of work for the coming year will include options to reconfigure services to better meet the needs of patients, developing integrated care pathways to improve the management of long term conditions and developing new and formal partnerships in academia, research and commercial enterprise. The latter will ensure that Sheffield Teaching Hospitals stays well and truly on the map when it comes to research, education and innovation.

We continue to go from strength to strength as an organisation. However our ultimate goal is to ensure that without exception our patients receive excellent clinical outcomes, that their experience of our services is as convenient and personal as possible, and that our staff feel committed and can give of their best. In short we want to match the best standards not just in the UK, but across the world. We will do this by focusing on 'quality outcomes' and by undertaking top quality teaching and research.

David Stone CBE
Chairman

Sir Andrew Cash OBE
Chief Executive

A Year in View

Management commentary

We have had an exciting year during 2009/10 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 iniatives which have taken place at Sheffield Teaching Hospitals over the past 12 months.

April 2009

First 'Blood Type Incompatible' Kidney Transplant in Sheffield

Christopher Ward, 22, was the first person in Sheffield to receive a kidney transplant from a donor with a different blood group. Christopher's mother Diane gave the ultimate gift to her son after three years of watching his life being restricted by kidney failure and daily dialysis.

'*I feel as if I have been given another chance at life,*' said Christopher. Kidney transplants into patients with a different blood group have previously resulted in very rapid severe rejection of the kidney within hours or days.

Dr William McKane, Clinical Director for Renal Services explains: '*Careful monitoring of Chris's antibodies combined with techniques to remove antibodies from his blood were important ingredients in our success.*

Amy Fretwell, who suffered from chronic kidney failure from the age of nine, was also given a new lease of life after having a kidney transplant at the Northern General Hospital last year.

Picture courtesy of Yorkshire Post Newspapers

The 18 year old became one of the youngest people to have ever had a kidney transplant at Sheffield Teaching Hospitals. The new kidney has given Amy the freedom to live a normal teenage life and enabled her to start her nursing apprenticeship at the Northern General Hospital's Cardiothoracic Unit.

During 2009/10 a major campaign was launched by the Trust to encourage more people to donate their organs.

May 2009

Apprentices - you're hired! Support for young Apprentices

Joe Duncan is one of 88 local students who took to the wards as part of our 'Apprentice in Care Scheme' - one of the first of its kind in the UK.

The scheme is part of the Trust's commitment to help young people achieve success through education and training opportunities. We have a high success rate with 60% of our apprentices gaining employment, entering nurse training, returning to college to access a higher level course or using the programme as a stepping-stone to another career. The Trust currently offers apprenticeships in Health Care, Pharmacy, Business, Administration and Estate services.

Management commentary

June 09

Gold standard heart care

A pioneering new service, which provides emergency treatment for patients who have suffered a heart attack, has been expanded to cover the whole of South Yorkshire and North Derbyshire.

The Primary Angioplasty Service, based at the Northern General Hospital provides a faster and more effective way for patients to receive the treatment they need.

Previously a patient would have been given thrombolytic drugs to unblock the coronary artery; they now undergo the latest angioplasty treatment.

Dr Julian Gunn, Consultant Cardiologist explains: '*Paramedics attending the 999 call will perform an electrocardiogram (ECG) and analyse the results straight away. If it is a heart attack they will be taken to the Cardiac Catheter Laboratory at the Northern General Hospital for a coronary angioplasty (a balloon inserted via a catheter to unblock the artery). This is a more reliable way of unclogging arteries. Patients recover more quickly and often they will be up and about by the next day.*'

A Royal College of Physicians report in 2009 showed 88% of patients received a primary angioplasty within 150 minutes of calling for help - ranking Sheffield Hospital's service amongst the fastest in the country

July 09

Maternity and Neonatal teams perform little miracles

Sisters Harriet and Lottie were able to welcome their baby brother to the family thanks to a ground-breaking operation at the Jessop Maternity Wing that saved his life.

Their mum, Michelle Fountain, feared she would lose her unborn baby after an ultrasound scan revealed a tumour the size of an orange growing on the front side of the baby boy's neck. Thanks to high- tech scanning, planning and a co-ordinated specialist team effort, baby Arthur was safely delivered and his tumour was then removed.

During the year the Jessop Wing's Neonatal unit which cares for premature babies was voted 'Neonatal unit of the year' by parents at the Big Heart Awards 2010, hosted by Mother & Baby magazine and special care baby charity Bliss.

A Year in View

August 09

Groundbreaking Research

A Sheffield mother has turned her life around after taking part in pioneering medical research to help prevent heart attacks.

Sheffield Teaching Hospitals is recognised worldwide as a leader in many areas of healthcare research and over the years has pioneered many new treatments benefitting millions of patients.

Brenda Vimpney was one those patients. She took part in a research trial for a new drug for heart attacks after suffering an attack herself.

She said: '*Suffering the heart attack was very upsetting and came as a complete shock. I felt as if I had lost control of my health and I felt really low. Taking part in this research was a way of getting back some control and it really helped to turn around my perspective on things. It also felt like I was making a valuable contribution because only by performing and participating in clinical research can doctors make improvements to treatments in the future.*"

September 09

More conventional appointments

Patients can now choose to have their x-ray or scan appointments in the evening or at the weekend.

The change to appointment scheduling took place after patients' comments suggested it would be more convenient to attend an appointment outside work and school hours.

Patients who attend their outpatient clinic appointment and who need an imaging investigation are also now given the choice of a suitable appointment date there or then or, in many cases, are offered the option to have the required scan on the same day.

An appointment reminder system using text and answer phone messages has been expanded successfully saving more than 13000 wasted appointments. The saving to the NHS is estimated to be as much as £1.4million.

Management commentary

October 09

Excellent care ensures bride gets to the church on time

Vicky Peverelle knows all too well why Sheffield Teaching Hospitals was rated as having excellent quality services in the official NHS Annual Health Check ratings.

The Trust is one of only a handful Hospital Groups in the UK to be awarded a rating of 'excellent' for the quality of its services and financial management three years running. Vicky suffered a stroke just five days before her wedding day.

She was rushed to the Northern General Hospital after suffering the stroke at 5am one morning. Vicky was then cared for at the Royal Hallamshire's Neurology ward, where she received clot busting drugs, which is nationally recognised as 'gold standard' of care for appropriate patients. Vicky, aged 45, said: "*Thanks to the hospital's fantastic care and quick treatment, I was able to have my dream wedding on the date planned.*"

Amanda Jones, Stroke Nurse Consultant, said: "*We continue to provide a very high quality service for our patients and we are also planning to create a new dedicated Stroke Unit which will enable us to provide an even better service in the future.*"

November 09

£6.2million expansion to protect patients' dignity

The Northern General Hospital has been expanded as part of a new £6.2million refurbishment to create more single sex accommodation because we know patients do not like sleeping next to a patient of the opposite sex when in hospital.

The new 28 bed ward includes eight single sex rooms with en-suite bathrooms and the remainder of the beds are in single sex bays. A 26 station renal dialysis outpatient ward has also been built. This means that mixed sex accommodation has been virtually eliminated in our hospitals.

Sharing with members of the opposite sex will only happen by exception based on clinical need, for example where patients need specialist equipment such as in the Critical Care Unit or when patients choose to share. The new facilities, along with an ongoing ward refurbishment programme, are part of a number of initiatives which have been introduced to ensure patients' privacy and dignity is respected. The Trust has also introduced new gowns which include shorts to wear underneath to better protect patients' dignity on the way to theatre.

A Year in View

December 09

Robot helps improve pharmacy service

The Royal Hallamshire Hospital's new state-of-the-art Pharmacy was officially opened in December by local MP Meg Munn.

The million pound refurbished facility is home to robot 'Ron-o-matic' - an automated dispensing system which has improved turnaround times for prescriptions, reduces the risk of dispensing errors and releases pharmacy staff members' time for ward-based patient care.

An electronic prescription tracking system has also been installed which has improved turnaround time for prescriptions and in the longer term will enable nursing staff to track progress of their patients' prescriptions in pharmacy.

January 2010

Staff praised for 'going the extra mile' after record A&E admissions

Superb team work was needed across the hospitals when the heavy snow fell last Winter.

The Trust recorded the highest number of admissions to Accident and Emergency in a single day in January and treated almost 500 people. In a one-hour period alone 42 people arrived at A&E with injuries after suffering a trip or fall on the ice, out of this, 41 had suffered a fracture.

However, the teams across the Hospitals took it all in their stride because business continuity plans are in place to cope with such eventualities to ensure we can continue to provide key services to our patients as far as is reasonably practicable. We have a number of business continuity leads whose role it is to ensure we have plans for any number of incidents.

We undertake regular tests of our major emergency plans at a local and regional level. During 2009/10 the Trust's Pandemic Flu plans were implemented as part of the management of the Swine Flu pandemic.

Management commentary

February 10

Zero tolerance against MRSA

All five of our hospitals were given a clean bill of health following an unannounced hygiene inspection by the Care Quality Commission (CQC) in February.

The Trust, which has one of the best records for preventing MRSA bacteraemias, passed all 15 of the standards which are designed to assess whether patients, staff and visitors are being adequately protected from infections like MRSA. Hilary Scholefield, Chief Nurse explains: '*Patient safety is our top priority so obviously clean hospitals and a zero tolerance approach to infection are key. Our staff work tirelessly to ensure patients are welcomed to a clean hospital and get the very best standard of care.*'

Other improvements include expanding the ward accreditation programme which is a system of ensuring local and national best practice in all wards and departments, to include the management of linen, mattresses and medical equipment. In addition, the MRSA screening programme has been enhanced and bespoke MRSA treatment protocols and clinics have been developed.

These initiatives have resulted in a 33% reduction in MRSA blood stream infections and a 24% fall in the number of cases of *C.difficile* compared to 2008/09. This means that the Trust continues to have amongst the lowest rates of MRSA and *C.difficile* in the country.

March 10

Operating Theatres are even safer

Operating theatres across the Trust are becoming even safer thanks to the introduction of a new surgical checklist which is part of the Patient Safety 1st campaign launched by the Trust last year.

Devised by the World Health Organisation, the checklist is a simple set of checks that are applied in three stages; before the patient is anaesthetised, before the operation starts and when it finishes.

Dr Des Breen, Associate Medical Director for Patient Safety, explains: '*Patient safety has always been our top priority and we have a good record in this area, but we must never be complacent and this checklist is an additional measure to ensure we keep our patients as safe as possible.*'

Diabetes patients are also set to benefit from the hospitals piloting the national Think Glucose project which is designed to improve the quality of care for diabetes patients. And finally ensuring patients have good nutrition remained a priority with the launch of a Malnutrition Universal Screening Tool (MUST+) which nurses can use to help identify adults who are malnourished, at risk of malnutrition or indeed obese.

Quality accounts

Providing our patients with high quality clinical care is our top priority.

We know how important it is to patients and their families to know that when they have to come into hospital they are going to receive the best possible care, be safe and cared for in a clean, welcoming and infection free environment.

That is why we are continually implementing quality improvement initiatives that further enhance the safety, experience and clinical outcomes for all our patients. This is reflected in the last three years' Care Quality Commission Annual Health Check in which Sheffield Teaching Hospitals was placed in the top 10% of UK hospitals for 'excellent' quality of services and financial management.

In recognition of our excellent clinical outcomes, including the success of operations and rigorous infection control, Sheffield Hospitals was also named 'Trust of the Year' by Dr Foster in 2005 and 2008.

Over the next few pages, we have outlined how we intend to go even further during the coming year and beyond to build on this solid foundation. We will continue to promote a culture of continuous quality improvement and encourage our staff to innovate and adopt 'best practice' in order to deliver the highest standard of care to our patients.

Sir Andrew Cash OBE
Chief Executive

The purpose of Quality Accounts like this one is fourfold;

- to enable Trust Boards to focus on quality improvement as a core function;
- to enable the public to hold NHS Trusts to account for the quality of the NHS healthcare services they provide;
- to help patients and their carers to make better informed health choices;
- to help our staff at all levels to understand and participate in our work to improve quality in everything we do.

It should be stressed that these accounts are not a substitute for other national or local priorities and the Trust has a full and total commitment to meeting the key standards set as Core Standards by the Care Quality Commission.

Our Quality Accounts detail our performance and progress during 2009/2010 as well as setting out the priorities which our patients and partner organisations have told us they feel are important during 2010/2011.

A new feature of our quality monitoring and improvement this year is the establishment of CQUIN or 'Commissioning for Quality and Improvement'.

This is a programme of schemes agreed between the Trusts and a local consortium of PCT commissioners that makes available an additional 0.5% of contract income, approximately £2.95m, for implementing agreed quality programmes.

The three quality improvement categories that we have chosen to prioritise are those set out by Monitor and the Health Care Commission. These are:

- Patient Safety
- Clinical Effectiveness
- Improving the Patient Experience

Sheffield Teaching Hospitals NHS Foundation Trust is committed to provide high quality, safe and cost effective care. We recognise that to achieve this our organisation must have strong executive and clinical leadership from the boardroom to the ward. We are proud of our achievements to date, especially our Hospital standardised mortality ratio (HSMR*) which consistently remains one of the best in the NHS in England.

Our 2009/2010 Quality Accounts have been approved by Sheffield Hospitals NHS Foundation Trust Board of Directors as a true representation of the quality of services provided and the priorities for improvement going forward.

Medical Director

A quality service

Do Sheffield Teaching Hospitals provide a 'quality' service for patients?

Sheffield Teaching Hospitals puts quality at the heart of everything we do. With the help of over 13,000 dedicated staff we have continued to make significant improvements in key quality measures including screening patients for infections like MRSA before they come into hospital. We plan to improve stroke care by introducing a new care pathway with a single point of access, in our aim to provide 'gold standard' care. We do, however, still face some challenges, including reducing the number of appointments which are wasted because people do not attend and also reducing the number of discharges which are delayed and we will look at ways of addressing these issues.

Embedding the drive for 'Quality' into daily practice

To ensure we do not become complacent and have a continued drive for quality we have developed a range of internal structures and processes to embed quality into daily practice on our wards and in all departments. Two examples of our work in this area are:

We are now able to gather patients' views about their care while they are still in hospital or receiving treatment by using a simple handheld electronic device. This will mean we can respond more quickly to patient feedback. The results from the monitoring are fed back to the ward or department involved and if areas for improvement are identified, actions will be put in place to improve services.

Celebrating success

We are encouraging a culture in our hospitals where staff feel recognised and rewarded, but where poor performance is also challenged and managed appropriately. We have introduced a performance management process which includes a visible celebration of success in quality improvement and the opportunity for high performing teams to present good quality performance to the Board.

Looking back

2009/2010 Quality Review: a summary of our achievements

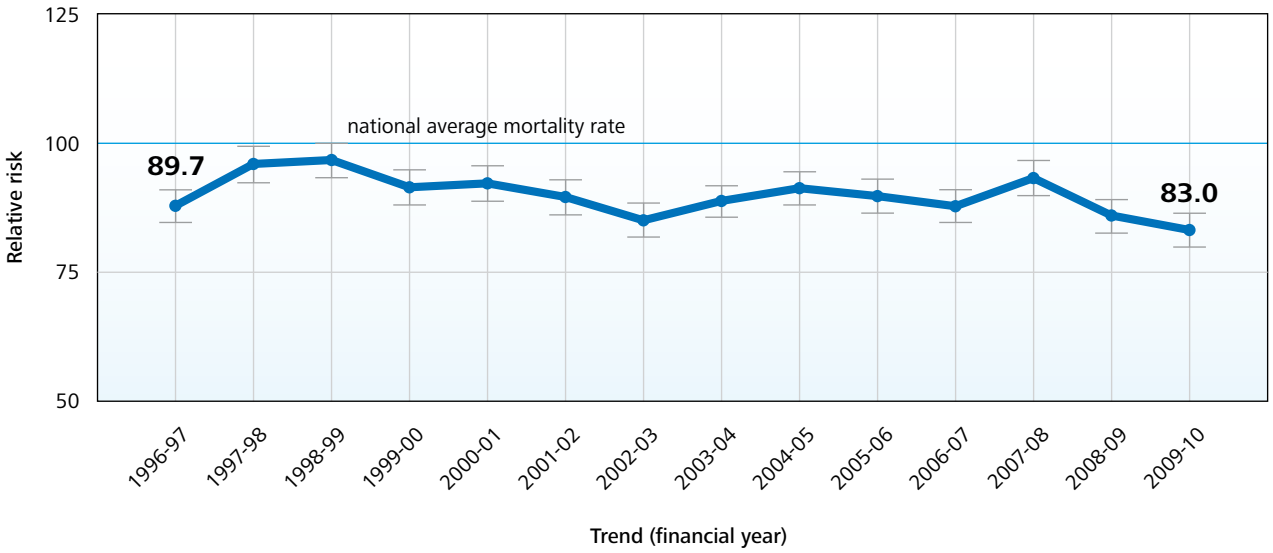
The Trust has made very good progress on its key performance targets during 2009-10. Of note during this period are the following achievements:

- Our continued board-to-ward focus and zero tolerance approach to infection prevention has sustained our reduction in both MRSA and *Clostridium difficile* cases, we are one of the best Hospital Trusts in the UK for low infection rates.
- Our Hospital Standardised Mortality Ratio (HSMR) remains one of the lowest in the NHS, well below that expected from a Trust of our size and complexity.
- Considerable investment in senior clinical positions dedicated to patient safety including an Associate Medical Director for Patient Safety.
- Becoming a member of the Patient Safety 1st campaign and introduction of the World Health Organisation Safer Surgery checklist.
- Strengthening clinical leadership and staff performance, in particular the role of the Consultant, Matron and Sister as the key gatekeepers of quality and patient safety.

One of the lowest mortality rates in the NHS

The Hospital Standardised Mortality Ratio (HSMR) is a measure of hospital mortality compared to the average for the NHS in England. For any year the NHS average will be 100. The graph below shows that the relative risk for Sheffield Teaching Hospitals NHS Foundation Trust is 83, which is much lower than the NHS average.

Mortality - relative risk compared to the NHS in England



Progress on our priorities from 2009-10

The following pages detail the quality improvements we have made during 2009-10 against the priorities identified in the 2008-09 Quality Report. In all of the areas we have been able to deliver further benefits to the high quality care we offer our patients.

Priority 1

To keep our patients safe from infections such as MRSA and *Clostridium difficile*.

Our stringent cleaning and infection prevention measures have meant the chances of patients acquiring an infection like MRSA while in our hospitals are well below most other large teaching hospitals. Despite this good performance we are never complacent and believe that we can introduce further measures to reach our aim of having zero preventable healthcare associated infections like MRSA and *Clostridium difficile*.

Our aim

To achieve a year on year reduction in the number of cases of MRSA and *Clostridium difficile* infection. Maintaining the Trust's position as a top performing Teaching hospital and move towards a zero rate of preventable infection.

Performance to date

Over the past five years there has been an 83% reduction in the number of MRSA bacteraemias. This includes a 33% reduction in cases detected during 2009-10 compared to last year. There has also been continued progress in reducing the number of cases of *Clostridium difficile* infection. Last year's 60% reduction has been followed this year by a further 24% fall in the number of cases.

What have we done so far?

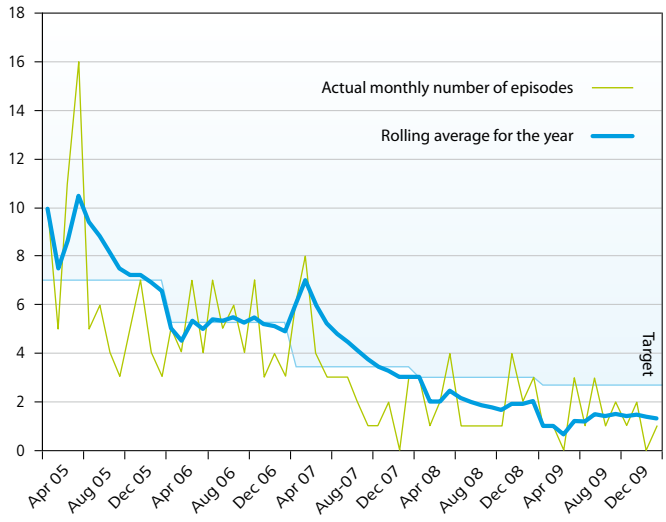
During 2009/2010 the Trust introduced a number of initiatives which have contributed to the continued reduction in the rate of MRSA bacteraemia and the number of cases of *Clostridium difficile* infection:

- We have revised our Infection Control Accreditation scheme and added several modules to expand the areas of care that are regularly audited. These include the management of mattresses, linen and medical equipment. The scheme has also been extended to encompass non-ward based areas as well as the in-patient wards. The Accreditation scheme is an annual check that wards and departments are achieving high standards of infection prevention and control practice and cleanliness.
- Ensuring commode cleanliness has continued to be a priority and regular spot audits are undertaken by the Infection Prevention and Control Team.
- All patients having a planned procedure are screened for MRSA before they come into the hospital. Anyone found to be carrying this organism is reviewed and a bespoke course of treatment instigated to reduce their risk of getting an MRSA infection. All patients admitted as an emergency are also screened for MRSA at, or shortly after, admission. This is well ahead of the March 2011 deadline set by the Department of Health for this requirement.

Priority 2

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

MRSA episodes



- Norovirus infection (otherwise known as winter vomiting disease) is a common problem during the winter months. Although it is not generally a serious illness in its own right, it can be unpleasant and cause disruption both in the hospital and the community. The Trust has extended the Norovirus testing service it provides to enable responsive management of any infections that occur. The service is provided 6 days a week and uses a molecular technique which picks up more cases than the tests used previously.
- The Infection Prevention and Control Team have written an Infection Prevention and Control e-learning package which will allow staff to undertake education and training on this topic in a flexible and consistent manner.

Board Sponsor

Hilary Scholefield
Chief Nurse/Chief Operating Officer

Implementation Lead

Dr Christine Bates
Director of Infection Prevention and Control

Director of Infection Prevention and Control Programme Manager

Christopher Morley
Deputy Chief Nurse

In the UK, survival rates for a range of procedures like heart operations and hip replacements are measured and all hospitals are scored either above, below or on the national average. Despite treating some of the sickest patients, death rates at Sheffield Teaching Hospitals are considerably below the national average (see www.nhs.choices.nhs.uk to compare hospitals.)

One of the reasons for this is because our priority is to keep our patients safe by making sure we reduce any potential risks of serious incidents (often called 'never events') occurring for example: wrong site surgery or very serious medication errors.

'Never Events' are serious, largely preventable patient safety incidents that should not occur if available preventable measures have been put in place. For example:

- Wrong site surgery.
- Instrument left in the patient after surgery.
- Incorrect placing of feeding tube.
- Incorrect chemotherapy.

Current performance

Sheffield Teaching Hospitals did not record any Never Events during 2009-10 but recognises that when treating over a million patients a year safety incidents can occur and wherever possible should be prevented.

Aim

- To reinforce that the safety of patients is everyone's highest priority, to create an awareness of safety risks and to reduce the frequency of incidents occurring by ensuring all preventable measures are put in place and audited.
- To understand how and why safety incidents occur and then year on year improve the safety of patients.

What have we done so far?

- Safety guidance is provided by the National Patient Safety Agency and we have processes in place to apply the guidance in full and then audit to ensure that the procedures are still effective, e.g. safe use of epidural equipment.
- We have an Associate Medical Director with a specific remit for patient and healthcare governance and patient safety.
- We have a Clinical Assessment Tool (CAT) which is a way to highlight key performance in clinical areas.
- Incidents are reviewed to understand why they happened and to look for things that can be changed to prevent them happening again.
- We have a Healthcare Governance Framework to provide assurance that patient safety is prioritised.

Review of quality performance priorities for 2009-10

- We have taken part in the National Patient Safety First Campaign and set up a number of patient safety working groups.
- A Patient Safety Board has been established and meets regularly to manage progress on patient safety initiatives.
- Guidance on 'Never Events' has been applied and all serious incidents are checked to identify if a never event has occurred.
- An assessment form has been used to detect if patients are at risk of developing a blood clot.
- New guidelines have been developed and introduced to prevent serious infections in patients with a reduced immune system at Weston Park Cancer Hospital.
- A new early warning system has been introduced to Jessop Wing to help detect when mothers are becoming unwell.
- 'Safer Surgery Checklists' have been developed and implemented.

New initiatives for 2010-11

The Patient Safety Board will continue to develop and manage safety initiatives including:

- Safety in Intensive Care Units to reduce infections
- Safety during operations, monitoring the use of the Safer Surgery checklists
- Safety for diabetic patients
- Preventing blood clots
- Safety for patients taking anti-coagulant medication
- Safety when patients become seriously unwell
- Safety for patients with a reduced immune system
- Preventing falls

Board Sponsor

Professor Mike Richmond
Medical Director

Implementation Lead

Dr Des Breen
Associate Medical Director

Programme Manager

Andy Challands
Acting Head of Patient & Healthcare Governance

Priority 3

Improve survival rates by providing 'gold standard' heart attack (primary angioplasty) treatment to all South Yorkshire, North Nottinghamshire and North Derbyshire patients.

Background

The key to improving outcomes after severe (ST elevation) heart attack is to re-establish coronary artery blood flow as quickly as possible and so limit damage to the heart muscle.

Coronary angioplasty is a technique for unblocking arteries carrying blood to the heart muscle. A small balloon at the tip of a catheter tube is inserted via an artery in the groin or arm and guided to the blocked artery in the heart. The balloon is inflated and then removed, leaving in place a 'stent' - a rigid support which squashes the fatty deposit blocking the artery, and allowing blood to flow more easily.

Primary angioplasty uses the techniques of coronary angioplasty, delivered on an emergency basis, and within a maximum of 150 minutes of the patient calling for help.

Primary angioplasty reduces mortality and improves longer term outcomes compared to the established practice of treating heart attack patients with clot busting drugs. The newer treatment requires high levels of clinical skill, expert multidisciplinary teams available 24/7, backup from intensive care and cardiac surgery, and access to specialist equipment.

In 2008 the Department of Health stated that Primary angioplasty should be made available to 95% of the UK population by 2011. This would involve establishing major Heart Attack Centres covering large catchment areas working in close partnership with upskilled ambulance personnel.

In June 2008 a Primary angioplasty service was established for Sheffield residents at the Northern General Hospital.

Aim

To expand the PPCI Service at the Northern General Hospital, offering immediate treatment to all ST elevation heart attack patients in South Yorkshire, North Nottinghamshire and North Derbyshire by the end of 2011.

Achievements in 2009-10

Our service capacity has been expanded at the Northern General Hospital Heart Attack Centre to meet the predicted demand for Primary angioplasty

Working with our colleagues in the Yorkshire Ambulance Service and East Midlands Ambulance Service we have established systems to transfer patients from the whole catchment area directly to the catheter laboratory where the angioplasty is performed

We have worked closely with colleagues in the surrounding hospitals to develop a model of care that allows patients to transfer to their local hospital once they are stable after the Primary angioplasty procedure.

We have centralised the care of all Sheffield residents suffering from acute chest pain that is suspected to be cardiac in origin at the Northern General Hospital, ensuring that patients with less severe symptoms also have access to state of the art treatment.

During 2009-10 the Primary Angioplasty Service was extended to cover the populations of Rotherham, Barnsley, Doncaster and North Nottinghamshire. The final stage of the service roll-out is planned for April 2010 when the service will cover North Derbyshire.

Board Sponsor

Professor Mike Richmond

Implementation Lead

Dr Julian Gunn
Consultant Cardiologist and
Clinical Lead for Primary Angioplasty

Programme Manager

Mrs Marie McKenniff
Group General Manager
South Yorkshire Regional Services.

Priority 4

Increase the number of patients who would recommend our hospitals to a friend/relative

As well as excellent clinical outcomes we want to ensure our patients have as good an experience as possible of being treated in our hospitals. This can include everything from the welcome they receive to the food they eat and being cared for in a conducive environment. We want our patients to feel they have been well looked after, and as a result are inclined to recommend our hospitals to their families and friends.

Aim/Goal

To increase the number of patients who recommend the Trust to a friend or relative, year on year.

Current Performance

In the national inpatient survey the following percentage of patients said they would recommend Sheffield Teaching Hospitals to a friend or relative:

2007 - 68.6% of patients responded "yes, definitely" and 22.5% responded "yes, probably" (total 91.1%)

2008 - 71% of patients responded "yes definitely" and 23.8% responded "yes probably" (total 94.8%)

2009 - 69.6% of patients responded "yes definitely" and 22.6% "yes probably" (total 92.2%)

As part of our programme of Frequent Feedback surveys, of the 1670 patients surveyed between June 2009 and February 2010, 83% said they would "definitely" recommend us to family and friends and 14% said "probably" (total 97%). As these figures highlight, our performance over the past three years has been consistently high.

What have we done so far?

- Since June last year we have been interviewing around 200 inpatients each month, seeking their feedback on a variety of aspects of their care. In March we started a new survey interviewing patients in the Accident and Emergency Department and in the summer we will be surveying children and young people to find out their views.
- Patient Reported Outcome Measures (PROMs) were implemented nationally from 1 April 2009 for four procedures (groin hernia repair, hip replacement, knee replacement and varicose vein surgery). This is the first time patients have been routinely asked to assess their health status before and after certain procedures. Results will enable Trusts to compare their performance against others and take actions where appropriate. Response rates from this Trust are good and results will be available from July 2010.
- Following the implementation of new national and local complaints procedures and to support our programme of patient and public engagement, the Trust has launched a new Patient Services Team. This team of dedicated staff deals on the spot with enquiries or concerns and brings together all aspects of patient feedback. A new complaints information leaflet and patient and visitor comment card have also been launched, enabling patients and visitors to comment more easily on our services. The Trust's new strategy for patient and public involvement has been out to consultation and the strategy will be launched in May 2010. The strategy builds on existing good practice and focuses activity on issues which are of highest importance to patients and have most impact on the quality of overall experience.
- New 'You Said… We Did' posters have been produced and are to be placed across the Trust to let patients and public know about service improvements which we have implemented as a result of patient feedback.

- Telephone interpreting has been introduced to help patients for whom English is not their first language. 78% of interpreting is now undertaken by telephone. This has improved the quality of service for patients through increased accessibility to interpreters and has also improved efficiency, enabling staff to contact an interpreter quickly and easily.

Identified Areas of Improvement

- The time taken to receive medications to take home once discharge has been agreed is an area identified for improvement in the national in-patient survey 2009, with 69.3% of patients whose discharge was delayed stating that waiting for medicines was the reason for the delay. This issue is being examined by the Pharmacy management and Trust discharge team.
- Out-patients waiting longer than they were told, or not being told how long the wait would be, is an area identified in the 2009 out-patient survey where our scores were lower than average. 66.5% of patients were not told how long they would have to wait and 13.4% of patients had to wait longer than they were told. this is one of our agreed priorities for improvement in 2010/11.
- Sharing bathroom or shower facilities with patients of the opposite sex has been highlighted as an area for action. In the 2009 national in-patient survey, 32.4% of patients said they used the same bathroom or shower areas as patients of the opposite sex, compared to an average score of 21% of patients nationally.

New Initiatives to be implemented in 2010/11

As a result of patient feedback to date we will be:

- Working with patients, governors and reception staff to set standards for receptions across the Trust. We are also working with the Customer Services Institute to ensure that the standards we adopt reflect best practice. This work will be supported by a programme of training for reception staff and a programme of mystery shopping to monitor the quality of reception services. Standards will include keeping patients informed of waiting times in out patient areas.
- Piloting a new role of meal time volunteers. Staff, patients and their families will be consulted and involved in setting up this new scheme. Good nutrition is linked to a speedy recovery and the valuable input from volunteers will enable us to ensure that mealtimes are an enjoyable experience for our patients. Volunteers are currently being recruited for this new role, and the project is planned to start in May.
- A new Surgical Assessment Centre will open this year. This will ensure patients receiving a clinical assessment to decide whether they need admitting to hospital in the specialties of Plastic Surgery, Orthopaedics or General Surgery, will be managed in an area which carefully safeguards their privacy and dignity. In addition both Renal Unit E and F are being refurbished and will (when completed) have a higher number of en-suite side rooms.

Board Sponsor

Professor Hilary Scholefield
Chief Nurse/Chief Operating Officer

Implementation Lead and Programme Manager

Sue Butler
Head of Patient Partnership

Looking forward

How we have prioritised our 2010/11 quality improvement initiatives.

After taking into account the views of our patients, staff, Governors, clinical advice and best practice our quality improvement priorities for 2010/11 are as follows:

Patient Safety

1 To keep our patients safe from infections such as MRSA and *Clostridium difficile* by achieving a year on year reduction.

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

Clinical effectiveness

3 To ensure that at least 80% of people who have suffered a stroke spend at least 90% of their time on a dedicated stroke unit.

Patient experience

4 A reduction in the number of patients who waited for longer than they were told, or were not told how long the wait would be for their appointment.

The review of our services also gives a clear picture of our performance in the areas which really matter to our patients and which are part of the annual NHS Health Check which all Trusts are measured against by the Care Quality Commission.

To determine these priorities we assessed each initiative in terms of:

- The impact it would have on improving safety, clinical outcomes and our patients' overall experience of their care.
- The feasibility of implementing the priority, for example whether we have the resources required to deliver the change. We also factored in areas of further improvement from inspection reports and patient feedback.

Our selected priorities and initiatives for 2010-11

Each of the quality priorities for 2010-11, along with how we hope to achieve them are described in detail on the following pages.

Priority 1

To keep our patients safe from infections such as *Clostridium difficile*.

Our stringent cleaning and infection prevention measures have meant the chances of patients acquiring an infection like *Clostridium difficile* while in our hospitals is well below most other large teaching hospitals. Despite this good performance we are never complacent and believe that we can introduce further measures to reach our aim of having zero preventable healthcare associated infections like *Clostridium difficile* and other hospital-acquired infections such as Norovirus and MRSA.

Our aim

To achieve a year on year reduction in the number of cases of *Clostridium difficile* and other hospital acquired infections. Maintaining the Trust's position as a top performing Teaching hospital.

Current performance

Over the past five years there has been an 83% reduction in the number of MRSA bacteraemias. This includes a 33% reduction in cases detected during 2009-10 compared to last year. There has also been continued progress in reducing the number of cases of *Clostridium difficile* infection. Last year's 60% reduction has been followed this year by a further 24% fall in the number of cases.

New initiatives for 2010/11

Over the course of 2010/ 2011 the Trust will introduce further measures to improve practice and achieve:

- Further reductions in the rate of *Clostridium difficile* and other hospital-acquired infections such as norovirus to keep our patients as safe as possible and become one of the best performing Teaching hospitals.
- Exceed Government requirements. by undertaking surveillance of other organisms, including methicilin sensitive *Staphylococcus aureus* and resistance strains of *E.coli*.

To achieve this in 20010/11 we will:

- Continue to revise our Infection Control Accreditation scheme to encompass any Recommendations of the Care Quality Commission Hygiene Code review.
- Investigate the use of new technology in optimising cleaning schedules and protocols.
- Roll out a computer based Infection Prevention and Control e-learning programme for all staff to use.
- Collect data to include *Staphyloccocus aureus* and *E.coli* bacteraemia. Feedback of audit and infection rate data to wards and departments will be expanded and this information will also be made more publicly available.
- Continue to work with colleagues in the primary care sector to optimise the care of patients with *Clostridium difficile* and MRSA and in the community
- Review the feedback process of Accreditation scheme audit results and investigate ways of expanding this to allow staff and patients greater access to their results.
- Continue to undertake reviews of areas with *Clostridium difficile* infections; this will include clinical practice, antibiotic prescribing and environmental cleanliness audits.
- Work with primary care colleagues to optimise antibiotic prescribing practice in the community
- Participate in a national multi-centre *Clostridium difficile* vaccine study.
- Introduce the World Health Organization safe surgery checklist to all operating theatres in the Trust during 2010/11, and monitor its use and effectiveness throughout the year.

Board Sponsor

Professor Hilary Scholefield
Chief Nurse/Chief Operating Officer

Implementation Lead

Dr Christine Bates
Director of Infection Prevention and Control

Programme Manager

Christopher Morley
Deputy Chief Nurse

Priority 2

80% of people who have suffered a stroke spend at least 90% of their time on a dedicated stroke unit.

Aim

By the end of 2010/11 80% of people who suffer a stroke will spend at least 90% of their time on a stroke unit. This is a Department of Health 'Vital Sign' standard.

Performance to date

An internal audit in Sheffield Teaching Hospitals indicated that in 2009-10, 65% of patients diagnosed with a stroke spent at least 90% of their inpatient stay on a stroke unit. However, in the first three months of 2010, the number of patients spending at least 90% of their time on a stroke unit had increased to 72%.

What we have done so far

In preparation for more changes in 2010/11, we have increased the coverage provided by specialist stroke care nurses to 7 days per week, to ensure that patients diagnosed with a stroke are seen by specialist staff after admission and admitted to the stroke unit.

New measures for 2010/11

We are going to re-organise stroke services in the Trust, centralising them on one site, with one point of entry. We are developing a specialist ambulance protocol to ensure that patients are quickly admitted straight onto the stroke unit. We are also working closely with our neighbouring District General Hospitals to ensure that effective and consistent treatment procedures are developed for the emerging regional stroke strategy.

Board Sponsor

Professor Mike Richmond, Medical Director

Implementation Leads and Programme Managers

Professor Graham Venables, Consultant Neurologist, Amanda Jones, Stroke Care Nurse Consultant

Priority 3

Patients waited for longer than they were told or were not told how long the wait would be.

Aim

Our priority for patient experience in 2010/11 will be to make sure that patients are kept informed of waiting times in out patient departments.

Background

In 2009 we interviewed patients on a variety of aspects of their care. We also noted in the 2009 outpatients survey that the Trust score was 10% below the national average in respect of patients waiting for longer than they were told or were not told how long the wait would be. 66.5% of patients were not told how long they would have to wait and 13.4% had to wait longer than they were told.

This indicates a need to improve the Trust's performance in this area and is the reason for selecting this as our patient experience priority for 2010/11.

Key improvement initiative

Our key improvement initiative in 2010/11 will be the development of customer service standards and a programme of training for outpatient reception staff to ensure that they keep people informed of waiting times in outpatient areas.

Monitoring and measurement

Progress will be monitored and measured by a programme of 'mystery shoppers' who will test the effectiveness and accuracy of reception services in keeping patients informed of their waiting times. We will also monitor the Trust's performance on this question in future national outpatient surveys.

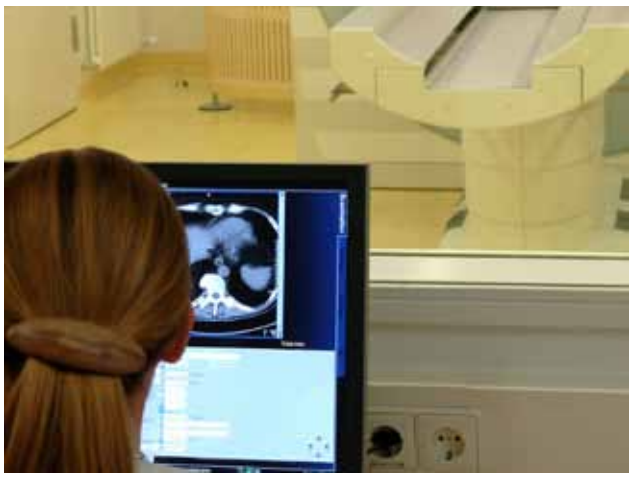
Board Sponsor

Professor Hilary Scholefield
Chief Nurse/Chief Operating Officer

Implementation Lead and Programme Manager

Sue Butler
Head of Patient Partnership

Quality overview



The table below is a review of how Sheffield Teaching Hospitals NHS Foundation Trust has performed against key national standards and targets over the past two years. This gives you an indication of the quality of the care you can expect when treated in our hospitals.

	2008-09	2009-10	Monitor*
Never Events 'Never Events' are serious, largely preventable patient safety incidents that should not occur if available preventable measures have been implemented. For example: wrong site surgery. The data source for this indicator is the National Patient Safety Agency.	0	0	No
Hospital Standard mortality ratio Mortality, or death, rates are calculated using the number of deaths at a hospital trust compared with the number of patients who would be expected to die, taking into account age, complexity of illness, deprivation and sex. The baseline for England is set at 100 and a lower figure indicates fewer patients died than expected; a higher one means more patients died. Sheffield Teaching Hospitals death rate is significantly below the national average. The data source for this indicator is: Hospital Episode Statistics (HES)	90.8	83	No
% of patients who were readmitted to hospital. The data source for this indicator is Hospital Episode Statistics (HES)	6.5%	6.5%	No
% of hip replacements we do in the trust that are revisions. The data source for this indicator is Hospital Episode Statistics (HES)	24.5%	24.6%	No
% of patients that would recommend our hospitals to a relative/friend The data source for this indicator is the National Inpatient Survey.	71% responded "Yes definitely" 23.8% responded "Yes probably" (Total 94.8%)	69.6% responded "Yes definitely" 22.6% responded "Yes probably" (Total 92.2%)	No
% of patients who spent less than 4 hours waiting in A&E. The target is 98%. The data source for this indicator is: a local data collection system that feeds the national Quarterly Monitoring Accident and Emergency return.	97.8%	To end of February 2010 98.3%	Yes

* Monitor standard
Foundation Trust Hospitals are regulated by a body called Monitor and the following standards are required by Monitor to be achieved by all UK Foundation Trust Hospitals

	2008-09	2009-10	Monitor
The trust has fully met the Care Quality Commission core standards. The data source for this indicator is local systems.			
Performance against existing NHS national targets and new NHS National targets.	In 2008/09 we fully achieved 19 of the 23 targets. The four targets we underachieved were: 1 The number of patients whose operation was cancelled on the day and who were not re-admitted within 28 days 2 The percentage of patients seen in A&E within 4 hours 3 The staff survey results 4 The percentage of stroke patients that spent 90% of their time in hospital on a stroke unit	Data not available at time of publication	No
Clostridium difficile year on year reduction (Trust attributable cases)	267 cases	202 cases	Yes
Reducing the number of MRSA blood stream infections to less than half the 2003/4 levels - The 2003/4 level was 103 All of the figures are entered onto MESS (Mandatory Electronic Surveillance System) and reported via the HCAI Data Capture System, Administered by the Health Protection Agency (HPA).	24 cases	16 cases	Yes
% of patients needing to be admitted to hospital who waited less than 18 weeks from referral to hospital to treatment. The data source for this indicator is the national returns we fill out from our local systems.	91.1%	To 29 March 2010 90%	Yes

	2008-09	2009-10	Monitor
% of patients who do not need to be admitted to hospital who waited less than 18 weeks from GP referral to hospital treatment. The data source for this indicator is the national returns we fill out from our local systems	96.8%	To 29 March 2010 97%	Yes
% of patients who waited less than 31 days from diagnosis to receiving their treatment for cancer. The data source for this indicator is the Exeter national cancer waiting times database.	100%	98%	Yes
% of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer. The data source for this indicator is the Exeter national cancer waiting times database.	95%	87%	Yes
% of patients who received thrombolysis treatment within the recommended time of 60 minutes. The data source for this information is MINAP audit.	No cases referred	No cases referred	Yes
% of patients who waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis. The data source for this indicator is the Exeter national cancer waiting times database.	100%	93%	Yes

Care Quality Commission registration

Every Hospital Trust in the country is monitored by the Care Quality Commission (previously the Healthcare Commission) to ensure a set of core standards is met.

In March 2009, Sheffield Teaching Hospitals NHS Foundation Trust became one of the first NHS Trusts to be given an unconditional licence to provide services under the new, tougher system for regulating standards in the NHS. From April 1, all NHS trusts in England have to be registered with the CQC by law to provide care. To be registered, trusts must show they meet new essential standards of quality and safety, which the regulator will constantly monitor.

As part of the CQC periodic review process, the Trust undertook a self assessment of Standards for Better Health for 2009-10 and made a mid-year declaration of full compliance on 7 December 2009. The Trust is unaware of any significant lapse in or insufficient assurance of compliance with any of the core standards for the period up to the 31 March 2010. Sheffield Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period and the Care Quality Commission has not taken enforcement against the Trust during 2009-10.

Care Quality Commission - Healthcare associated infections

From 1 April 2009, the Trust was also registered with the Care Quality Commission for the control and prevention of healthcare-associated infections (HCAI). In January 2010, the Care Quality Commission inspected the Trust to ensure it was meeting the new regulation on Health Care Acquired Infections and following the supporting Code of Practice and related guidance. The HCAI inspection report found no concerns about the 15 measures that it measured and no evidence that the Trust breached the regulation to protect patients, workers and others from the risk of acquiring a healthcare-associated infection.

A review of our services

During 2009-10 the Trust provided or subcontracted general hospital services to the 530,000 people of Sheffield, tertiary services to the 1.7 million population of South Yorkshire, North Derbyshire and North Nottinghamshire and a number of important national services including radiosurgery, limb reconstruction, ocular oncology, rare cancer treatments, transplant surgery, and the treatment of pulmonary vascular disease. The Board 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 2009-10 represents 100% of the total income generated (£598m) from the provision of NHS services by Sheffield Teaching Hospitals for 2009-10.

Clinical Audits

During 2009-10, 30 National Clinical Audits and two National Confidential Enquiries covered NHS Services that Sheffield Teaching Hospitals provides.

During that period, Sheffield Teaching Hospitals participated in 93% National Clinical Audits and 100% National Confidential Enquires of the National Clinical Audits and National Confidential Enquires which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that Sheffield Teaching Hospitals was eligible to participate in during 2009-10 are as follows:

Continuous (all patients)

VSSGBI Vascular Society Database
NNAP: neonatal care
NDA: national diabetes audit
ICNARC CMPD: Adult critical care units
National Elective Surgery PROMS: four operations*
NIAP: Adult cardiac interventions: coronary angioplasty
Congenital Heart Disease: paediatric cardiac surgery (adult only)
NJR: hip and knee replacements
Renal Registry: renal replacement therapy
NLCA: lung cancer
NBOCAP: bowel cancer
DAHNO: head and neck cancer
Adult cardiac surgery: CABG and valvular surgery
MINAP: AMI & other ACS
Heart Failure Audit
Pulmonary Hypertension Audit
NHFD: hip fracture
TARN: severe trauma
NHS Blood & Transplant: intra-thoracic transplants
NHS Blood & Transplant: renal transplants
NHS Blood & Transplant: potential donor audit

Intermittent samples of patients

National Audit of Dementia: dementia care (n=40).
National Comparative Audit of Blood Transfusion: Use of red cells in neonates and children
National Comparative Audit of Blood Transfusion: Audit of blood collection process
British Thoracic Society: Adult asthma
College of Emergency Medicine: asthma
College of Emergency Medicine: fractured neck of femur

One-off: All patients

National Mastectomy and Breast Reconstruction Audit
National Oesophago-gastric Cancer Audit
RCP Continence Care Audit

National Confidential Enquiries

NCEPOD (EESE & PN)
CEMACH/ CEMACE: perinatal mortality 100% (92/92)

NB: The Trust was not eligible to participate in the following intermittent sample audits as clinical audit data collection was not required in 2009-10.

National Kidney Care Audit (2 days, patient transport survey 2008)
National Sentinel Stroke Audit (n=40-60)
National Falls and Bone Health Audit (n=60)

The National Clinical Audits and National Confidential Enquires that STHFT participated in during 2009/10 are as follows:

Continuous (all patients)

VSSGBI Vascular Society Database
NNAP: neonatal care
NDA: national diabetes audit
ICNARC CMPD: Adult critical care units
National Elective Surgery PROMS: four operations*
NIAP: Adult cardiac interventions: coronary angioplasty
Congenital Heart Disease: paediatric cardiac surgery (adult only)
NJR: hip and knee replacements
Renal Registry: renal replacement therapy
NLCA: lung cancer
NBOCAP: bowel cancer
DAHNO: head and neck cancer
Adult cardiac surgery: CABG and valvular surgery
MINAP: AMI & other ACS
Heart Failure Audit
Pulmonary Hypertension Audit
NHFD: hip fracture
NHS Blood & Transplant: intra-thoracic transplants
NHS Blood & Transplant: renal transplants
NHS Blood & Transplant: potential donor audit

Intermittent samples of patients

National Audit of Dementia: dementia care (n=40). Started March 2010
National Comparative Audit of Blood Transfusion: Use of red cells in neonates and children
British Thoracic Society: Adult asthma
College of Emergency Medicine: asthma
College of Emergency Medicine: fractured neck of femur

One-off: All patients

National Mastectomy and Breast Reconstruction Audit
National Oesophago-Gastric Cancer Audit
RCP Continence Care Audit
National Confidential Enquiries
NCEPOD (EESE & PN)
CEMACH/ CEMACE: perinatal mortality 100% (92/92)

NB: The Trust will also participate in the following intermittent sample audits in 2010/11.

National Kidney Care Audit (2 days, patient transport survey. Due again October 2010)
National Sentinel Stroke Audit (n=40-60, due in Oct 2010) Organisational audit undertaken April 2009 and due again in April 2010, n=1)
National Falls and Bone Health Audit (n=60). Starts September 2010.

TARN: severe trauma and the National Comparative Audit of Blood Transfusion: Audit of blood collection process are not part of the National Clinical Audit & Patient Outcomes Programme or part of our local PCT Commissioner Audit requirements and hence other priorities have taken precedence during 2009/10. However, the Trust is actively looking to participate in 'TARN' in the future. Another factor in the decision not to participate in the "Audit of blood collection process" was that an audit project was already being undertaken in the Trust along similar lines and this would have been a duplication of work. Future National Comparative Audits of Blood Transfusion will be considered as they arise.

The National Clinical Audits and National Confidential Enquires that STHFT participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each Audit or Enquiry as a percentage of the number of registered cases required by the terms of that Audit or Enquiry.

Continuous (all patients)

VSSGBI: Vascular Society Database	57% (314/556)
NNAP: neonatal care	100% (720/720)
NDA: national diabetes audit	100% (5288/5308)
ICNARC CMPD: Adult critical care units	100% (1000/1000)
National Elective Surgery PROMS patient questionnaire returns: four operations	49% (943/1907)
NIAP: Adult cardiac interventions: coronary angioplasty	100% (1406/1406)
Congenital Heart Disease: paediatric cardiac surgery (adults)	100% (13/13)
NJR: hip and knee replacements*	80% (941/1177)
Renal Registry: renal replacement therapy	100% (1333/1333)
NLCA: lung cancer	94% (450/480)
NBOCAP: bowel cancer	100% (322/322)
DAHNO: head and neck cancer	100% (159/102)
Adult cardiac surgery: CABG and valvular surgery	100% (2222/2222)
MINAP: AMI & other ACS	100% (1297/1297)
Heart Failure Audit	100% (408/408)
Pulmonary Hypertension Audit	100% (1392/1392)
NHFD: hip fracture (Commenced data submission October 1st 2009)	69% (186/271)
NHS Blood & Transplant: intra-thoracic transplants	100% (114/114)
NHS Blood & Transplant: renal transplants	100% (87/87)
NHS Blood & Transplant: potential donor audit	100%*

Intermittent samples of patients

National Comparative Audit of Blood Transfusion: Use of red cells in neonates and children	100% (40/40)
British Thoracic Society: Adult Asthma	100% (69/69)
College of Emergency Medicine: asthma	100% (50/50)
College of Emergency Medicine: fractured neck of femur	100% (50/50)

One-off: All patients

National Mastectomy and Breast Reconstruction Audit	96%*
National Oesophago-Gastric Cancer Audit	100% (320/266)

National Confidential Enquiries

NCEPOD EESE	81% (21/26)
PN study	57% (13/23)
CEMACH/ CEMACE: perinatal mortality	100% (97/97)

N.B. Data for projects marked with an asterisk* require further validation. Where data are 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.

No reports from National Clinical Audits completed in 2009/10 have yet been released. However, reports were reviewed by STHFT in 2009/10 which related to previous data collections.

The reports of 72 local Clinical Audits were reviewed by the Provider in 2009-10 and STHFT intends to take the following actions to improve the quality of healthcare provided:

A&E Re-audit of Sepsis Management

Recommendations and Action Plan

- Changes within the Emergency Department, including the installation of a blood gas analyser, have been found to make a positive difference in the compliance to the Severe Sepsis Guidelines.
- Increased teaching in sepsis for junior doctors and nurses has further improved standards of care. Further education is continuing.
- Development and display of posters in accessible ward areas containing information on severe sepsis diagnosis and the elements of the severe sepsis 'care bundle'.
- Participation in a re-audit in 2010 as a part of the College of Emergency Medicine's 'Surviving Sepsis' campaign.

Developing the Radiology Film Audit at Sheffield Teaching Hospitals

The radiology film audit operates several times a year to check the quality and timely reporting of radiographs according to Royal College of Radiology guidelines. Clinical information provided on referral cards is scanned onto an electronic system - the quality of this process is also assessed. It has been identified that although standards are usually high, this continuous audit cycle could be improved by setting up an electronic database to store the results of the audits which would enable comparisons across specialities and between both hospital sites. The Clinical Effectiveness Unit will be assisting in the development of this in 2010/11.

Smoking Cessation Advice Given to Patients in Acute Medicine

As a result of this audit several recommendations were made and acted on. Results were taken and presented to the Tobacco Control Group at the Trust and resulted in considerable interest and debate.

- The audit results were publicised to the medical doctor workforce. A grand round highlighting Smoking Cessation and brief intervention was arranged to raise awareness amongst medical staff.
- A number of Smoking Cessation posters have been designed and widely distributed throughout the Trust in high visibility areas to promote Smoking Cessation awareness amongst patients and staff.

Clinical Research

The number of patients receiving NHS Services provided or subcontracted by Sheffield Teaching Hospitals in 2009-10 that were recruited during that period to participate in Research approved by a Research Ethics Committee was 19,500.

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

In 2009-10, Sheffield Teaching Hospitals was involved in conducting 450 Clinical Research Studies. Sheffield Teaching Hospitals used national systems to manage the studies in proportion to risk. Of the 188 studies given permission to start, 181 were given permission by an authorised person less than 30 days from receipt of a valid complete application.

97% of these studies were established and managed under national model agreements and 15 percent of the 450 eligible Research involved used a Research Passport. In 2009-10 the National Institute for Health Research (NIHR) supported 220 of these studies through its Research Networks.

CQUIN Payment Framework

In 2009-10, 0.5% of our contract income, approximately £2.95m was conditional on achieving quality improvements and innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and the local consortium of PCT commissioners through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed quality improvement goals for 2009-10 and for the following 12 month period are available on request by emailing the Service Development Department at quality@sth.nhs.uk

Data Quality

Sheffield Teaching Hospitals submitted records during 2009-10 to the secondary uses service for inclusion in the Hospital episodes statistics which are included in the latest published data. The percentage of records in the published data which included the patients valid NHS number was:

% for admitted patient care	98.0%
% for outpatient care	98.2%
% for accident and emergency care	89.5%

The percentage of records in the published data which included the patients valid general medical practice code was:

% for admitted patient care	99.9%
% for outpatient care	99.8%
% for accident and emergency care	99.5%

Sheffield Teaching Hospitals score for 2009-10 for information quality and records management, assessed using the Information Governance Toolkit was (65%).

STHFT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published Audit for that period for diagnosis and treatment coding (Clinical Coding) were 7.7%.

Primary diagnosis incorrect	6.7%
Secondary diagnosis incorrect	9.4%
Primary procedures incorrect	10.4%
Secondary procedures incorrect	12.0 %

A partnership committed to quality healthcare

We have worked alongside our main Commissioner, Local Authority and Local Involvement Networks to agree the priorities for improvement contained within this document.

We are grateful for the constructive and helpful comments made by our partner organisations and as well as making suggested amendments to this document we will be discussing with them how best to take forward the issues they have raised during 2010/11. In particular we have given a commitment to include staff training on dementia as a future priority and we will be discussing how we do this with our partners over the coming months.

Statement from NHS Sheffield

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

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

Sheffield Teaching Hospitals provides a very wide range of general and specialised services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. Nonetheless, we believe that the specific priorities for 2010/11 which the Trust has highlighted in this report - infection control, patient safety, stroke care and waiting times in clinics - are appropriate areas to target for continued improvement.

Our strategy for improving health and health services in Sheffield, Achieving Balanced Health, sets out clear priorities for ensuring that, wherever possible, patients can be looked after in their own homes and that, where treatment in hospital is required, they have access to services which offer excellence in terms of clinical outcomes and patient experience. NHS Sheffield is fully committed to continuing its close co-operation with the Trust over the coming year on these important issues.

Statement from Sheffield LINk

The Sheffield LINk has considered the draft Quality Account document received on 16th April 2010 provided by Sheffield Teaching Hospital NHS Foundation Trust for the period 2009-2010 and we have the following comments on the content of the document -

- The guidelines DoH, Gateway Ref no 13463 states that Quality Accounts should show where improvements are required and although some of this has been demonstrated more details would have been helpful.
- In relation to the section on hospital acquired infection on pages 21 and 22, we understand that the Staff Survey as published by CQC indicates inadequate hand washing facilities in some areas and a lack of training opportunities, below the national level.
- Regarding the new complaints information leaflet and new patient and visitors comment card mentioned on page 25 as Priority 4 - feedback from LINk visits suggests patients and visitors are not actively made aware of these. We would be interested to know patients and visitors are informed about these leaflets. The LINk participated in the Trusts consultation on the Strategy for Patient and Public Involvement and general feedback through the LINk was very positive and constructive.
- On page 29, under the identified areas for improvement, it would be helpful to know what actions the Trust is taking to address these.

- We feel that the section dealing with *C.Diff* should include other hospital-acquired infections such as norovirus, which was a very significant issue this winter.
- We note the proposal to move stroke services to one site. The LINk has concerns that moving older people between hospitals will have a detrimental effect on them. Consideration should be given to providing rehabilitation on both sites.
- We would add to Priority 3 that refers to patients waiting time in outpatient departments, to say that pharmacy services for discharge from hospital are an issue that is frequently brought to LINk's attention and needs further improvement.

Additional recommended priority

We would also recommend a further priority is added to next year's Quality Account:-

That the Trust gives some focus to training of all staff in the care of older patients especially those with dementia, as up to 70% of acute hospital beds are currently occupied by older people and 20-40% of these are likely to be people with cognitive impairment including those with dementia and delirium. The majority of these are not known to specialist mental health services. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation. The National Audit Office estimates the costs of this to be more than £6 million per year in an average hospital therefore cost to the Trust will be around £12 million.

We suggest in order to meet this area of concern that the Trust makes a commitment to implementing the requirements of the local and national dementia strategies:

Quality Overview

The LINK is pleased to note the great improvements in *C.Diff* reduction and the other indicators that have improved since 2008-09. We are concerned that performance on some of the measures on cancer waiting times have deteriorated which would be a concern to patients.

We look forward discussing our general comments with The Trust and to working with them on the priorities in the Account during 2010/11.

Statement from Sheffield City Council Health and Community Care Scrutiny Board

The Sheffield City Council Health and Community Care Scrutiny Board is grateful to colleagues from STHFT for attending the Board meeting on the 19th April to discuss the Quality Account for 2009/10 and for providing draft copies for comment.

We note that this is the first year of the production of the Quality Account and as such, it was subject to an ongoing process of evolution, which would take on board feedback from a number of advisory and interest groups. The Scrutiny Board is pleased to be part of that process.

We are pleased to note that the Account will be available in the 5 most prevalent languages, as advised by Sheffield City Council, and the Accounts will also be available on the Trust's website, where there was a facility for viewers to change the language and font size. It will include a paragraph to outline the availability of additional languages/ formats. Any request received could be produced and distributed within 48 hours.

We suggest that the language in the Account should be as jargon free as possible and examples of outcomes should be included within the report, to help engage the public. Whilst this was welcomed, it was noted that direction from the Department of Health was prescriptive in how parts of the documentation should be set out.

We do not feel able to comment on the Trust performance against the past year priorities identified in the 2009/10 Account, but we are pleased to receive assurance that the issues we raised at our discussion on April 19th will be addressed by the Trust, and that some of them are already included in the Account for 2010/11. These all fall under the under the heading of Patient Experience and Dignity and related to improvements to the patient nutrition services, the effect of locating the OPD Pharmacy from the OPD building to the main building, improving staff training in the Outpatient departments and the inclusion of dementia care in the Account for 2010/11. As such we wish to see the following included in the Account for 2010/11: nutrition and meals, single sex accommodation, treatment and care pathway for dementia, end of life care, waiting times in Outpatient Departments, including pharmacy services, and infection, and we look forward to discussing these issues with the Trust in 2010/11.

Right treatment, right place at the right time

QualityCounts
outcomes, improvement, efficiency

We are constantly striving to improve the quality of the care we provide for our patients, but this does not always involve investing in new equipment or treatment. Sometimes we are able to do so by changing the way in which a particular service is provided.

During 2009/10 this was a real focus for the organisation and in particular we began to look at how we can better configure our services within our hospitals. When the two trusts merged back in 2001 many services were duplicated. Over the years a lot has been achieved in this area and we have now entered the final phase. During the year a Service Configuration Board was set up comprising clinicians, senior nurses and managers to look at the optimum provision of services to reflect best clinical practice and we began discussing initial views with our Commissioners and health/social care partners to ensure an integrated approach. It is envisaged that this work will progress over the coming year.

We also launched our Quality Counts Service Improvement programme, which focuses on improved patient care and value for money for the taxpayer. Effective leadership, clinical ownership and staff engagement continue to be the key drivers in delivering these service improvements now and into the future. The key themes of the work focus on the whole care pathway or 'patient journey' considering if there are better, quicker or more innovative ways of delivering a patient's care.

Service line reporting (a form of patient level costing) was also rolled out across the Trust in 2009/10 allowing services to gain a better understanding and control of their resources and identify further opportunities to improve performance and efficiency.

Mental Health Strategy

There is a complex interplay between mental and physical health.

Our mental health strategy aims to orientate our services to the mental health needs of patients, to support a positive approach to mental health promotion and care, and to provide clear direction for the development of the services we provide. The Trust is a member of the Sheffield Mental Health Partnership Board and has been in discussion with commissioners throughout the year about service improvements.

Patient Satisfaction is Our Aim

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. In December we became the first NHS Trust in the Yorkshire and Humber region to become a member of the National Institute of Customer Service which will enable us to achieve a national quality standard demonstrating the Trust's commitment to providing world class customer service. We are currently working with the Institute, patients, Governors and Receptionists to develop new standards of customer service for reception desks.

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

During 2009/10 we have made a number of key changes to the ways in which we respond to and support complainants. These changes include:

Providing an early personalised acknowledgement by telephone wherever possible.

A new system for risk assessing and scoring all new concerns so that straightforward issues are resolved speedily. An escalation process has been put in place to review, at a more senior level, when a complaint is reopened or progresses to the next stage.

Face to face meetings are routinely offered as a helpful way of achieving a satisfactory resolution.

A sample of complaint responses is audited each quarter by a group of Trust staff and patient and public governors.

During the year, the Trust received 1519 complaints, 93% percent of which were responded to within 25 working days. Comments and suggestions we have received have enabled us to improve our services. For example:

Case Managers have been introduced on the Trauma wards. Their role is to work closely with the medical and nursing staff, particularly in regard of patients with complex medical needs and dementia. One key element of their role is to enhance communication with patients' families.

It has been agreed that only essential activities regarding therapy will be undertaken on the day of discharge for patients who have had joint replacement surgery. This will help to prevent patients feeling rushed and overwhelmed before being discharged home.

A complainant's experience is being used as a case study in breast feeding training sessions for staff.

Changes have been made to improve the cataract pre assessment documentation in Ophthalmology.

'You said… We did' posters

Examples of service improvements made as a direct result of patient feedback are now being promoted across the Trust.

New 'You said… We did' posters are displayed in key areas to show how the Trust has listened and responded to patients' comments and to encourage more patients to give us feedback about their experiences.

The National In-Patient Survey

The National In-Patient Survey reflects the priorities and concerns of patients. It is based on what is most important from the patient's perspective such as hospital food, cleanliness, level of privacy and care and treatment.

When the 2008 survey was repeated in 2009 and we received 464 completed responses, from a total of 850 questionnaires. Once again our overall performance was very good. In comparison with 2008 we had improved in a number of areas, performing significantly better in two questions. In particular the survey showed a 7 per cent improvement in patients who shared a sleeping area with patients of the opposite sex. Overall ratings of care remain extremely high, with 93 per cent of patients rating their care as excellent, very good or good. Other areas where the Trust performed well were:

- Admission process well organised
- Patients have confidence and trust in doctors;
- Privacy when being examined or treated;
- Doctors and nurses working together
- Involved in decisions about discharge

Working in partnership with patients and community groups

The Trust is committed to delivering high quality services that are patient-focused.

To help to ensure that it does so, it works closely with, consults and involves other organisations, local groups, patients and the public as appropriate. During 2009/10 we have redesigned our existing service user groups in conjunction with staff and service users. We are also using different methods of engagement such as email, texting, telephone and web forums, which will also be supported by meetings as appropriate.

We are in the process of establishing a central database of around 5,000 people and for each person we will hold a record of their particular areas of interest. This will mean that when we start a new project we can contact all those interested in that topic who may want to have input. A new advisory group will also oversee and steer the patient and public involvement programme, which will be based around aspects of care which are most important to patients. The group members will represent all sections of the community and will report to the Trust Equality and Human Rights Committee.

Frequent Feedback

Since June 2009, the Trust has been working with the Picker Institute to implement Frequent Feedback, a system for collating patient feedback using handheld electronic equipment.

The system allows the Trust to obtain ongoing, on the spot feedback from patients and to make improvements to services based on what patients tell us. Trained volunteers interview around 250 patients per month. Real time feedback means we are able to detect problems early and take action to make improvements. To date over 2000 in patient interviews have been completed across the Trust. A survey of the Accident and Emergency Department commenced in March 2010 and a survey of children and young people will commence during the summer.

Variety in Volunteering

The Trust attracts many people willing to become volunteers and help us in our work. We have received national recognition and praise for our work in engaging with young people through volunteering.

Working closely with schools, colleges and other groups within the community across Sheffield, we encourage 16 to 24 year-olds, particularly those who may otherwise be socially excluded, to get involved in healthcare and help them decide their future career choices.

We have recently streamlined our volunteer activities to ensure that volunteer roles have maximum benefit for patients and visitors. Volunteer roles include interviewing patients to obtain patient feedback, meeting and greeting patients and visitors in main entrances and assisting patients at meal times.

We have introduced a mystery shopping programme where volunteers visit different areas across the Trust, and record their observations and experience. This data is fed back to staff who can then identify service improvements based on the findings.

The Voluntary Services Team has also contributed to the Department of Health's national volunteer strategy which was launched in March 2010. The Trust features as an example of good practice.

Keeping Patients Informed

We want to make sure that all the information we provide for patients is not only informative and accurate, but also clear and easy to understand.

To ensure that all our patients can access good quality information, guidelines for providing patient information in alternative formats were developed during the year to support patients with language support needs, visual impairment and learning disabilities. The guidelines draw on best practice from a range of organisations including the RNIB and MENCAP.

The development of easy read information received a particular boost this year from the Charitable Trust, who kindly provided funding for the PhotoSymbols3 image library and easy read training for staff. The new 'Coming into hospital for an operation' leaflet follows best practice advice from the learning disability charity CHANGE and similar style leaflets are now planned for other areas.

We are also keen that patients with a long term condition continue to have access to reliable and relevant information throughout their journey. Information Prescriptions have been designed to do just this. To support the roll out of this new initiative we have begun working with NHS Sheffield, Sheffield City Council and other partners to ensure that the information we provide is consistent across the city.

Under the direction of the Sheffield First Partnership Health and Wellbeing Board, we have begun work on identifying local diabetes information which will complement the national diabetes Information Prescriptions already available via NHS Choices. Information Prescriptions are likely to become more widely available over time and we plan to continue our work with other long term conditions in due course.

Safe and Effective Care

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.

In April 2009, the Care Quality Commission (CQC) replaced the Healthcare Commission and became the regulator of health and adult social care. Last year marked a transition from a process of self-assessment against the Standards for Better Health as part of the Annual Health Check to a new system of registration with the CQC, which came into force from 1st April 2010.

Annual Health Check

The Annual Health Check, carried out by the CQC, uses a complex set of standards to assess trusts and provide the public with an overall rating of how NHS organisations are performing.

Each Trust receives two ratings on a four-point scale of 'excellent', 'good', 'fair' or 'weak'. One rating covers the quality of services, measured against the Government's core standards and national targets; the other relates to the use of resources, measured against how well trusts manage their finances. We were one of only a handful of trusts nationally to achieve a double rating of excellent for three consecutive years.

Self-Assessment

As part of the Annual Health Check process for 2009/10, the Trust completed a self-assessment process and declared full compliance with relevant Core Standards for Better Health.

Registration with the Care Quality Commission

Under the transitional arrangements for 2009/10, the Trust registered with the CQC for the prevention and control of Healthcare Associated Infections (HCAI).

In January, the CQC inspected the Trust to ensure it was meeting the new HCAI regulation and that it was following the Code of Practice and related guidance. The CQC did not identify any concerns and gave the Trust a clean bill of health in respect of rigorous infection control.

In early 2010, the Trust applied to register with the CQC and declared compliance with the CQC essential standards of quality and safety. Since April 2010, the Trust is registered with the CQC for all its regulated activities across all its locations.

Clinical Audits

Each year clinicians and managers in the Trust register between 350 and 400 clinical audit and service review projects with the Clinical Effectiveness Unit (CEU). The Trust's CEU is one of the largest in the country. It aims to promote and support the implementation of clinically effective practice based on best available evidence. The Trust has an impressive track record for co-coordinating the implementation of national guidance both within the Trust and across the city and our internal prioritisation and review systems for clinical audit and clinical effectiveness projects are robust and well established.

We have a strong commitment to education and to providing clinicians with the opportunity to access training and support for clinical effectiveness activity through our close links with Sheffield Hallam University. This has established the Trust as a national leader for clinical audit training. We are the only NHS provider of a postgraduate accredited clinical audit course in England.

The Postgraduate Certificate in Clinical Audit & Effectiveness received national funding during 2008/09 and has been opened up to NHS clinicians and managers across England, Scotland and Northern Ireland. The course aims to enable students to develop evidence based clinical standards for practice within a theoretical framework and to apply clinical audit critically as a tool for evaluating and improving the quality of health care. The CEU also provides training covering the 5 Stages of Clinical Audit, Managing Change effectively and Train the Trainers in Clinical Audit, which is again nationally funded.

We have continued with the implementation of Dr Foster Real Time Monitoring (RTM) and Practice and Provider Monitor (PPM) across the Trust. These systems enable users to recognise where there is variation in activity or outcomes compared to our peers and to see whether or not that variation is statistically significant. Mechanisms are in place to ensure mortality outcomes are routinely reported to the Clinical Effectiveness and Patient and Healthcare Governance Committees and that any variances are explored in conjunction with the relevant clinical directorates.

Information Governance Assurance

The Trust has a continuing programme of work to ensure that person identifiable information (PID) is safe and secure when it is 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 data flow mapping, safe haven and other forms of security and risk assessment. There were no Information Governance Serious Untoward Incidents (IG SUIs), data breaches or losses reported during the year. See table below:

Summary of Other Personal Data Related incidents in 2009/10

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	Nil
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	Nil
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	Nil
IV	Unauthorised disclosure	Nil
V	Other	Nil

NHS Litigation Authority

The NHS Litigation Authority (NHSLA) administers a Risk Management Scheme covering NHS organizations against the cost of litigation. Trusts are assessed against 50 criteria covering a wide range of topics such as consent, resuscitation, infection control and complaints. Additional assessment is in carried out in Trusts which have maternity services.

The standards can be assessed at three levels:

- Having suitable policies in place
- Providing evidence that the Trust is working to these policies
- Monitoring the effectiveness of these policies

The NHSLA assessors visited the Trust in February 2010 and conducted two separate assessments one involving the whole Trust and one involving just maternity services. The Trust passed both assessments at Level 1 and consequently receives a discount on the premiums it pays to NHSLA. The Trust is already preparing for an assessment at Level 2.

Regulatory ratings

For 2009/10,the regulatory ratings are as follows:

Q1-FRR-3	Governance - Green Mandatory services - Green
Q2-FRR-4	Governance - Amber Mandatory services - Green
Q3-FRR-3	Governance - Amber Mandatory services - Green
For all four quarters of 2008/09 we were rated	
FRR-4	Governance - Green Mandatory services - Green

A Good Corporate Citizen

Throughout the year, the Trust has identified opportunities to make optimum use of its Foundation status and 'punch its weight' in contributing to the local economy. We have drawn up and committed to deliver a 10-point "pledge", which sets out how we will help raise attainment and aspiration in Sheffield. For example, we have offered 88 apprenticeship places providing opportunities for local young people to develop skills and gain meaningful employment.

We have appointed Trust Healthcare Ambassadors who are working with designated schools to lead careers events and experiential learning. We have worked with the Sheffield 14-19 partnership group to develop a Health and Social Care Diploma Facility to build relationships with the workforce of the future, including work experience facilities.

The Trust is now an active member of Sheffield First, the Local Strategic Partnership, and is closely involved in steering the delivery of strategic aims and objectives that comprise the Local Area Agreement for Sheffield. The Trust also sits on the Health and Wellbeing Thematic Partnership. We have recruited a new Sheffield First partner member of the Governors' Council.

The Trust has developed proactive links with the City's Economic Partnership, Creative Sheffield and also with the Sheffield Chamber of Commerce. We worked productively with these partners to start to develop new opportunities that will benefit our patients and staff as well as the wider economy.

Caring for the Environment

We recognise that being part of the NHS, we have an important role to play in reducing carbon emissions, a key cause of climate change. Our carbon footprint is 275,000 tonnes of carbon dioxide per year. During the year, the Trust worked with partners at national, regional and local level to develop a sustainable development action plan and a number of key objectives were set.

These are designed to ensure sustainable development across the Trust and within the local community. They include ensuring business plans and service specifications include actions on sustainable development and any redesign of patient care and treatment pathways are low or zero carbon. During the year we appointed a Sustainability Manager and became a member of the 10:10 campaign. Our membership of the Sheffield First Partnership also enables us take an active role in promoting sustainable development in the city.

Monitoring and reporting are necessary for checking progress towards our sustainable development objectives. It allows the Trust to understand the task ahead regarding the Climate Change Act carbon reduction targets to reduce CO_2 emissions by 30% by 2030 and 80% by 2050 (on 1990 emissions). Monitoring and reporting will be carried out yearly, to take account of how the Trust has changed. This will help to ensure that key stakeholders, including employees, are kept informed and therefore that sustainable development remains a priority.

"Our mission is to have a positive impact on local health and wellbeing while reducing our negative impacts on the climate and environment. We will work in partnership with staff, patients, visitors and the community to ensure their personal mission statement is to 'Be Green".

be green

Imagine. Believe. Care.
Sustainability at Sheffield Teaching Hospitals.

There are two key strategic aims which the Trust will address:

- Mitigation and reduction of carbon dioxide emissions
- Adaption and preparation to changing environmental, social and economic climates

The Trust has written a Sustainable Development Management Plan which prioritises the first steps in developing a Sustainable Development Programme.

Following on from this Plan, the Trust has now formed a governance structure. The Sustainable Development Strategy Group and the Sustainable Development Implementation Group are charged with developing and implementing specific action plans relating to the major carbon emission and the 'NHS Good Corporate Citizenship' components.

- Energy and Water
- Procurement
- Travel
- Waste
- Estate Management
- Community Engagement
- Workforce

Feeding into this group will be the Sustainable Development Workforce Group, a collection of interested staff, who will test and monitor success of schemes directly related to staff throughout their 'on the ground' experiences.

The Sustainable Development Strategy Group will mainly work to embed sustainable development into the Trust-wide corporate agenda. The key aim of this group will be to ensure that all Directorates follow the strategies developed by the group and disperse the principles of sustainable development into all Trust programmes.

The Sustainable Development Implementation Group will have the ability to develop and implement schemes relating to the strategies set by the Sustainable Development Strategy Group..

The main areas for future development include;

- low carbon patient pathways and Tele-Health projects
- energy and water efficiency measures
- waste minimisation projects
- encouragement of low carbon travel
- development of sustainable procurement activities
- encouragement of health and wellbeing.

The Trust will aim to achieve a 10% reduction on our 2007 emissions by 2015, followed by a 30% reduction by 2030 and 80% by 2050 on our 1990 baseline.

As with other large organisations, the Trust is faced constantly with the conflict between the need for staff to get to work and the environmental impact of car travel.

However, with the help of the Trust's Travel Plan we hope to manage our travel and transport needs in a more sustainable manner. The aim of the Plan is to cut the number of single occupancy car journeys and encourage staff, visitors and patients to travel in more environmentally efficient ways. Registrations to "Liftshare" the national car share database have continued to grow.

We continue to work closely with South Yorkshire Passenger Transport Executive (SYPTE) and other partners to provide better public transport access to our hospital sites. In 2009 Sheffield Community Transport took over the running of the H1 Shuttle Bus providing 2 new buses with low floor access. The reliability of the service has attracted many more passengers from among staff and the local community. The service has been extended to include a 6am and 6:30am run from both RHH and NGH and these journeys are attracting an increasing number of passengers.

The i-Choose a Bicycle scheme has encouraged almost 300 members of staff to acquire a bike and leave their cars at home. Three new cycle shelters have been installed across the Trust in an attempt to accommodate the increase in cycle use. Walking and cycling initiatives are in place to coincide with Walk to Work Week and National Bike Week.

Area	2008/9 Non-financial data (applicable metric)	2009/10 Non-financial data (applicable metric)	2008/9 Expenditure (£k)	2009/10 Expenditure (£k)
Finite Resources (all sites):	2008/09	2009/10	2008/09	2009/10
Water	1181918 cu.m	1132943 cu.m	£1,026.538	£1,031,129
Electricity	66491309 KWh	63808048 KWh	£8,464,343	£6,380,805
Gas	161264764 KWh	149605627 KWh	£4,837,943	£3,470,851
Other energy consumption	3726000 KWh	3615000 KWh	£109,731	£106,462

Waste minimisation and management

Waste Output 2009/10:

Type	Tonnes
Household (Recovery)	2521.99
Household (Landfill)	196.57
Clinical (HTI)	108.92
Clinical (Non Burn)	1518.5
Recycling	206.46

Household Waste Spend = £287,651.00

Clinical Waste Spend = £739,324.00

Recycling Spend = £15,283.00

Hazardous Waste Spend = £13,090.00

Total Spend = £1,055,348.00

Percentage of Household Waste Recycled / Recovered = 93.28%

Percentage of Household Waste Landfilled = 6.72%

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.

During 2009/10 a stress risk assessment tool and support packages have been rolled out across the Organisation as well as training level 2 support staff. We have piloted this tool prior to integrating it into risk assessment and governance procedures. We have also provided training at executive level and produced self-help materials for all managers and staff. We have also introduced a number of training and support initiatives for managers to help them to handle sickness and absence amongst their staff more effectively and appropriately, resulting in a reduction in sickness levels. We also provide a full range of Occupational Health services for staff.

We make sure that a wide range of education and training opportunities are available to all staff. This is done through a comprehensive directory of in-house training, which is delivered throughout the year and covers both mandatory training and ongoing continuing professional development. The Trust also supports an increasing number of e-learning modules, giving staff the flexibility to access training at a location convenient to them. Strong links with Sheffield Hallam University and Sheffield University ensure that staff have access to higher-level education specific to their roles.

During 2009/10, we introduced a new development programme for our Health Care Assistants to address activities of daily living as well as essence of care and NSF frameworks. Changes have also been made to the Newly Qualified Staff Development programme to ensure that learning is based on the six core dimensions of the Knowledge and Skills Framework. The new Foundation Development Programme also includes an element of medicines management.

Providing Opportunities

The Trust employed over 30 people into entry-level jobs through its Employability scheme during 2009/10.

This scheme draws from a diverse recruitment base of the unemployed, single parents and those who have recently been made redundant. It works with local communities in the north and south of Sheffield to provide the workforce of the future. The scheme, which is supported by the Sheffield Work and Skills Board, is considered a pathfinder project providing entry into health sector employment. We have also been re-awarded the 'Two Ticks' Positive about Disability symbol for our work in the recruitment and retention of staff with disabilities.

Leadership

The Trust is keen to develop leadership potential among staff.

During the year we continued the implementation of the Leadership and Management Development Framework programmes at the four levels. This included the second senior managers and clinicians development programme, run in conjunction with Sheffield Hallam University and a programme specifically aimed at senior sisters. We also piloted the NHS Institute's Productive Leader Programme and plans are in place to cascade this throughout the organisation.

The year's Leaders Conference focused on one of the supporting pillars of Corporate Strategy: delivering a consistently high quality patient experience. It set out to inspire and inform the 270 staff that attended so that they can continue to make real improvements to the quality of our patients' experience.

Once again we celebrated the dedication and achievement of individuals and teams from across the Trust at the annual Thank You Awards. The awards highlight the way in which our staff are willing to work over and above the call of duty to ensure that the needs of our patients are met and are the focus of everything that we do.

i-Choose, the Trust's salary sacrifice scheme has been very successful It offers staff the opportunity to select a brand new cycle and safety accessories and childcare vouchers pre tax and National Insurance.

Let's Talk

The Trust has recognised the importance of staff engagement to productivity and well being and has identified it as a key pillar in the Corporate Strategy. The annual NHS staff survey is used to gain important feedback from staff and to identify areas for development. Following a disappointing staff satisfaction score in 2008, the Trust held a series of 'Let's talk' events to identify the issues that really mattered to staff. This involved over 600 staff from across the Trust sharing their views and suggestions for improvement.

Following these sessions, actions to address the issues raised in the short, medium and longer term were identified and an action plan drawn up which is monitored by the 'Let's talk' steering group, chaired by the Chief Executive.

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.

This work is measured via the annual staff survey results which showed an improved staff satisfaction score for STH for 2009 compared to 2008. 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.

LET'S TALK

listening… sharing… improving

b) Summary of Performance - NHS 2009 Staff Survey

	2008	2008	2009		Improvement / Deterioration
Response Rate	STH	National Average*	STH	National Average	
	54%	52%	45%	55%	-9

	2008		2009		Improvement / Deterioration
Top 4 Ranking Scores	STH	National Average	STH	National Average	
KF9 % staff working extra hours	60	68	58	65	-2 (Imp)
KF27 % staff experiencing harassment / bullying / abuse from staff in last 12 months	25	19	14	18	-11 (Imp)
KF4 % staff agreeing they have an interesting job	82	79	83	80	+1 (Imp)
KF18 % staff suffering work related injury in last 12 months	20	17	15	17	-5 (Imp)
Bottom 4 Ranking Scores	STH	National Average	STH	National Average	
KF7 % staff working in a well structured team	31	37	29	38	-2 (deter)
KF29 impact of health/wellbeing on ability to perform activities	n/a	n/a	1.69	1.57	n/a
KF13 % of staff appraised in last 12 months	55	64	50	70	-5 (deter)
KF14 % of staff having well structured appraisals in last 12 months.	20	26	21	30	+1 (Imp)

Improvements

The Trust made significant improvements in areas relating to bullying and harassment as the table below shows.

Where staff experience was most improved

Key finding	STH 2008	STH 2009	Improvement
KF27 % of staff experiencing, harassment, bullying/abuse from staff in last 12 months	25	14	-11
KF26 % of staff experiencing harassment, bullying abuse from patients/ relatives in last 12 months	27	20	-7
KF16 support from immediate managers	3.43	3.60	0.17
KF28 perceptions of effective action from employer towards violence and aggression	3.43	3.58	0.15

N.B. There is no deterioration in staff experience to report as there was no deterioration in any of the key findings.

Areas of concern

An action plan has been drafted to address particular areas of concern in the staff survey. As two of the bottom 4 ranking indicators in the 2009 survey relate to appraisal, it has been decided to review the Trust's appraisal process.

The Trust also scored poorly on the two indicators introduced to measure health and well being. A senior lead for health and well being has been identified and a programme of work to address health and well being issues in the Trust will begin shortly.

Future priorities and targets

The action plan developed via the 'Let's Talk' events is still being implemented but the next phase of this work includes holding 'Let's talk 'events in individual care groups/directorates to increase the opportunity for managers to learn from staff feedback.

This work will be monitored via the 'Let's talk' steering group chaired by the Chief Executive who will report back to the Trust Executive Group. The impact of this work will be measured via the staff survey, particularly with regard to the staff satisfaction and staff engagement scores. Although both these scores were average for acute Trusts in 2009, the target is to see a year on year improvement.

Everyone Counts

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

The lead for Equality and Human Rights in the Trust is the Trust Secretary, supported by the Organisational Development Manager (Equality). The Trust Secretary chairs the Equality and Human Rights Steering Group, which reports to the Trust Executive Group, and to the Healthcare Governance Committee, which is a committee of the Board of Directors. This ensures that equality and diversity issues are considered at a strategic level. Operationally each care group has identified an Equality and Human Rights lead to promote the sharing of good practice in equality and diversity across the Trust.

Equality and Diversity performance is monitored via the governance arrangements with the Healthcare Governance committee receiving 6 monthly reports on progress and via the NHS staff survey. The Trust has published race, disability and gender equality schemes and has revised the action plans for these in consultation with service users. Employment monitoring statistics are published annually on the Trust's website together with equality impact assessments for Trust policies and services. The programme of impact assessments across the Trust is still ongoing.

The Trust was rewarded the 'two ticks' symbol for its commitment to employing staff with disabilities and in the 2009 NHS staff survey 92% of staff reported that they had equal opportunities for career progression and promotion which was above average for acute Trusts in the NHS.

The Trust has recently sought external expertise to undertake an Independent Equality Review across the Trust both in service provision and as an employer in order to further develop good practice in this area. The review identified much good practice in equality and diversity across the Trust and made a number of recommendations in order to further develop good practice. An action plan has been developed and will be implemented during 2010/11.

In addition to implementing the action plan drawn up in response to the independent equality review, a key priority area for the Trust will be the development of a single equality scheme across all six equality strands, which will be developed in consultation with service users in order to meet the requirements of the new Single Equality Act which comes into force later this year. Through working in partnership with other organisations across the city e.g. Sheffield College and Sheffield First, the Trust is also working to ensure a more diverse workforce and has agreed a target of employing four more employees with learning disabilities in the next year.

The implementation of the Equality action plan and the development of the Single Equality Scheme will be monitored via the Healthcare Governance Committee, the Trust Executive Group and the NHS staff survey.

Annual Equality & Diversity Report					
		Staff 2008/09	%	Staff 2009/10	%
Age	**16-20**	337	2.46%	320	2.24%
	21-25	1146	8.37%	1254	8.78%
	26-30	1699	12.41%	1831	12.83%
	31-35	1714	12.52%	1733	12.14%
	36-40	1886	13.77%	1886	13.21%
	41-45	1992	14.55%	2028	14.21%
	46-50	1878	13.71%	1980	13.87%
	51-55	1466	10.71%	1558	10.91%
	56-60	1006	7.35%	1057	7.40%
	61-64	445	3.25%	464	3.25%
	65-70	119	0.87%	156	1.09%
	71-75	6	0.04%	8	0.06%
	Totals	**13694**	**100.00%**	**14275**	**100.00%**
Ethnicity	**Asian or Asian British**	748	5.46%	771	5.40%
	Black or Black British	549	4.01%	596	4.18%
	Chinese	64	0.47%	75	0.53%
	Mixed	194	1.42%	206	1.44%
	Not Stated	338	2.47%	313	2.19%
	Other	114	0.83%	116	0.81%
	White	11687	85.34%	12198	85.45%
	Totals	**13694**	**100.00%**	**14275**	**100.00%**
Gender	**Male**	3176	23.19%	3324	23.29%
	Female	10518	76.81%	10951	76.71%
	Totals	**13694**	**100.00%**	**14275**	**100.00%**
Recorded Disability	**Yes**	41	0.30%	61	0.43%
	No	13653	99.70%	14214	99.57%
	Totals	**13694**	**100.00%**	**14275**	**100.00%**

NB Does not include Bank staff. Based on Primary assignment. As at 31 March

Research and Innovation

The Corporate Strategy for 2008 to 2012 sets out a vision for the Trust to be a provider of world-class health services, and top quality teaching and research. We want to be 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 so that we are recognised as a centre for innovation and invention.

With annual research income in excess of £15m, Sheffield Teaching Hospitals is amongst the largest healthcare research institutions in the UK. Research activities are directed to areas of excellence, with NIHR Biomedical Research Units established in both Bone and Cardiovascular disease, and with Neuroscience a major centre of academic and clinical investigation. STH is also notable for its pioneering work in Diabetes, Respiratory Medicine, Rheumatology and Oncology, with many large-scale studies underway. Translational research initiatives led by STH include the Devices for Dignity Healthcare Technology Co-operative operating nationally to bring technological solutions to patients' needs, and the NIHR South Yorkshire Collaboration for Leadership in Applied Health Research and Care, uniting 16 organisations to transfer research findings into practical patient care in the management of long-term conditions. Specific initiatives resulting from the creation of a joint research office with the University of Sheffield will include dedicated teams for categorised project processing and significant strengthening of the STH commercial research profile.

In 2009/10 we worked hard to support and encourage innovation throughout the organisation and there has been a substantial increase in the number of projects coming on stream.

With the bureaucratic burden on researchers seeming only to increase, the Trust has recently commissioned a significant programme of development within Medical Imaging and Medical Physics (MIMP) to bring new systems to the Trust that will streamline the research governance process, allow greater investigator participation in research management and provide additional data to support grant applications. During the year the innovations fund called the Bright Ideas Fund, provided modest amounts of start up funding for staff to help them work up new ideas. We have run four internal workshops to showcase existing innovations and to encourage more by making staff aware of the help and support available by having a dedicated Innovation website.

NHS Chief Executive, David Nicholson meets local innovators

'Devices for Dignity' Healthcare Technology Cooperative

The Trust is one of only two in England to pilot a Department of Health initiative to create healthcare technology co-operatives (HTCs).

The HTC is a national resource established to address areas of unmet clinical need. Focusing on three themes (Assistive Technology, Renal Technology and Urinary Continence) it is delivering innovative medical devices to support patients with long term conditions, which preserve their dignity and independence.

Two years on and Devices for Dignity continues to grow stronger and has recently been awarded a further 3 years of funding. In the first 2 years D4D has leveraged over £1.3 million in additional funding to support its growing number of research initiatives. D4D has a robust portfolio of 18 collaborative research and development projects and has 3 clinical trials planned for 2010. The initiative is currently receiving new project enquiries at the rate of 3 per week The first product to market "The Dignity Commode" will be available August 2010 and D4D have successfully secured Regional Innovation Funds to carry out the adoption campaign.

Health Innovation and Education Cluster Award

Over £3m of funding was awarded to Sheffield Teaching Hospitals, along with other NHS organisations and Universities across the Yorkshire and Humber region, to establish a new initiative to ensure patients receive better care.

The Yorkshire and Humber HIEC (Health Innovation & Education Cluster) is the largest of 17 new nationally funded initiatives that will combine the expertise of the NHS, universities and industry to promote innovation in the NHS and improve quality and productivity. Initially the HIEC will focus on the three key theme: long term conditions, maternal and infant health, and patient safety. The long term conditions group will identify groups of patients with long term conditions, such as diabetes and stroke, with a view to supporting and enhancing their care through the use of new technology.

Bio-medical Research Units

Considerable progress has been made since the success of our joint bid with the University of Sheffield to develop two National Institute for Health Research (NIHR) Biomedical Research Units, in musculoskeletal and cardiovascular disease, last year.

The management infrastructure has been put in place with the creation of a Biomedical Research Units Board of which the Trust's Chief Executive Officer is a member. The Board has a high level overview of research strategy and the development of new initiatives. We have also established a joint Biomedical Research Unit executive to provide a coordinated approach to setting up the new units within the Trust's existing management structures and to assist in other development issues such as staff recruitment.

The Cardiovascular Biomedical Research Unit (CVBRU) has been established in partnership with the Sheffield Teaching Hospitals NHS Foundation Trust and the University of Sheffield funded by a National Institute of Health Research (NIHR) grant. The establishment of the CVBRU in Sheffield will help scientists and clinicians ensure that the discoveries made in our research laboratories are advanced into clinical care and that patients in our hospitals are given an opportunity to participate in clinical research trials with the long term goal of developing better treatments, diagnostic tools and drugs to treat cardiovascular (heart) and pulmonary hypertension disease.

The NIHR award is for 4 years and has provided £2 million of funding for specialist clinical research facilities and equipment and £3.75 million to fund a clinical research team as well as the running costs of the unit.

The Cardiovascular Biomedical Research Unit is co-located with the NIHR Bone Biomedical Research Unit on the ground floor and the Clinical Research Facility on the second floor; the three units together form the new state of the art Centre for Biomedical Research.

The NIHR Bone Biomedical Research Unit (BRU) is now into its third year and aims to improve the diagnosis, management and treatment of musculoskeletal diseases by carrying out world class clinical research.

We have had significant success in the area of patient and public involvement in our research. Over the last year, our 'Lay Advisory Panel for Bone Research' has continued with its excellent work by giving advice on our research topics and research study methodology.

The Unit has now completed its first two fully NIHR funded studies. A total of 250 volunteers were recruited and we will be reporting the findings to the national and international scientific community in late 2010. In the first study the team conducted an investigation of the changes in bone structure over life in men and women using a high resolution CT machine. The study found that bone loss occurs with ageing, as expected, but the way the bone is lost in trabecular and cortical bone differs between men and women and this might explain why women are more prone to fractures in later life. A study in which we have compared the health risks in patients who have had the metal-on-metal hip prosthesis as compared to the more conventional hip prosthesis has also been undertaken. The outcome of the trial will inform surgeons as to which form of hip replacement is best in which patients.

A Bone BRU training programme has been established to ensure continuing professional development for all staff.

Collaboration for Leadership in Applied Health Research and Care

In 2008 we put in a successful bid to the National Institute of Health Research, on behalf of our partners in South Yorkshire, to become one of the country's nine Collaborations for Leadership in Applied Health Research and Care Consortia (CLAHRC).

By forging a mutually beneficial, forward-looking partnership between Sheffield's two universities and the region's NHS and 3rd sector organisations, the South Yorkshire Consortium (CLAHRC SY)

NIHR CLAHRC for South Yorkshire

aims to develop the self-management and self-care of long-term conditions through applied research, health technology innovations and the translation of knowledge into quality patient care.

The success of our application resulted in a £20 million investment in the health of the region which focuses on 11 research themes. Five of these relate to the self-management of chronic conditions:

- chronic obstructive airways disease (COPD),
- stroke,
- diabetes,
- obesity including childhood obesity and
- depression.

The use of existing, new and emerging technologies forms another key area, with two research themes in Tele-health and Tele-care and Genetics. The final implementation themes cover inequalities in health, intelligent commissioning, knowledge into action, and user-centred healthcare design. Through this work, we hope to change the care and services provided in South Yorkshire, allowing us to move towards a truly patient centred holistic approach to research and evidence implementation.

Since CLAHRC-SY was launched in 2008, the level of commitment from our partner organisations has been outstanding. We now have 37 projects underway, including 15 research and 22 implementation projects.

Our User-Centred Healthcare Design (UCHD) theme set up its first project in the medical outpatients department at the Royal Hallamshire Hospital and aims to provide better outpatient services for older people. A help point, staffed by volunteers, is already being tested, while recommendations about transport to and from the hospital have been made, which is hoped will lead to further improvements.

The Translating Knowledge into Action (TK2A) theme is currently addressing the problem of malnutrition amongst patients with long-term conditions (LTC) in hospital settings. An after action review process, enabling staff to understand why things happened as they did and to learn from that experience, is now being piloted with the Trust's practice development and clinical effectiveness teams.

The Diabetes theme is conducting an evaluation of the use of services by adolescents with type 1 Diabetes. While helping to shape a new model of care for young people, this will also prove useful for commissioners.

Resulting from membership of the North Trent Stroke Project Strategy Board, the Stroke theme is working with the Trust and Yorkshire Ambulance Service to assess the impact of the Government's FAST (Face, Arm, Speech, Time) campaign on referrals and evaluating a social marketing intervention for stroke awareness.

Our Telehealth and Care technologies theme (TACT), which focuses on identifying and implementing new technological solutions for people with LTC and to meet the challenges of successful ageing, is already developing close links with industry. Its work will contribute towards providing a robust clinical and cost effectiveness evidence base necessary to underpin the future mainstreaming of these technologies.

Training the healthcare professionals of the future.

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

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

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

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

Working with our 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	3824
Patient Constituency	3457
Staff Constituency	13786
Total membership	21,067

As well as providing people with the opportunity to become involved in the development of their local hospitals, members receive a free copy of 'Good Health', a quarterly newspaper providing health information and news about hospital services. We also run a series of exclusive members' events including lectures on topics of interest to the general public. Over 300 people attended the 2009/10 lecture series.

One of our key strengths remains the involvement of people who live locally or who have received treatment at one of our hospitals in our Governors' Council. The Council is made up of 37 foundation trust governors. In September 2009 the Governors' Council updated its terms of reference and identified its purpose as twofold

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

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

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

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

The Council appoints the Trust's non-executive directors, including the chair and determines their remuneration. During 2009/10 the Nominations Committee reappointed Vickie Ferres and Professor Anthony Weetman as non executive directors. The Council also approves the appointment or removal of the Trust's auditors following a recommendation from a nominated sub-group of the Board of Directors.

The Governors' Council

All the public and patient governors are elected for a three-year term of office while the term for governors representing partner organisations is negotiable by their employing organisation.

At the end of March 2010, membership of the full Governors' Council was as shown:

Sheffield Teaching Hospitals NHS Foundation Trust Governors' Council		
Constitution	**Governor**	**Expiration of Term of Office**
Patient	Joe Abson	30 – 6 -10
	John Holden	30 - 6 – 12
	John Laxton	30 – 6 - 11
	Shirley Lindley	30 – 6 - 12
	Graham Thompson	30 – 6 -11
	Christina Wakefield	30 – 6 -11
	Michael Warner	30 – 6 - 12
Public – North	Georgina Bishop	30 – 6 – 11
	George Clark	30 – 6 – 11
	Kaye Meegan	16 – 10 – 09
Public - South West	Charlie Khan	30 – 6 – 10
	Andrew Manasse	30 – 6 – 12
	Philip Seager	30 – 6 – 11
Public - West	Anne Eckford	30 – 6 – 10
	John Warner	30 – 6 – 10
	Beryl Wilson	30 – 6 – 12
Public - South East	Yvonne Challans	30 – 6 – 12
	Richard Chapman	30 – 6 - 10
	Danny Roberts	30 – 6 - 12
Staff:		
Medical & Dental	Frank Edenborough	30 – 6 – 12
Nursing & Midwifery	Rose Bollands	30 – 6 – 12
Allied Health Professionals, Scientists & Technicians	Viv Stevens	30 – 6 – 12
Managerial, Administrative & Clerical	Mark Hattersley	30 – 6 – 12
Ancillary, Works & Maintenance	VACANT	

Parner Organisations	
Organisation	**Governor**
NHS Sheffield	Jeremy Wight
Sheffield City Council	Gail Smith Richard Webb
NHS Yorkshire & Humber	Vacant
The University of Sheffield	Dominic Shellard
Sheffield Hallam University	Rhiannon Billingsley
Sheffield College	Heather MacDonald
South Yorkshire Police	Paul Broadbent
Sheffield Health & Social Care Trust	Martin Rosling
Sheffield First Partnership	Jack Scott
Voluntary Action Sheffield	To be confirmed
Outside Sheffield PCT	Annette Leban

Governors' Council – Attendance at Meetings					
Governor Date Elected/ Re-elected	3-3-09	2-6-09	29-9-09	1-12-09	2-3-10
J Abson **1-7-07**	Apols	✓	Apols	Apols	×
G Bishop **1-7-07**	✓	✓	Apols	✓	✓
R Bollands **1-7-04** **1-7-06** **1-7-09**	✓	✓	Apols	✓	Apols
Y Challans **1-7-09**	N/A	N/A	✓	✓	✓
R Chapman **1-7-04** **1-7-07**	×	✓	✓	Apols	Apols
G Clark **1-7-08**	✓	✓	✓	✓	✓
S Coldwell **1-7-04** **9-6-06**	✓	✓	N/A		
M Collins **1-7-04** **1-7-06**	✓	✓	N/A		
A Eckford **1-7-07**	✓	✓	✓	Apols	✓
F Edenborough **1-7-09**	N/A	N/A	✓	✓	✓
M Hattersley **1-7-04** **1-6-06** **1-7-09**	✓	✓	✓	✓	✓
E Hill **1-7-06**	×	×	N/A		
J Holden **1-7-04** **1-7-06** **1-7-09**	✓	✓	✓	✓	✓
J Hulse **1-7-06**	×	×	N/A		
C Khan **1-7-07**	×	×	×	×	Apols

Governors' Council - Attendance at Meetings					
Governor Date Elected/ Re-elected	3-3-09	2-6-09	29-9-09	1-12-09	2-3-10
J Laxton **1-7-08**	Apols	✓	Apols	✓	✓
S Lindley **1-7-09**	N/A	N/A	✓	✓	✓
A Manasse **1-7-09**	N/A	N/A	✓	✓	✓
K Meegan **16-10-06**	Apols	✓	Apols	✓	✓
C Rawding **1-7-06**	×	×	N/A		
D Roberts **1-7-09**	N/A	N/A	✓	✓	✓
P Seager **1-7-04** **1-7-05** **1-7-08**	✓	Apols	✓	✓	Apols
V Stevens **1-7-09**	N/A	N/A	✓	✓	Apols
G Thompson **1-7-08**	✓	✓	✓	✓	✓
C Wakefield **1-7-08**	✓	✓	✓	✓	✓
J Warner **1-7-08**	✓	Apols	Apols	✓	✓
M Warner **1-7-09**	N/A	N/A	✓	✓	✓
S Westby **1-7-04** **1-7-06**	✓	✓	N/A		
B Wilson **1-7-04** **1-7-06** **1-7-09**	✓	✓	×	✓	✓
S Wilson **1-7-04** **1-7-06**	✓	✓	N/A		

Governors' Council – Attendance at Meetings					
Partner Governor Year Appointed	3-3-09	2-6-09	29-9-09	1-12-09	2-3-10
J Wight 2007	Apols	✓	✓	Apols	Apols
R Billingsley 2008	Apols	Apols	✓	×	×
D Shellard 2008	×	×	×	×	×
A Laban 2009	×	×	Apols	×	×
P Broadbent 2008	×	Apols	×	✓	Apols
R Webb 2010	N/A	N/A	N/A	N/A	✓
M Rosling 2008	Apols	Apols	Apols	×	×
H McDonald 2008	Apols	×	✓	✓	✓
G Smith 2010	N/A	N/A	N/A	N/A	✓
J Scott 2009	✓	×	×	×	×

Governors' Council – Attendance at Meetings					
Exec NED Officer	3-3-09	2-6-09	29-9-09	1-12-09	2-3-10
D Stone Chairman	✓	✓	✓	✓	✓
A Cash	✓	✓	✓	✓	✓
N Priestley	✓	✓	Apols	✓	✓
H Scholefield	R Parker	✓	✓	✓	✓
C Welsh	✓	N/A	N/A		
M Richmond	✓	✓	✓	✓	✓
C Linacre	✓	✓	✓	✓	✓
J Watts until 4.09	Apols	N/A			
M Gwilliam after 4.09	N/A	✓	✓	✓	Apols

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 the whole gamut 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.

Director of Finance Review

Neil Priestley
Director of Finance

The 2009/10 financial year has been an extremely challenging one and is almost certainly indicative of the difficult financial environment the NHS will face in the coming years.

The Trust's 2009/10 Annual Accounts reflect a major exercise in the year to formally revalue the Trust's land and buildings using the new Modern Equivalent Asset basis of valuation. The impact of this and the general economic downturn resulted in a major reduction to land and building values and a major non-cash impairment charge.

The Accounts therefore show an operating deficit of £54.2m. However, if the 'technical' non-cash impact of the estate revaluation is excluded, the Trust's "real" operating position is a surplus of £0.98m which is 0.12% of turnover for the year. Whilst this is clearly a relatively modest surplus, it does reflect continued financial stability for the Trust alongside its significant service achievements.

The Trust's income grew significantly in 2009/10 as shown below:

	£M	% increase over 2008/09
Income from patient services	647.9	7.9
Other Operating income	141.7	8.3
Total Income	789.6	7.9

The national inflation and CQUIN funding accounts for 2.2% of the patient services income increase but the balance reflects the major and growing demands on the Trust's services during 2009/10.

Despite the income growth, the Trust again faced a major efficiency requirement of £24.3m. The cumulative requirement over 2009/10 and the previous 3 years was £114m.

The Trust failed to deliver around £5m of its efficiency plans in 2009/10 which almost certainly reflects the difficulty of this cumulative challenge. However, the coming years will almost certainly require even greater levels of efficiency savings which necessitates an even greater level of focus and insight in this area.

Pay Costs rose by 6.8% in the year which partly reflects pay awards and the transition to the Agenda for Change pay system but also the additional staff required to deliver the growth in services. Drug costs and clinical supplies and services both rose by over 10% and purchase of healthcare from non-NHS bodies rose by over 15%, again indicative of the demands on services. It is also worthy of note that Clinical Negligence costs almost doubled to just over £10m.

Total capital expenditure for the year was £39.1m which again represents a major investment in the Trust's facilities and equipment. Slippage, due to planning and operational pressures, and £1.5m of unanticipated capital income resulted in an under spend against available resources of £6.2m. However, these resources will be carried-forward to undertake the planned schemes in 2010/11.

As in previous years, the Trust's capital programme sought to achieve a balance between maintaining and replenishing the infrastructure, reducing risk, improving the patient experience and facilitating new, improved and expanded services. The 2009/10 capital expenditure is analysed as follows:

	£,000	£,000
Service Development	**25,818**	
NGH Clinical Research Facility & Biomedical Research Units		4,296
Renal Dialysis Unit		3,424
Renal Inpatient Ward		3,263
RHH Theatre Admissions Unit		2,715
Radiopharmacy Facilities		2,047
Reconfiguration of Ophthalmic Outpatient Department		1,805
Miscellaneous Clinical and Corporate Accommodation		1,551
Cystic Fibrosis Inpatient Facilities		1,146
Reconfiguration of Burns Unit		407
Dental Hospital Expansion		382
Multi-Disciplinary Team Facilities/ RHH N Floor Lecture Theatre		368
Renal F Floor Conversion		347
Reconfiguration RHH C Floor Pharmacy		341
Expansion of Neonatal Intensive Care		324
Laboratory Medicine Facilities		259
Other smaller schemes		3,143
Medical Equipment	**5,616**	
Additional MRI Scanner, RHH		1,862
Patient monitors		798
Scopes		606
Replacement Gamma Camera		351
DNP Polariser		347
Other		1,652
Statutory Compliance	**678**	
Fire Safety		292
Moving & Handling		137
Other (eg Security, Road Safety, DDA compliance etc)		249
Information Technology	**1,460**	
Single Patient Record & Admission System		440
Dental Hospital IT Infrastructure		389
Other		631
Infrastructure	**5,520**	
Ward Refurbishments & creation of 3rd Medical Admissions Unit		2,748
Electrical Capacity & Resilience and Energy Reduction schemes		609
Replacement NGH Boiler		493
Other		1670
Total Expenditure	**39,092**	

Total capital income available to the Trust for the year was £45.2m and is analysed as follows:-

	£,000
Internally Generated Resources	38,345
External NHS Funding	5,899
Other Donations/Contributions	999
Total Income	**45,243**

The Trust's net assets employed at 31 March 2010 were £361.0m compared with £514.3m at the previous year-end. The reduction is due to the impact of the revaluation of the Trust's estate referred to above. The reduced valuations attached to the Trust's land and buildings have no impact on its financial health. Net current assets at 31 March 2010 were £13.7m, although there were also non-current liabilities of £6.8m. Outstanding "borrowings" relating to the loan for the Northern General Hospital Critical Care Unit and the Hadfield Block PFI contract totalled £39.8m at the year-end.

Cash balances were £42.1m at the year-end, a reduction of £3.1m over the year. Of the £42.1m, around £11m relates to previous operating surpluses which it is planned to utilise on capital schemes in the coming years and around £16m relates to capital, R&D and other commitments. This leaves a £15m uncommitted balance which the Trust believes is the minimum required to maintain a satisfactory working capital position and to provide a degree of financial security in the difficult years ahead.

On Monitor's Financial Risk Rating of one to five, where one represents very high risk and five very low risk, the Trust's position hovered between a three and a four throughout the year.

The Trust was at all times compliant with its Prudential Borrowing Limit and its private patient income was well within level specified in the statutory Cap.

Overall, therefore, the Trust's 2009/10 financial results are satisfactory, particularly when set alongside the excellent service achievements and the challenging financial environment. However, it is very clear that the Trust, along with the rest of the NHS, faces an immensely difficult financial future as growing demands on services exceed any growth in funding. Further very significant efficiency targets are therefore unavoidable as appear to be cuts to Education and Training funding following the Department of Health's MPET Review. In addition to this, other funding cuts are a strong possibility as commissioners also have to deliver significant savings. The Trust remains committed to delivering high quality services and to achieving real efficiency savings to manage the future financial pressures and to protect our services. However, we are under no illusions about the size of the challenge ahead.

Public Interest Disclosure

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

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

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

The Board of Directors can be contacted by writing to:

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

Senior Independent Director

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

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

The Chairman

David Stone CBE, Chairman

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

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

The Executive Directors

Sir Andrew Cash OBE

Chief Executive

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

He has worked at local, regional and national level. He has worked by invite at the Department of Health Whitehall on a number of occasions. He is a visiting Professor in Leadership Development at the Universities of York and Sheffield.

Andrew has been Chief Executive of Sheffield Teaching Hospitals NHS Foundation Trust since its inception in July 2004. Prior to that he was the first Chief Executive of the newly merged Sheffield Teaching Hospitals, which came into effect in April 2001.

Professor Hilary Scholefield

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. She chairs the National Association of UK University Hospitals Nurse Directors' Group. Hilary is also a Member of the NIHR Advisory Board, Member of the Centre of Excellence Advisory Board, Next Stage Review, Visiting Professor, Faculty of Health and Well -Being, Sheffield Hallam University, Member, Advisory Panel to NHS Chief Executive and Minister for Health, High Quality for All, Member, National Quality Board and Member, NETSCC SDO NHS Evaluation Panel.

Chris Linacre

Director of Service Development

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

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

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.

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 HR at Central Manchester and Manchester Children's University Hospital.

Phil Brennan

Estates Management Director

Phil Brennan was appointed as Estates Director in March 2008, following a period in an acting position. Phil is a chartered engineer and has worked in both the private and public sectors.

He joined the NHS in 1981 and has worked in Sheffield's acute sector ever since. He became Deputy Director Estates, responsible for operational services, in 2001, taking on responsibility for capital projects (engineering design) in 2003.

The following employees attend the Board of Directors meetings but do not sit on the Board.

Julie Phelan

Communications Director

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

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

Neil Riley

Trust Secretary

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

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

The Non-Executive Directors

John Donnelly

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

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

Vickie Ferres

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

A Sheffield resident, Vickie has extensive experience in working with elderly 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 and of the South Yorkshire Probation Board and is the current chair of the Human Tissue Authority.

Jane Norbron

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

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

Vic Powell

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

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

Iain Thompson

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

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

Professor Anthony Weetman

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

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

Standards of Business Conduct - Declaration of Interests. Members of the Board of Directors and other Executive Directors			
Date	**Name**	**Job Title**	**Interests**
18.1.10	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 Brother - Northern Regional Chairman of Building Design Partnership
14.1.10	Mr. John Donnelly	Non Executive Director	Trustee - Sheffield Hospitals Charitable Trust Chair - General Medical Council Fitness to Practice Panels
10.2.10	Ms. Vickie Ferres	Non Executive Director	Chief Executive - Age Concern, Doncaster Husband - Non Executive Director, Sheffield Care Trust
14.1.10	Ms. Shirley Harrison	Non Executive Director	Member, North Trent Consumer Research Panel (unpaid) Lay peer reviewer: NHS SDO R&D Programme Associate Consultant, SCALE Consultants Ltd
20.1.10	Mr. Chris Linacre	Director of Service Development	Non Executive Director of Medipex Ltd Non Executive Director of EPAQ Ltd (a company in which the Trust has a shareholding) Non Executive Director of Zilico Ltd (formerly called Aperio Diagnostic - a company in which the Trust has a shareholding)
10.2.10	Ms. Jane Norbron	Non Executive Director	Company Director of Jane Norbron Limited - Acts as Business Consultant and Performance Coach Involved with organisation International Women of Excellence (Registered Charity) (unpaid) - promotes the appointment of women to senior positions Accredited management assessment centre for the Institute for the Motor Institute (Sector Skills Council)
13.1.10	Mr. Vic Powell	Non Executive Director	Member of DoH Foundation Trust Finance Facility
18.1.10	Professor Mike Richmond	Medical Director	Undertakes Private Practice at Thornbury Hospital Visiting Professor, Faculty of Health & Wellbeing, Sheffield Hallam University
14.1.10	Mr. Neil Riley	Trust Secretary	Visiting Professor, Faculty of Health and WellBeing, Sheffield Hallam University from 1st May 2005 to 31st July 2009 Vice Chairman of the FTN Company Secretary Network (w.e.f. 1.1.08)
19.1.10	Professor Hilary Scholefield	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
20.1.10	Mr. David Stone	Chairman	Trustee of Weston Park Cancer Care Appeal Trustee of Freshgate Foundation Trustee of Sheffield Botanical Gardens Trust Guardian, Sheffield Assay Office Honorary Consul, Republic of Finland Chairman, Cutlers Hall Preservation Trust
13.1.10	Professor Anthony Weetman	University Representative	Chair, Medical Schools Council Chair, Clinical Endocrinology Trust Board member, UK Clinical Aptitude Test Member of Council, Royal College of Physicians of London Member, Health and Education National Strategic Exchange Member, Joint Medical Consultative Committee Member, UUK Health and Social Care Advisory Committee
19.1.09	Professor Chris Welsh (Retired Nov 2009)	Chief Operating Officer STHFT Medical Director Yorks & Humber SHA	In Private Medical Practice based at Claremont Hospital Part owner and Director of C. L. Welsh and Company Limited

Nil Returns		
Date	**Name**	**Job Title**
13.1.10	Mr. Philip Brennan	Director of Estates Management
14.1.10	Mr. Neil Priestley	Director of Finance
14.1.10	Mrs. Julie Phelan	Communications Director
25.1.10	Mr. Iain Thompson	Non Executive Director
14.1.09	Mr. Mark Gwilliam	Director of Human Resources (From 04.09)
13.2.09	Mr. John Watts	Director of Human Resources (Retired 04.09)

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 2009/10 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.

Meetings of the Board

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

The individual attendance by Directors is noted at each meeting and reviewed by the chairman. Attendance may be affected by sickness or annual leave. Individual attendance for 2009/10 is as follows:

Attendance at Board Meetings	
Board Members	Attendance Rate (Out of 13 meetings unless otherwise stated)
David Stone CBE, Chairman	12
Sir Andrew Cash OBE, Chief Executive	12
Chris Linacre, Director of Service Development, Deputy Chief Executive	13
Neil Priestley, Director of Finance	13
Professor Mike Richmond, Medical Director	12
Professor Hilary Scholefield, Chief Nurse/Chief Operating Officer	13
John Watts, Director of Human Resources until 4.09	1/1
Mark Gwilliam, Director of Human Resources after 4.09	11/12
Professor Chris Welsh, Chief Operating Officer STHFT, Medical Director Yorks & Humber SHA retired 30 November 2009	9/9
Julie Phelan, Communications Director	11
Neil Riley, Trust Secretary	12
John Donnelly, Non-executive Director	11
Vickie Ferres, Non-executive Director	11
Shirley Harrison, Non-executive Director	12
Jane Norbron, Non-executive Director	13
Vic Powell, Non-executive Director	11
Iain Thompson, Non-executive Director	11
Professor Anthony Weetman, Non-executive Director, University Representative	11

Committees of the Board

The Management Audit Committee (MAC) is appointed by the Board of Directors and consists of more than three non-executive directors of the Trust. The Director of Finance, the Chief Internal Auditor and a representative from the external auditor normally attend meetings.

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

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

Attendance at Management Audit Committee	
Board Members	Attendance Rate (Out of five meetings unless otherwise stated)
John Donnelly, Non-executive Director (Chair of Committee)	4
Shirley Harrison, Non-executive Director	5
Vic Powell, Non-executive Director	5
Neil Priestley, Director of Finance	5
Neil Riley, Trust Secretary	4
Professor Anthony Weetman, Non-executive Director	4

Attendance at Finance Committee	
Board Members	Attendance Rate (Out of 12 meetings unless otherwise stated)
David Stone, Chairman	6
Sir Andrew Cash, Chief Executive	10
John Donnelly, Non-executive Director	10
Chris Linacre, Director of Service Development	9/9
Vic Powell, Non-executive Director (Chair of Committee)	12
Neil Priestley, Director of Finance	12
John Watts, Director of Human Resources until 4.09	1/1
Mark Gwilliam, Director of Human Resources from 4.09	9/11
Chris Welsh, Chief Operating Officer STHFT until 12.09	6/9
Hilary Scholefield, Chief Nurse/Chief Operating Officer from 12.09	1/3

Attendance at Human Resources Committee	
Board Members	Attendance Rate (Out of four meetings unless otherwise stated)
Vickie Ferres, Non-executive Director	1
Jane Norbron, Non-executive Director (Chair of Committee)	4
Mark Gwilliam, Director of Human Resources	4

Attendance at Healthcare Governance Committee	
Board Members	Attendance Rate (Out of twelve meetings unless otherwise stated)
Phil Brennan, Director of Estates Management	10
Vickie Ferres, Non-executive Director	11
Chris Linacre, Director of Service Development	10
Professor Mike Richmond, Medical Director/ Nominated Deputy	12
Neil Riley, Trust Secretary	10
Professor Hilary Scholefield, Chief Nurse/Chief Operating Officer/ Nominarted Deputy	12
Iain Thompson, Non-executive Director	11
John Watts, Director of Human Resources until 4.09	1/1
Mark Gwilliam, Director of Human Resources from 4.09	5/11
Professor Anthony Weetman, Non-Executive Director, University Representative	9
Professor Chris Welsh, Chief Operating Officer STHFT, Medical Director Yorks & Humber SHA	0/8
Shirley Harrison, Non-executive Director	1/2

Attendance at Remuneration Committee	
Board Members	Attendance Rate (Out of two meeting unless otherwise stated)
David Stone, Chairman (Chair of Committee)	2
Sir Andrew Cash, Chief Executive	1
John Donnelly, Non-executive Director	2
Vickie Ferres, Non-executive Director	2
Jane Norbron, Non-executive Director	2
Vic Powell, Non-executive Director	2
Neil Priestley, Director of Finance	1 (not required at one meeting)
Neil Riley, Trust Secretary	2
Iain Thompson, Non-executive Director	1
Mark Gwilliam, Director of Human Resources	2
Professor Anthony Weetman, Non-executive Director	2
Shirley Harrison, Non-executive Director	2

Governance code

The Board has considered the Monitor Code of Governance and is compliant with the Code as evidenced in the relevant sections of the Annual Report with the exception of the following:

The Board does not believe that the re-appointment of executive directors at no more than five years is required, given the existence of robust annual appraisal arrangements for directors. From April 2010, this requirement is no longer included in the Code of Governance.

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

Remuneration

Further details of remuneration are given in the remuneration report on page 80. The accounting details for pensions and other retirement benefits are set out in the accounts on page 98.

Countering fraud and corruption

The Board remains committed to maintaining an honest and open atmosphere within the Trust; ensuring all concerns involving potential fraud have been identified and rigorously investigated.

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

Health and safety

The Trust remains committed to ensuring that it protects the health and safety of its patients, staff, and visitors.

During 2009/10 it continued to work positively with the Health and Safety Executive and other relevant organisations to improve safety standards within the Trust.

Remuneration Report

Remuneration committee

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

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

The directors of finance and human resources are in attendance at all meetings to advise the committee and ensure that an appropriate record of proceedings is kept.

Remuneration of chairman and non-executive directors

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

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

Remuneration of senior managers

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

Assessment of performance

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

During the year regular reviews take place to discuss progress, and there is an end of year review to assess achievements and performance. The executive directors are assessed by the chief executive; following this there is a meeting between the chairman and each executive director to discuss their performance.

The chairman undertakes the performance review of the chief executive and non-executive directors.

Individual performance review is well established in the Trust, and is an integral part of developing the executive and non-executive directors' personal development plans.

Performance pay

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

Duration of Contracts

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

The chairman and the non-executive director appointments are due for renewal as shown:

Duration of Contracts			
Name	Position	Term of Office Commenced	Term of Office Ends
David Stone	Chairman	Reappointment commenced 1 July 2008	30 June 2012
John Donnelly	Non-executive director	Reappointment commenced 1 July 2006	30 June 2010
Vickie Ferres	Non-executive director	Reappointment commenced 1 July 2009	30 June 2013
Shirley Harrison	Non-executive director	Appointment commenced 1 November 2007	30 June 2011
Jane Norbron	Non-executive director	Appointment commenced 1 July 2007	30 June 2011
Vic Powell	Non-executive director	Reappointed commenced 1 July 2007	30 June 2011
Iain Thompson	Non-executive director	Appointment commenced 1 May 2008	30 April 2012
Anthony Weetman	Non-executive director	Reappointment commenced 1 July 2009	30 June 2013

Early Termination Liability

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

Name	Date of Contract	Unexpired term at 31 March 2010
Andrew Cash	1 July 2004	12 years
Chris Welsh	1 July 2004	3 years
Hilary Scholefield	1 February 2006	20 years
Chris Linacre	1 July 2004	6 years
Neil Priestley	1 July 2004	18 years
John Watts	1 July 2004	4 years
Mark Gwilliam	1 March 2009	19 years
Mike Richmond	28 April 2008	13 years

Other Information:

Please refer to the notes in the 09/10 Accounts contained on pages 90-121 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Increases in Pension at age 60 during 09/10
- Value of the cash equivalent transfer value at the beginning of the year
- Increase in the cash equivalent transfer value during 09/10.

Sir Andrew Cash, OBE
Chief Executive

27 May 2010

Independent auditor's report

I have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the period ended 31 March 2010 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared in accordance with the accounting policies set out within them.

I have also audited the information in the Remuneration Report that is described as having been audited.

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

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the Director of Finance Review, included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual 2009-10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the period then ended in accordance with the accounting policies adopted by the Trust;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Director of Finance Review, included in the annual report, is consistent with the financial statements.

Certificate

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

Damian Murray
Officer of the Audit Commission
3 Leeds City Office Park
Holbeck
Leeds
LS11 5BD
1 June 2010

Statement of the Chief Executive's responsibilities

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

Under the NHS Act 2006, Monitor has directed the 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/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
27 May 2010

Financial statements

Sheffield Teaching Hospitals NHS Foundation Trust

Foreword to the accounts

These accounts for the year ended 31 March 2010 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed

Sir Andrew Cash, OBE
Chief Executive
27 May 2010

Statement of Comprehensive Income for the year ended 31 March 2010

	NOTE	**2009/10 £000**	2008/09 £000
Operating income from continuing operations	3.1	**789,553**	731,536
Operating expenses from continuing operations	4.1	**(828,775)**	(716,282)
OPERATING (DEFICIT) / SURPLUS		**(39,222)**	**15,254**
FINANCE COSTS			
Finance income	7.1	**243**	2,417
Finance expense - financial liabilities	7.2	**(2,549)**	(2,602)
Finance expense - unwinding of discount on provisions		**(56)**	(55)
PDC Dividends payable		**(12,570)**	(14,077)
NET FINANCE COSTS		**(14,932)**	**(14,317)**
(Deficit) / Surplus from continuing operations		**(54,154)**	**937**
Other comprehensive income			
Revaluation losses and impairment losses on property, plant and equipment		**(102,338)**	(3,081)
Increases in donated asset reserve due to receipt of donated assets		**901**	1,279
Reduction in donated asset reserve in respect of depreciation and impairment on donated assets		**(2,131)**	(2,662)
Other recognised losses		**(24)**	(59)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(157,746)**	**(3,586)**

The notes on pages 90 to 121 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement of Financial Position 31 March 2010

	NOTE	**31 March 2010** **£000**	31 March 2009 £000	1st April 2008
Non-current assets				
Intangible assets	8.1	**1,169**	1,325	538
Property, plant and equipment	9.1	**386,885**	541,198	541,175
Investments	12	**0**	0	0
Trade and other receivables	14.1	**4,522**	3,655	2,926
Total non-current assets		**392,576**	546,178	544,639
Current assets				
Inventories	13.1	**12,059**	9,638	8,287
Trade and other receivables	14.1	**32,185**	31,655	32,671
Cash	23	**42,072**	45,212	54,794
Total current assets		**86,316**	86,505	95,752
Current liabilities				
Trade and other payables	16.1	**(58,593)**	(55,631)	(63,871)
Borrowings	18	**(1,345)**	(1,328)	(842)
Provisions due within one year	21	**(1,678)**	(7,689)	(21,384)
Other liabilities	17	**(11,019)**	(9,881)	(7,292)
Total current liabilities		**(72,635)**	(74,529)	(93,389)
Total assets less current liabilities		**406,257**	558,154	547,002
Non current liabilities				
Borrowings	18	**(38,497)**	(39,841)	(30,638)
Provisions due after one year	21	**(2,498)**	(2,375)	(2,343)
Other liabilities	17	**(4,295)**	(1,625)	(2,050)
Total non-current liabilities		**(45,290)**	(43,841)	(35,031)
Total assets employed		**360,967**	514,313	511,971
FINANCED BY:				
Taxpayers' equity				
Public Dividend Capital		**324,607**	320,207	314,279
Revaluation reserve	22	**27,346**	121,081	131,009
Donated asset reserve		**28,914**	41,563	42,855
Income and expenditure reserve		**(19,900)**	31,462	23,828
Total taxpayers' equity		**360,967**	514,313	511,971

The financial statements on pages 86 to 121 were approved by the Management Audit Committee under delegated authority from the Board on 27 May 2010 and were signed on behalf of the Board by

Sir Andrew Cash OBE, Chief Executive
27 May 2010

Statement of Changes in Taxpayers' Equity

	Note	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
		£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009		514,313	320,207	121,081	41,563	31,462
Deficit for the year		(54,154)				(54,154)
Revaluation (losses) and impairment (losses) on property, plant and equipment		(102,338)		(90,919)	(11,419)	
Increase in the donated asset reserve due to receipt of donated assets		901			901	
Reduction in the donated asset reserve in respect of depreciation and impairment of donated assets		(2,131)			(2,131)	
Other recognised gains and losses		(24)				(24)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		0		(2,816)		2,816
Public Dividend Capital received		4,400	4,400			
Taxpayers' Equity at 31 March 2010		**360,967**	**324,607**	**27,346**	**28,914**	**(19,900)**
Taxpayers' Equity at 1 April 2008 - restated	32.1	511,971	314,279	131,009	42,855	23,828
Surplus for the year		937				937
Revaluation (losses) and impairment (losses) on property, plant and equipment		(3,081)		(3,172)	91	
Increase in the donated asset reserve due to receipt of donated assets		1,279			1,279	
Reduction in the donated asset reserve in respect of depreciation and impairment of donated assets		(2,662)			(2,662)	
Other recognised gains and losses		(59)				(59)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		0		(6,756)		6,756
Public Dividend Capital received		5,928	5,928			
Taxpayers' Equity at 31 March 2009		**514,313**	**320,207**	**121,081**	**41,563**	**31,462**

Statement of Cash Flows 31 March 2010

Cash flows from operating activities	NOTE	2009/10 £000	2008/09 £000
Operating (deficit)/surplus from continuing operations		(39,222)	15,254
Non-cash income and expense:			
Depreciation and amortisation		26,357	31,338
Impairments		65,154	1,569
Reversals of impairments		(288)	(398)
Transfer from the donated asset reserve		(2,131)	(2,662)
(Increase) in Trade and Other Receivables		(1,413)	(494)
(Increase) in Inventories		(2,421)	(1,351)
Increase/(Decrease) in Trade and other Payables		6,575	(4,150)
Increase in Other Liabilities		3,784	2,164
(Decrease) in Provisions		(5,944)	(13,719)
Net cash generated from operations		**50,451**	**27,551**
Cash flows from investing activities			
Interest received		248	2,582
Purchase of financial assets		0	(90,000)
Sale of financial assets		0	90,000
Puchase of intangible assets		(376)	(2,862)
Purchase of Property, Plant and Equipment		(42,332)	(37,916)
Sales of Property, Plant and Equipment		0	360
Net cash (used in) investing activities		**(42,460)**	**(37,836)**
Cash flows from financing activities			
Public dividend capital received		4,400	5,928
Loans received		0	11,000
Loans repaid		(780)	(780)
Capital element of Private Finance Initiative Obligations		(548)	(531)
Interest paid		(832)	(997)
Interest element of Private Finance Initiative obligations		(1,715)	(1,750)
PDC Dividend paid		(12,640)	(14,077)
Cash flows from other financing activities		984	1,910
Net cash (used in)/generated from financing activities		**(11,131)**	**703**
(Decrease) in cash and cash equivalents		**(3,140)**	**(9,582)**
Cash and Cash equivalents at 1 April		45,212	54,794
Cash and Cash equivalents at 31 March		**42,072**	**45,212**

Notes to the accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2009/10 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.

1.1 Income

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

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

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

1.2 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

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

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

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

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 capitalised 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. Prior to 1st April 2009, specialised operational property was valued on the basis of depreciated replacement cost on a replacement of existing asset rather than modern substitute basis.

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

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

Depreciation

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

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

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

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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'.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated assets

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

Private Finance Initiative (PFI) transactions

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

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

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

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. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

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. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

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

Amortisation

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

1.6 Government grants

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

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

1.7 Inventories

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

1.8 Financial instruments and financial liabilities

Recognition

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

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

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

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

De-recognition

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

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

Classification and Measurement

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

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

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

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

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

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

Loans and receivables

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

The Trust's loans and receivables comprise cash and cash equivalents and NHS back to back debtors.

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

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

Available-for-sale financial assets

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

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

Other financial liabilities

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

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

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

Determination of fair value

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

Impairment of financial assets

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

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

1.9 Leases

Finance leases

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

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

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. Leased land is treated as an operating lease.

1.10 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

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 21.

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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.12 Public dividend capital

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

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

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, net cash held with the Office of the Paymaster General/ Government Banking Services 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 expense in the period in which they arise.

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

1.16 Third party assets

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

2 Segmental Analysis

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

3.1 Income from Activities

	2009/10	2008/09
	£'000	£'000
Elective income	**144,890**	137,040
Non Elective income	**173,208**	160,931
Outpatient income	**107,600**	98,632
A&E Income	**10,461**	9,750
Other NHS Clinical income	**208,377**	190,464
Private Patient Income	**3,335**	3,838
Total income from activities	**647,871**	**600,655**
Other operating income		
Research and development	**9,967**	8,328
Education and training	**68,543**	64,424
Transfer from donated asset reserve in respect of depreciation and impairment on donated assets	**2,131**	2,662
Non-patient care services to other bodies	**45,113**	42,010
Other	**15,831**	13,439
Profit on disposal of other tangible fixed assets	**97**	18
Total other operating income	**141,682**	**130,881**
TOTAL OPERATING INCOME	**789,553**	**731,536**

3.2 Private patient income

	2009/10	2008/09	Base year (2002-03)
	£'000	£'000	£'000
Private Patient Income	**3,335**	3,898	2,919
Total patient related income	**647,871**	600,655	367,927
Proportion (as percentage)	**0.51%**	0.65%	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. Comparative figures have been restated to reflect the update issued by Monitor in February 2010.

3.3 Operating lease income

	2009/10	2008/09
	£'000	£'000
Rents recognised as income in the period	247	217
TOTAL	**247**	**217**
Future minimum lease payments due		
- not later than one year;	255	217
- later than one year and not later than five years;	458	1
- later than five years.	1,478	1,521
TOTAL	**2,191**	**1,739**

3.4 Operating Income (by type)

	2009/10 £'000	2008/09 £'000
Foundation Trusts	**4**	0
Strategic Health Authorities	**1,354**	898
Primary Care Trusts	**634,844**	567,776
Local Authorities	**42**	113
Department of Health	**3,436**	23,864
NHS Other	**1,481**	1,131
Non NHS: Private patients	**2,431**	3,025
Non NHS: Overseas patients (non-reciprocal)	**904**	813
NHS injury scheme (was Road Traffic Act Scheme)	**3,234**	2,972
Non NHS: Other*	**141**	63
Total Income from activities	**647,871**	**600,655**

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

Other Operating Income	**2009/10 £'000**	2008/09 £'000
Research and Development	**9,967**	8,328
Education and Training	**68,543**	64,424
Transfers from the donated asset reserve in respect of depreciation and impairment of donated assets	**2,131**	2,662
Non patient care services to other bodies	**45,113**	42,010
Profit on disposal of other tangible fixed assets	**97**	18
Other	**15,831**	13,439
Total Other income	**141,682**	130,881

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 R&D activities of £9.967m, relates to the provision of mandatory services under the Trust's terms of authorisation.

4 Operating Expenses

4.1 Operating expenses comprise:

	2009/10 Total	2008/09 Total
	£'000	£'000
Services from other NHS Foundation Trusts	**6,338**	6,095
Services from other NHS Trusts	**5,473**	5,311
Services from other NHS bodies	**7,483**	6,491
Purchase of healthcare from non NHS bodies	**12,157**	10,529
Executive Directors' costs	**1,307**	1,346
Non-Executive Directors' costs	**185**	180
Staff costs	**483,686**	452,872
Drugs costs	**77,307**	69,771
Supplies and services - clinical	**73,361**	66,659
Supplies and services - general	**7,417**	6,933
Establishment	**7,168**	7,346
Research and Development	**5,938**	2,984
Transport	**811**	752
Premises	**26,856**	29,390
Increase in provision for impairment of receivables	**2,391**	3,144
Other impairment of financial assets	**169**	0
Depreciation on property, plant and equipment	**26,018**	31,078
Amortisation on intangible assets	**339**	260
Impairments of property, plant and equipment	**65,154**	1,569
Reversal of impairments of property, plant and equipment	**(288)**	(398)
Audit services- statutory audit	**56**	87
Further audit assurance services	**3**	1
Clinical negligence	**10,100**	5,127
Legal fees	**1,128**	1,510
Consultancy costs	**3,305**	3,280
Training, courses and conferences	**1,655**	1,880
Insurance	**766**	620
Losses, ex gratia & special payments	**903**	298
Other	**1,589**	1,167
	828,775	716,282

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

4.2 Arrangements containing an operating lease

	2009/10	2008/09
	£'000	£'000
Minimum lease payments	**1,557**	1,714
Contingent rents	**0**	0
Less sublease payments received	**0**	0
	1,557	**1,714**

4.3 Arrangements containing an operating lease

	2009/10	2008/09
	£'000	£'000
Future minimum lease payments due:		
Within 1 year	**205**	1,445
Between 1 and 5 years	**2,672**	3,404
After 5 years	**1,847**	377
	4,724	5,226

4.4 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	To 31 March 2010				To 31 March 2009			
	Salary (bands of £5000) £000	**Other Remuneration (bands of £5000)** £000	**Benefits in Kind Rounded to the nearest £100**	**Employee Short term benefits - Employer's National Insurance Rounded to the nearest £100**	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Employee Short term benefits - Employer's National Insurance Rounded to the nearest £100
Sir A J Cash Chief Executive	**215-220**			**25,600**	210-215			25,300
Mr J Watts Director of Human Resources (Until 12.4.09)	**0-5**			**400**	125-130			14,400
Mr N Priestley, Director of Finance	**150-155**			**17,200**	145-150			16,900
Mr M Richmond, Medical Director (Appointed 28 April 2008)	**165-170**			**22,100**	145-150			20,300
Professor H Scholefield, (Chief Nurse until 30 November 2009, Chief Nurse and Chief Operating Officer from 1 December 2009)	**145-150**			**16,600**	125-130			14,500
Mr C Welsh Chief Operating Officer (until 30.11.09)	**65-70**	**45-50**		**13,300**	120-125	40-45		19,600
Mr C C Linacre Director of Service Development	**135-140**			**15,700**	135-140			15,400
Mr M Gwilliam Director of Human Resources (from 1.5.09)	**100-105**			**10,100**	n/a			n/a
Mr I Thompson, Non Executive Director	**15-20**			**1,300**	10-15			1,300
Mr J P Donnelly, Non-Executive Director	**15-20**			**1,300**	15-20			1,200
Ms V R Ferres, Non Executive Director	**15-20**			**1,300**	15-20			1,200
Mr V G W Powell, Non Executive Director	**15-20**			**1,600**	15-20			1,500
Mrs J Norbron, Non Executive Director	**15-20**			**1,300**	15-20			1,200
Ms S Harrison, Non-Executive Director	**15-20**			**1,300**	15-20			1,200
Prof A P Weetman, Non Executive Director	**15-20**			**1,300**	15-20			1,200
Mr D Stone, Chairman	**55-60**			**6,700**	55-60			6,500

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31.3.10 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Sir A J Cash, Chief Executive	5-7.5	350-352.5	1,951	1,772	135	30,200
Mr J Watts, Director of Human Resources (Until 12.4.09)	n/a	n/a	n/a	n/a	n/a	600
Mr N Priestley, Director of Finance	5-7.5	197.5 - 200	900	817	63	21,000
Mr M Richmond, Medical Director, with effect from 28.4.08	10-12.5	207.5 - 210	1,124	992	107	26,400
Professor H Scholefield, (Chief Nurse until 30.11.09, Chief Nurse and Chief Operating Officer from 1.12.09)	27.5-30	217.5 - 220	930	754	157	20,400
Mr C Welsh, Chief Operating Officer (until 30.11.09)	n/a	n/a	n/a	n/a	n/a	9,600
Mr C C Linacre, Director of Service Development	2.5 - 5	265 - 267.5	n/a	1,620	n/a	19,300
Mr M Gwilliam, Director of Human Resources (from 1.5.09)	10-12.5	32.5 - 35	144	85	51	12,900

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

5.1 Employee Expenses

	2009/10 Total £'000	**Permanent**	**Other**	2008/09 Total £'000	Permanent	Other
Salaries and wages	**403,850**	**397,990**	**5,860**	378,424	373,595	4,829
Social Security Costs	**28,634**	**28,634**	**0**	27,457	27,457	0
Employer contributions to NHSPA	**44,815**	**44,815**	**0**	42,461	42,461	0
Other pension costs	**48**	**48**	**0**	48	48	0
Agency/contract staff	**7,646**	**0**	**7,646**	5,828		5,828
	484,993	**471,487**	**13,506**	454,218	443,561	10,657

The above figure of £484,993k is net of the amount of £1,479k (12 months to 31 March 2009 £1,339k) in respect of capitalised salary costs included in fixed asset additions (note 9.1).

5.2 Average number of persons employed (WTE basis)

	2009/10 Total Number	**Permanent**	**Other**	2008/09 Total Number	Permanent	Other
Medical and dental	1,630	1,563	67	1,548	1,515	33
Administration and estates	2,506	2,392	114	2,387	2,298	89
Healthcare assistants and other support staff	1,397	1,339	58	1,374	1,292	82
Nursing, midwifery and health visiting staff	5,086	4,816	270	4,957	4,723	234
Scientific, therapeutic and technical staff	1,947	1,934	13	1,905	1,886	19
Total	**12,566**	**12,044**	**522**	12,171	11,714	457

5.3 Employee benefits

	2009/10 £000	2008/09 £000
None	**0**	0
	0	0

5.4 Early Retirements Due to Ill Health

	2009/10 £'000	**2009/10 Number**	2008/09 £'000	2008/09 Number
Number of early retirements agreed on the grounds of ill health		**12**		18
Cost of early retirements agreed on grounds of ill health	**709**		771	

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:

	2009/10	2008/09
Number of non NHS invoices paid	**158,675**	156,697
Number of non NHS invoices paid within 30 days	**151,293**	147,762
Percentage of invoices paid within 30 days	**95.35%**	94.30%
	£'000	£'000
Value of non NHS invoices paid	**268,422**	257,682
Value of non NHS invoices paid within 30 days	**252,222**	239,800
Percentage of invoices paid within 30 days	**93.96%**	93.06%
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

	2009/10 £000	2008/09 £000
Bank account interest	**243**	2,417
	243	2,417

7.2 Finance costs - interest expense

	2009/10 £000	2008/09 £000
Loans from the Foundation Trust Financing Facility	**834**	851
Finance Costs in PFI obligations		
Main Finance Costs	**1,459**	1,493
Contingent Finance Costs	**256**	258
	2,549	2,602

7.3 Impairment of assets

	2009/10 £,000	2008/09 £,000
Loss or damage from normal operations	**88**	261
Abandonment of assets in course of construction	**1,173**	860
Changes in market price	**63,605**	50
TOTAL	**64,866**	1,171

Changes in market price include the devaluation of land and property associated with the introduction of the Modern Equivalent Asset valuation measure of depreciated replacement cost at 1 April 2009 and the full revaluation of the estate at 31 March 2010.

8.1 Intangible fixed assets 2009/10

	Total £'000	Software licences £'000
Gross cost at 1 April 2009	**2,303**	2,303
Reclassifications	**111**	111
Additions - purchased	**72**	72
Disposals	**(6)**	(6)
Gross cost at 31 March 2010	**2,480**	**2,480**
Amortisation at 1 April 2009	**978**	978
Provided during the year	**339**	339
Disposals	**(6)**	(6)
Amortisation at 31 March 2010	**1,311**	**1,311**
Net book value		
- Purchased at 31 March 2009	**1,321**	1,321
- Donated at 31 March 2009	**4**	4
Total at 31 March 2009	**1,325**	**1,325**
Net book value		
- Purchased at 31 March 2010	**1,166**	1,166
- Donated at 31 March 2010	**3**	3
Total at 31 March 2010	**1,169**	**1,169**

8.2 Intangible fixed assets 2008/09

	£'000	£'000
Gross cost at 1 April 2008	**1,309**	1,309
Reclassifications	**692**	692
Additions - purchased	**355**	355
Disposals	**(53)**	(53)
Gross cost at 31 March 2009	**2,303**	**2,303**
Amortisation at 1 April 2008	**771**	771
Provided during the year	**260**	260
Disposals	**(53)**	(53)
Amortisation at 31 March 2009	**978**	**978**
Net book value		
- Purchased at 1 April 2008	**529**	529
- Donated at 1 April 2008	**9**	9
Total at 1 April 2008	**538**	538
Net book value		
- Purchased at 31 March 2009	**1,321**	1,321
- Donated at 31 March 2009	**4**	4
Total at 31 March 2009	**1,325**	**1,325**

8.3 Intangible assets acquired by government grants

	2009/10 £,000
Initial fair value	**0**
Carrying amount at 31 March 2009	**0**
Carrying amount at 31 March 2010	**0**

8.4 Economic life of intangible assets

Software has been given an economic life of five years

9. Property, Plant and Equipment

9.1 Property, Plant and Equipment 2009/10	Total £'000	Land £'000	Buildings exc dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000
Cost or valuation at 1 April 2009	**670,949**	28,870	468,803	2,448	19,267	106,905	1,047	21,821	21,788
Additions - purchased	**38,119**	0	9,195	11	26,245	2,112	61	80	415
Additions - donated	**901**	0	130	0	379	385	0	7	0
Impairments charged to revaluation reserve	**(94,496)**	(11,609)	(82,791)	(96)	0	0	0	0	0
Reclassifications	**(111)**	0	22,701	0	(32,924)	8,319	49	654	1,090
Other Revaluations	**(121,751)**	(523)	(121,091)	(137)	0	0	0	0	0
Disposals	**(4,024)**	0	(1)	0	0	(3,586)	(135)	(113)	(189)
Cost or valuation at 31 March 2010	**489,587**	**16,738**	**296,946**	**2,226**	**12,967**	**114,135**	**1,022**	**22,449**	**23,104**
Depreciation at 1 April 2009	**129,751**	0	34,600	214	0	65,637	741	12,724	15,835
Provided during the year	**26,018**	0	14,212	106	0	7,829	69	2,671	1,131
Impairments recognised in operating expenses	**65,154**	25	64,980	61	0	25	38	0	25
Reversal of impairments	**(288)**	0	(249)	(39)	0	0	0	0	0
Reclassifications	**0**	0	0	0	0	0	0	0	0
Other Revaluations	**(113,909)**	(25)	(113,542)	(342)	0	0	0	0	0
Disposals	**(4,024)**	0	(1)	0	0	(3,586)	(135)	(113)	(189)
Depreciation at 31 March 2010	**102,702**	**0**	**0**	**0**	**0**	**69,905**	**713**	**15,282**	**16,802**
Net book value									
- Purchased at 31 March 2009	**476,329**	27,376	375,078	2,068	19,130	37,770	284	9,073	5,550
- Finance Lease at 31 March 2009	**23,310**	0	23,310	0	0	0	0	0	0
- Donated at 31 March 2009	**41,559**	1,494	35,815	166	137	3,498	22	24	403
Total at 31 March 2009	**541,198**	**28,870**	**434,203**	**2,234**	**19,267**	**41,268**	**306**	**9,097**	**5,953**
Net book value									
- Purchased at 31 March 2010	**344,396**	15,853	259,384	2,047	12,891	41,012	291	7,105	5,813
- Finance Lease at 31 March 2010	**13,578**	0	13,578	0	0	0	0	0	0
- Donated at 31 March 2010	**28,911**	885	23,984	179	76	3,218	18	62	489
Total at 31 March 2010	**386,885**	**16,738**	**296,946**	**2,226**	**12,967**	**44,230**	**309**	**7,167**	**6,302**

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

9.3 Property, Plant and Equipment 2008/09	Total £'000	Land £'000	Buildings exc dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000
Cost or valuation at 1 April 2008	**647,418**	28,902	452,659	2,598	17,568	103,046	975	20,664	21,006
Additions - purchased	**35,123**	0	2,223	0	28,878	3,104	133	531	254
Additions - donated	**1,279**	0	27	0	758	443	0	0	51
Impairments charged to revaluation reserve	**0**	0	0	0	0	0	0	0	0
Reclassifications	**(692)**	0	20,113	0	(27,077)	3,877	0	1,624	771
Other Revaluations	**(6,901)**	64	(6,219)	114	(860)	0	0	0	0
Disposals	**(5,278)**	(96)	0	(264)	0	(3,565)	(61)	(998)	(294)
Cost or valuation at 31 March 2009	**670,949**	**28,870**	**468,803**	**2,448**	**19,267**	**106,905**	**1,047**	**21,821**	**21,788**
Depreciation at 1 April 2008	**106,243**	0	17,955	114	0	61,244	742	11,282	14,906
Provided during the year	**31,076**	0	19,543	113	0	7,677	60	2,436	1,247
Impairments recognised in operating expenses	**708**	0	447	0	0	258	0	3	0
Reversal of impairments	**(398)**	0	(398)	0	0	0	0	0	0
Reclassifications	**0**	0	0	0	0	23	0	1	(24)
Other Revaluations	**(2,960)**	0	(2,947)	(13)	0	0	0	0	0
Disposals	**(4,918)**	0	0	0	0	(3,565)	(61)	(998)	(294)
Depreciation at 31 March 2009	**129,751**	**0**	**34,600**	**214**	**0**	**65,637**	**741**	**12,724**	**15,835**
Net book value									
- Purchased at 1 April 2008	**474,355**	27,408	373,850	2,309	17,119	38,358	202	9,366	5,743
- Finance Lease at 1 April 2008	**23,975**	0	23,975	0	0	0	0	0	0
- Donated at 1 April 2008	**42,845**	1,494	36,879	175	449	3,444	31	16	357
Total at 1 April 2008	**541,175**	**28,902**	**434,704**	**2,484**	**17,568**	**41,802**	**233**	**9,382**	**6,100**
Net book value									
- Purchased at 31 March 2009	**476,329**	27,376	375,078	2,068	19,130	37,770	284	9,073	5,550
- Finance Lease at 31 March 2009	**23,310**	0	23,310	0	0	0	0	0	0
- Donated at 31 March 2009	**41,559**	1,494	35,815	166	137	3,498	22	24	403
Total at 31 March 2009	**541,198**	**28,870**	**434,203**	**2,234**	**19,267**	**41,268**	**306**	**9,097**	**5,953**

9.4 Analysis of Property, Plant and Equipment									
Net book value									
- Protected assets at 31 March 2009	465,307	28,870	434,203	2,234	0	0	0	0	0
- Unprotected assets at 31 March 2009	75,891	0	0	0	19,267	41,268	306	9,097	5,953
Total at 31 March 2009	**541,198**	**28,870**	**434,203**	**2,234**	**19,267**	**41,268**	**306**	**9,097**	**5,953**

9.5 Economic life of Property, Plant and Equipment

	Minimum Life (years)	Maximum Life (years)
Land	Indefinite	Indefinite
Buildings excluding dwellings	5	45
Dwellings	15	25
Assets under construction	0	0
Plant and Machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture and Fittings	10	10

9.6 Net Book Value covered by each method for determining fair value

Non-Property Valuations

Method For Determining Fair Value	Plant & Machinery £,000	Transport Equipment £,000	Information Technology £,000	Furniture & Fittings £,000	PFI arrangements £,000
Depreciated Historical Cost Basis (as a proxy for fair value for short life assets)	44,230	309	7,167	6,302	0

Property Valuations

Method For Determining Fair Value	Land £,000	Buildings excluding dwellings £,000	Dwellings £,000
Modern Equivalent Asset (no Alternative Site) Basis	16,738	296,946	2,226

In Year Revaluation was undertaken at 31 March 2010

10 Assets held under finance leases

10.1 Assets held under finance leases 2009/10

	Total £'000	PFI Arrangements £'000
Cost or valuation at 1 April 2009	**24,758**	24,758
Additions - purchased	**97**	97
Additions - donated	**0**	0
Impairments charged to revaluation reserve	**(9,393)**	(9,393)
Reclassifications	**0**	0
Other Revaluations	**(1,884)**	(1,884)
Disposals	**0**	0
Cost or valuation at 31 March 2010	**13,578**	**13,578**
Depreciation at 1 April 2009	**1,448**	1,448
Provided during the year	**436**	436
Impairments recognised in operating expenses	**0**	0
Reversal of impairments	**0**	0
Reclassifications	**0**	0
Other revaluations	**(1,884)**	(1,884)
Disposals	**0**	0
Depreciation at 31 March 2010	**0**	**0**
Net book value		
- Purchased at 1 April 2009	**23,310**	23,310
- Donated at 1 April 2009	**0**	0
Total at 1 April 2009	**23,310**	**23,310**
Net book value		
- Purchased at 31 March 2010	**13,578**	13,578
- Donated at 31 March 2010	**0**	0
Total at 31 March 2010	**13,578**	**13,578**

10.2 Assets held under finance leases 2008/09

	Total £'000	PFI Arrangements £'000
Cost or valuation at 1 April 2008	**24,699**	24,699
Additions - purchased	**59**	59
Additions - donated	**0**	0
Impairments charged to revaluation reserve	**0**	0
Reclassifications	**0**	0
Revaluation surpluses	**0**	0
Disposals	**0**	0
Cost or valuation at 31 March 2009	**24,758**	**24,758**
Depreciation at 1 April 2008	**724**	724
Provided during the year	**724**	724
Impairments recognised in operating expenses	**0**	0
Reversal of impairments	**0**	0
Reclassifications	**0**	0
Revaluation surpluses	**0**	0
Disposals	**0**	0
Depreciation at 31 March 2009	**1,448**	**1,448**
Net book value		
- Purchased at 1 April 2008	**23,975**	23,975
- Donated at 1 April 2008	**0**	0
Total at 1 April 2008	**23,975**	**23,975**
Net book value		
- Purchased at 31 March 2009	**23,310**	23,310
- Donated at 31 March 2009	**0**	0
Total at 31 March 2009	**23,310**	**23,310**

10.3 Analysis of Property, Plant and Equipment

Net book value		
- Protected assets at 31 March 2010	**13,578**	13,578
- Unprotected assets at 31 March 2010	**0**	0
Total at 31 March 2010	**13,578**	**13,578**

Net book value		
- Protected assets at 31 March 2009	**23,310**	23,310
- Unprotected assets at 31 March 2009	**0**	0
Total at 31 March 2009	**23,310**	**23,310**

The only finance lease the trust has is categorised as a Private Finance Initiative (PFI) arrangement. The trust has no finance leases in respect of land, buildings, dwellings, assets under construction, plant and machinery, transport equipment, information technology or furniture & fittings.

11.1 Non-current assets for sale and assets in disposal groups 2009/10

There were no non current assets for sale and assets in disposal groups in 2009/10 or 2008/09

12 Fixed asset investments

The Trust has holdings in Zilico (formerly Aperio) Diagnostics and Epaq , companies commercially developing intellectual property. The Trust's holding in these companies carry a minimal value at the balance sheet date (31.03.2010) and at 31 March 2009

The Trust owns 40% (40% 31 March 2009) of the share capital of Epaq, and 22.22% (22.22%, 31 March 2009) of the share capital of Zilico.

13.1 Inventories

	31 March 2010 £'000	31 March 2009 £'000	1 April 2008 £'000
Consumables	**12,059**	9,638	8,287
TOTAL	**12,059**	**9,638**	**8,287**

13.2 Inventories recognised in expenses

	2009/10 £'000	2008/09 £'000
Inventories recognised in expenses	**84,847**	77,119
Write down of inventories recognised as an expense	**64**	167
Total Inventories recognised in expenses	**84,911**	**77,286**

14.1 Trade receivables and other receivables

	31 March 2010 Total £'000	31 March 2009 Total £'000	1 April 2008 Total £'000
Amounts falling due within one year:			
NHS receivables	**24,344**	22,394	18,236
Other receivables with related parties	**4,529**	4,503	4,454
Provision for impaired receivables	**(5,911)**	(3,797)	(1,303)
Prepayments	**1,488**	814	750
Accrued income	**13**	17	181
PDC receivable	**70**	0	0
Other receivables	**7,652**	7,724	10,353
Sub Total	**32,185**	31,655	32,671
Amounts falling due after more than one year:			
NHS receivables	**271**	258	268
Other receivables	**4,251**	3,397	2,658
Sub Total	**4,522**	3,655	2,926
TOTAL	**36,707**	**35,310**	**35,597**

14.2 Provision for impairment of receivables

	2009/10 £'000	2008/09 £'000
At 1 April 2009	**3,797**	1,303
Increase in provision	**3,466**	3,419
Utilised	**(277)**	(650)
Unused amounts reversed	**(1,075)**	(275)
At 31 March 2010	**5,911**	**3,797**

14.3 Analysis of impaired receivables

	2009/10 £'000	2008/09 £'000
Ageing of impaired receivables		
Up to three months	**1,762**	2
In three to six months	**223**	366
Over six months	**3,926**	3,429
Total	**5,911**	**3,797**
Ageing of non-impaired receivables past their due date		
Up to three months	**5,051**	6,158
In three to six months	**2,942**	1,147
Over six months	**1,564**	1,665
Total	**9,557**	**8,970**

15 Current asset investments

	2009/10 £'000	2008/09 £'000
Additions	**0**	90,000
Disposals	**0**	(90,000)
Cost or valuation at 31 March 2010	**0**	**0**

16 Payables

16.1 Trade and other payables

	31 March 2010 Total £'000	31 March 2009 Total £'000	1 April 2008 Total £'000
Amounts falling due within one year:			
NHS payables	**12,610**	12,358	13,216
Amounts due from related parties	**8,144**	4,688	4,652
Trade payables - capital	**6,475**	10,017	14,078
Other trade payables	**10,945**	4,672	9,783
Other payables	**138**	2,696	387
Accruals	**10,555**	11,441	12,483
Social Security and other taxes	**9,726**	9,759	9,272
Total current trade and other payables	**58,593**	**55,631**	**63,871**

16.2 - Early retirements detail included in NHS payables above

	31 March 2010 Total £'000	Number	31 March 2009 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	**5,548**		5,599	

17 Other liabilities

Current	**31 March 2010**	31 March 2009	1 April 2008
	£'000	£'000	£'000
Deferred Income	**10,596**	9,468	6,874
Deferred Government Grant	**423**	413	418
Total Other Current liabilities	**11,019**	**9,881**	**7,292**
Non-current			
Deferred Income	**2,475**	0	0
Deferred Government Grant	**1,820**	1,625	2,050
Total Other Non-current Liabilities	**4,295**	**1,625**	**2,050**

18 Borrowings

Current	**31 March 2010 £'000**	31 March 2009 £'000	1 April 2008 £'000
Loans from Foundation Trust Financing Facility	**780**	780	311
Obligations under Private Finance Initiative contracts	**565**	548	531
Total Current Borrowings	**1,345**	**1,328**	**842**
Non- current			
Loans from Foundation Trust Financing Facility	15,961	16,740	6,989
Obligations under Private Finance Initiative contracts	22,536	23,101	23,649
Total other non-current borrowings	**38,497**	**39,841**	**30,638**

Borrowings consist of

1 A Foundation Trust Financing Facility Loan with £16,741k outstanding at the balance sheet date. This is repayable in 43 half yearly installments over the 21.5 years ending 30th September 2031. Interest of 4.80% is payable on this loan.

2 A Private Financing Initiative contract with a private company with £23,102k outstanding at the balance sheet date. This is repayable in a series of monthly installments over the 26.75 years ending 31 December 2036. Interest of 6.30% is payable on the loan.

19 Prudential Borrowing Limit

	2009/10 £'000	2008/09 £'000
Total long term borrowing limit set by Monitor	**169,300**	157,700
Working capital facility agreed by Monitor	**60,000**	46,000
TOTAL PRUDENTIAL BORROWING LIMIT	**229,300**	**203,700**
Long term borrowing at 1 April	**41,169**	31,480
Net actual long term borrowing/repayment in year	**(1,328)**	9,689
Long term borrowing at 31 March	**39,841**	**41,169**
Working capital facilty at 1 April 2009	**0**	0
Net actual borrowing/repayment in year	**0**	0
Net Working capital facility at 31 March	**0**	**0**

	2009/10		2008/09	
	Limit	**actual**	Limit	actual
Minimum Dividend Cover	**>1**	**3.95**	>1	3.38
Minimum Interest Cover	**>3**	**20.47**	>3	18.26
Minimum Debt Service Cover	**>2**	**11.83**	>2	11.47
Maximum Debt Service to Revenue	**<2.5%**	**0.56%**	<3%	0.60%

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 four 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 & Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The financial ratios for 2009/10 (2008/09) as published in the Pudential Borrowing Code are shown above with the actual level of achievement for the period.

During 2006/07 the trust received approval for an £18.3m long term loan to fund its critical care expansion scheme.

£7.3m of this facility was drawn in November 2007. The balance of £11.0m of this facility was drawn on 10th April 2008.

20.1 Finance Lease Obligations

	Minimum Lease Payments		Present Value of Minimum Lease Payments	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Gross lease liabilities	0	0	0	0
of which liabilities are due				
- not later than one year;	0	0	0	0
- later than one year and not later than five years;	0	0	0	0
- later than five years.	0	0	0	0
Finance charges allocated to future periods	0	0	0	0
Net lease liabilities	**0**	**0**	**0**	**0**
- not later than one year;	0	0	0	0
- later than one year and not later than five years;	0	0	0	0
- later than five years.	0	0	0	0

20.2 PFI Obligations (on Statement of Financial Position)

	31 March 2010 £'000	31 March 2009 £'000
Gross PFI liabilities	107,285	110,084
of which liabilities are due		
- not later than one year;	2,870	2,800
- later than one year and not later than five years;	12,214	11,916
- later than five years.	92,201	95,368
Finance charges allocated to future periods	(84,184)	(86,435)
Net PFI liabilities	**23,101**	**23,649**
- not later than one year;	565	548
- later than one year and not later than five years;	2,423	2,358
- later than five years.	20,113	20,743

20.3 The trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 Mar 2010 Hadfield Block £000	31 March 2009 Hadfield Block £000
26th to 30th years (inclusive)	2,870	2,800

20.4 Amounts included within operating expenses in respect of PFI transactions deemed to be on the categories listed below:

	2009/10 £000	2008/09 £000
Building Maintenance	248	248
Insurance	125	125
Other management services	86	86
Depreciation	436	724
	895	**1,183**

20.5 Finance charges in respect of PFI transactions are shown under note 7.2

20.6 Scheme Details

Estimated capital value of the PFI scheme	£13,578k
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	27
Contract end date	December 2036

20.7 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.

21 Provisions for liabilities and charges

	Current			Non Current		
	at 31 Mar 2010 £'000	at 31 March 2009 £'000	at 1 April 2008 £'000	at 31 Mar 2010 £'000	at 31 March 2009 £'000	at 1 April 2008 £'000
Pensions relating to other staff	173	160	156	2,498	2,375	2,343
Legal claims	392	477	551	0	0	0
Agenda for Change	436	5,709	15,345	0	0	0
Other	677	1,343	5,332	0	0	0
	1,678	**7,689**	**21,384**	**2,498**	**2,375**	**2,343**

	Pensions relating to other staff £'000	Legal claims £'000	Agenda For Change £'000	Other £'000	31 March 2010 Total £'000	31 March 2009 Total £'000
At start of period	2,535	477	5,709	1,343	**10,064**	23,727
Arising during the year	254	455	3,268	462	**4,439**	5,217
Utilised during the year	(174)	(378)	(8,541)	(724)	**(9,817)**	(16,350)
Reversed unused	0	(162)	0	(404)	**(566)**	(2,587)
Unwinding of discount	56	0	0	0	**56**	55
At 31 March	2,671	392	436	677	**4,176**	10,062

Expected timing of cashflows	£'000	£'000	£'000	£'000	**£'000**	£'000
Within one year	173	392	436	677	**1,678**	7,687
Between one and five years	655	0	0	0	**655**	609
After five years	1,843	0	0	0	**1,843**	1,766

Pensions relating to other staff represents liabilities relating to staff retiring before April 95 (£633k) and Injury Benefit Liabilities (£2,037k).

Injury Benefits are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority.

The value shown is the discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown.

Legal claims relate to claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by the NHSLA, who provide an estimate of the Trust's probable liability.

Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA and not included above.

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

Other provisions relate to:-

- Costs likely to be incurred under the trust workforce reduction scheme (£34k).
- Costs likely to be incurred due to Carbon Trading scheme (£79k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (£564k)

The actual value of costs incurred under the Carbon Trading Scheme will depend on the actual quantity of CO_2 produced in the years up to 2011/2012.

Of the above total provision and related payments , some £290,703 has been covered by "back-to-back" income arrangements with the Trust's major Purchasers (31 March 2009 £275,574).

£47,070,937 is included in the provisions of the NHS Litigation Authority at 31/03/2010 in respect of clinical negligence liabilities of the Trust (31 March 2009 £38,081,454).

22 Revaluation reserve

	Total Revaluation Reserve	Revaluation Reserve -property, plant and equipment
	£000	£000
Revaluation reserve at 1 April 2009	121,081	121,081
Revaluation (losses) and impairment (losses) on property, plant and equipment	(90,919)	(90,919)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	(2,816)	(2,816)
Revaluation reserve at 31 March 2010	**27,346**	**27,346**
Revaluation reserve at 1 April 2008	131,009	131,009
Revaluation (losses) and impairment (losses) on property, plant and equipment	(3,172)	(3,172)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	(6,756)	(6,756)
Revaluation reserve at 31 March 2009	**121,081**	**121,081**

23 Cash and cash equivalents

	31 March 2010	31 March 2009
	£000	£000
At 1 April	45,212	54,794
Net change in year	(3,140)	(9,582)
At 31 March	**42,072**	**45,212**
Broken down into:		
Cash at commercial banks and in hand	257	570
Cash at OPG (Office of Paymaster General)/Government Banking Service	41,815	44,642
Other current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	**42,072**	**45,212**
Bank overdraft	0	0
Cash and cash equivalents as in Statement of Financial Position	**42,072**	**45,212**

24. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £6.2m (31 March 2009, £12m).

The major components of these commitments are as follows:

Scheme	Property, Plant & equipment at 31 March 2010
	£'000
Renal F Floor Conversion	1,161
Reconfiguration of Burns Unit	955
Cystic Fybrosis In-patients facilities	622
Reconfiguration of Ophthalmic Out-patients Department	503
Computer Room Environments - Royal Hallamshire Hospital	117
Other Estates Projects	1,330
Equipment Commitments	1,508
Total	**6,196**

25. Events after the reporting period

On the 23rd April 2010, the Department of Health confirmed agreement to a £16m loan for new Laboratory Medicine Facilities from the Foundation Trust Financing Facility. The loan will be repayable by March 2035 and attracts a fixed interest rate of 4.49%.

26. Contingencies

	2009/10	2008/09
	£000	£000
Gross value	(276)	(248)
Amounts recoverable	0	0
Net contingent liability	**(276)**	**(248)**

Contingencies represent the consequences of losing all current third party legal claim cases (see note 21).

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

These entities are listed below:

	09/10		08/09	
	Income	Expenditure	Income	Expenditure
	£'000	£'000	£'000	£'000
Sheffield PCT	330,816		325,401	
Bassetlaw PCT	7,591		9,500	
Derby County PCT	26,919		31,397	
Barnsley PCT	173,793		111,471	
Rotherham PCT	24,917		27,531	
Doncaster PCT	16,137		22,474	
Leicestershire County and Rutland	31,752		11,928	
Yorkshire and The Humber Strategic Health Authority	66,197		63,035	
Yorkshire Ambulance Service NHS Trust		4,056		3,793
NHS Litigation Authority		10,557		5,582
National Blood Authority		7,709		1,379
NHS Blood and Transplant Agency				5,198
National Health Service Logistics Authority		12,569		11,125
Doncaster and Bassetlaw Hospitals NHS Foundation Trust		6,724		5,150
Sheffield Health and Social Care NHS Foundation Trust		1,959		3,130
Sheffield Children's Hospital NHS Foundation Trust	6,578	4,168	5,882	2,962

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Department of Education and Skills in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common control of Monitor.

During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non clinical support services.

Of the Trust's total receivables of £36,707k at 31 March 2010, (note 14.1) £24,615k 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 income from NHS Trusts in respect of clinical support services provided. £3,331k was receivable from the University of Sheffield at 31 March 2010 in respect of clinical and estates support services provided.

Professor C Welsh and Professor A P Weetman have 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 £4,107k (2008/2009 £3,845k.)

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at a local private hospital. This amounted to £7,525k (2008/2009 £5,342k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Payables falling due within one year of £58,593k (note 16.1) include £12,610k owing to NHS bodies. This sum includes monies owing to the Department of Health in respect of pension contributions, and to other NHS Trusts for clinical support services received.

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 organisations 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 £1.2m (2008/09, £2.6m). 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.

28 Financial Instruments

28.1 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E Account £000	Held to maturity £000	Available-for-sale £000	Total £000
Trade and other receivables excluding non financial assets (at 31 March 2010)	28,545	0	0	0	28,545
Cash and cash equivalents at bank and in hand (at 31 March 2010)	42,072	0	0	0	42,072
Total at 31 March 2010	**70,617**	**0**	**0**	**0**	**70,617**
Trade and other receivables excluding non financial assets (at 31 March 2009)	28,745	0	0	0	28,745
Cash and cash equivalents at bank and in hand (at 31 March 2009)	45,212	0	0	0	45,212
Total at 31 March 2009	**73,957**	**0**	**0**	**0**	**73,957**
Trade and other receivables excluding non financial assets (at 1 April 2008)	29,497	0	0	0	29,497
Cash and cash equivalents at bank and in hand (at 1 April 2008)	54,794	0	0	0	54,794
Total at 1 April 2008	**84,291**	**0**	**0**	**0**	**84,291**

28.2 Financial liabilities by category

	At 31 March 2010 Other financial liabilities	At 31 March 2010 Liabilities at fair value through the I&E Account	At 31 March 2010 Total
Liabilities as per balance sheet	£000	£000	£000
Borrowings excluding Finance lease and PFI liabilities	16,741	0	16,741
Obligations under Private Finance Initiative contracts	23,101	0	23,101
Trade and other payables excluding non financial assets	43,319	0	43,319
Provisions under contract	4,176	0	4,176
Total at 31 March 2010	**87,337**	**0**	**87,337**

	At 31 March 2009	At 31 March 2009	At 31 March 2009
Borrowings excluding Finance lease and PFI liabilities	17,520	0	17,520
Obligations under Private Finance Initiative contracts	23,649	0	23,649
Trade and other payables excluding non financial assets	40,273	0	40,273
Provisions under contract	10,062	0	10,062
Total at 31 March 2009	**91,504**	**0**	**91,504**

	At 1 April 2008	At 1 April 2008	At 1 April 2008
Borrowings excluding Finance lease and PFI liabilities	7,300	0	7,300
Obligations under Private Finance Initiative contracts	24,180	0	24,180
Trade and other payables excluding non financial assets	54,183	0	54,183
Provisions under contract	23,727	0	23,727
Total at 1 April 2008	**109,390**	**0**	**109,390**

28.3 Fair values of financial assets at 31 March 2010

	Book Value	Fair value
	£000	£000
Non current trade and other receivables excluding non financial assets	271	271
Total	**271**	**271**

28.4 Fair values of financial liabilities at 31 March 2010

	Book Value	Fair value
	£000	£000
Provisions under contract	4,176	4,176
Loans	16,741	16,741
Total	**20,917**	**20,917**

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 remaining period of 21.5 years, in line ith the associated assets, and interest is charged at 4.80%, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 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 expendture from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

29 Third Party Assets

The Trust held £15,034 (31 March 2009, £9,345) at bank and in hand at 31 March 2010 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

30 Losses and Special Payments

There were 148 (457 in the year to 31 March 2009) cases of losses and special payments totalling £645k (12 months to 31 March 2009, £766k) approved during the financial year.

There was one case of an individual loss exceeding £100,000.

31. 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 £12,570k (12 months to 31 March 2009 £14,077k) bear to the average net relevant assets during the twelve month period of £359,173k (12 months to 31 March 2009 £421,334k), that is 3.5% (2008-09 - 3.3%). This is calculated as follows:

	31 March 2010	31 March 2009
	£'000	£'000
Total Capital and Reserves	360,967	514,313
Less - Donated Asset Reserve	(28,914)	(41,563)
Less - Cash held at Office of the Paymaster General	(41,815)	(44,642)
Net Relevant Assets	290,238	428,108
Average Net Relevant Assets	359,173	421,333
Dividend paid per Cash Flow statement	12,640	14,077
Dividend Debtor	(70)	0
Total Dividend paid and payable per Statement of Comprehensive Income	12,570	14,077
Percentage	3.5%	3.3%

32 Explanation of transition to adopted International Financial Reporting Standards (IFRSs)

32.1 Statement of Financial Position

As stated in note 1. these are the Foundation Trust's first financial statements prepared in accordance with adopted IFRSs

The accounting policies set out in notes 1.1 to 1.16 have been applied in preparing the financial statements for the year ended 31 March 2010, the comparative information presented in these financial statements for the year ended 31 March 2009 and in the preparation of an opening IFRS balance sheet at 1 April 2008.

In preparing its opening IFRS balance sheet the Foundation Trust has adjusted amounts reported previously in financial statements prepared in accordance with its old basis of accounting (UK GAAP). An explanation of how the transition from UK GAAP to adopted IFRSs has affected the Trust's financial position, financial performance and cash flows is set out in the following table and notes that accompany the table.

	Note	31st March 2009 UK GAAP £000	Effect of transition to adopted IFRSs £000	Adopted IFRSs £000	1st April 2008 UK GAAP £000	Effect of transition to adopted IFRSs £000	Adopted IFRSs £000
Non-current assets							
Intangible assets	a	3,269	(1,944)	1,325	2,835	(2,297)	538
Property, plant and equipment	b	515,772	25,426	541,198	514,732	26,443	541,175
Trade and other receivables	c	0	3,655	3,655	0	2,926	2,926
Total non-current assets		**519,041**	**27,137**	**546,178**	**517,567**	**27,072**	**544,639**
Current assets							
Inventories		9,638	0	9,638	8,287	0	8,287
Trade and other receivables	d	35,777	(4,122)	31,655	35,826	(3,155)	32,671
Cash and cash equivalents		45,212	0	45,212	54,794	0	54,794
Total current assets		**90,627**	**(4,122)**	**86,505**	**98,907**	**(3,155)**	**95,752**
Current liabilities							
Trade and other payables	e	(63,696)	8,065	(55,631)	(69,025)	5,154	(63,871)
Borrowings	f	0	(1,328)	(1,328)	0	(842)	(842)
Provisions	g	0	(7,689)	(7,689)	0	(21,384)	(21,384)
Other liabilities	e	0	(9,881)	(9,881)	0	(7,292)	(7,292)
Total current liabilities		(63,696)	(10,833)	(74,529)	(69,025)	(24,364)	(93,389)
Total assets less current liabilities		**545,972**	**12,182**	**558,154**	**547,449**	**(447)**	**547,002**
Non-current liabilities							
Borrowings	f	(18,365)	(21,476)	(39,841)	(9,039)	(21,599)	(30,638)
Provisions	g	(10,062)	7,687	(2,375)	(23,727)	21,384	(2,343)
Other liabilities	e	0	(1,625)	(1,625)	0	(2,050)	(2,050)
Total non-current liabilities		(28,427)	(15,414)	(43,841)	(32,766)	(2,265)	(35,031)
Total assets employed		**517,545**	**(3,232)**	**514,313**	**514,683**	**(2,712)**	**511,971**
FINANCED BY:							
Taxpayers' equity							
Public dividend capital		320,207	0	320,207	314,279	0	314,279
Revaluation reserve	h	121,070	11	121,081	130,998	11	131,009
Donated asset reserve		41,563	0	41,563	42,855	0	42,855
Income and expenditure reserve	i	34,705	(3,243)	31,462	26,551	(2,723)	23,828
Total taxpayers' equity		**517,545**	**(3,232)**	**514,313**	**514,683**	**(2,712)**	**511,971**

Notes

a. Software items redefined as Property, Plant and Equipment under IFRS

b. Hadfield Wing PFI property added and software items redefined from Intangibles

c. Longer term receivables re-categorised under IFRS

d. Long term receivables re-categorised and residual PFI debtor deleted.

e. Re-categorisation of other liabilities under IFRS, and inclusion of additional £2,596k (1st April 2008 £2,449k) holiday pay accrual

f. Re-categorisation of short term element of loan and addition of PFI liability

g. Shorter term provisions re-categorised under IFRS

h. Effect of bringing PFI assets onto statement

i. Effect of bringing PFI assets and holiday pay accrual into account under IFRS

32.2 Statement of Comprehensive Income

	£,000
Surplus for 2008/09 under UK GAAP	**1457**
Adjustment for:	
Private Finance Initiative	**(373)**
Annual Leave Accrual	**(147)**
Surplus for 2008/09 under IFRS	**937**

32.3 Cash flow for 2008/09

The UK GAAP 2008/09 cashflow statement incuded a net decrease in cash of £9,582k. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cashflows under IFRS.

Statement on Internal Control

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 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I recognise that risk management is pivotal to developing and maintaining robust systems of internal control required to manage risks associated with the achievement of organisational objectives and compliance with Terms of Authorisation as a Foundation Trust.

The leadership and accountability arrangements concerning risk management are included in the Trust's Risk Management Strategy and Policy, job descriptions and identified risk-related objectives.

The Board of Directors is collectively and individually responsible for ensuring sound risk management systems are in place. The Board of Directors is supported by a number of formal committees with a remit to oversee and monitor the effectiveness of risk management, internal control and assurance arrangements including:

- Management Audit Committee
- Healthcare Governance Committee
- Finance Committee
- Human Resources Committee
- Remuneration Committee

The committees are chaired by non-executives and minutes and relevant reports are submitted to the Board of Directors.

As Chief Executive, I am accountable for risk management and my office, through the Trust Secretary, has an overarching responsibility for the development and maintenance of a cohesive and integrated framework and shared processes for the management of all risk.

Operationally, risk management is delegated to the Trust Executive Group which reports through the Chief Executive to the Board of Directors. Executive Directors and Associate Directors are responsible for managing risk in accordance with their portfolios and as reflected in their job descriptions.

In addition to the corporate responsibilities outlined above, Clinical Directors, Directorate Managers and Departmental Heads have devolved responsibility for ensuring effective risk management in accordance with the Trust's Risk Management Strategy and Policy within their own areas.

The Risk Management Strategy and Policy indicates the level of training for all grades of staff commensurate with their responsibility for risk management.

Training is determined by the personal development process at an individual level and by training needs analyses at a strategic level. Advice on generic and specific risk management training, either internally or externally delivered, is available to staff and managers via the Department of Patient and Healthcare Governance and the Learning and Development Department.

Health and Safety Training, Information Governance and Equality and Human Rights are core topics in the Trust's mandatory training programme. All directorates are required to produce a risk-based induction and update plan for mandatory training.

The Patient and Healthcare Governance Department provides support and expert advice and guidance.

Incidents, claims, patient feedback and risks assessments are reviewed as part of a scheduled programme. The results of audits, national surveys, external agency visits and accreditations reports and external reports are also routinely reviewed. Issues raised by such reviews are used to ensure lessons are learnt and to improve practice. In addition, the Trust is continuing to develop expertise and capacity to undertake root cause analysis.

The risk and control framework

The Risk Management Strategy and Policy was approved by the Board in January 2010 following a major review. It is widely promoted across the organisation and is available to all staff on the Trust intranet. New organisational arrangements to strengthen risk management and governance, including the Safety and Risk Management Board and Risk Validation Group, were launched to complement the strategy and policy.

The strategy and policy sets out the organisation's strategic intent which aims to strike a balance between innovation, opportunity and risk, seeking to enhance performance and provide high quality care in a safe environment. It defines the framework and systems used to identify and manage risk; explicitly links risk management to the achievement of corporate and local risks and clarifies accountability arrangements and individual and collective roles and responsibilities for risk management at all levels across the organisation. It also provides improved guidance for staff to help identify, assess, action, and monitor risk including procedural guidance for completing risk assessment forms, when to escalate risks and how to use the Trust's electronic Risk Register, (Datix Risk Management System).

The policy and strategy clearly defines risk and includes guidance on the systematic identification, assessment and scoring of risk using a standard likelihood and consequence matrix. The score enables risks to be prioritised and identifies at what level in the organisation risk should be managed and when the management of a risk should be escalated within the organisation. This is an indication of the Trust's general approach to risk appetite but it should be acknowledged that decisions regarding acceptable or unacceptable levels of risk in relation to specific risk issues are also affected by financial capacity, the need to maintain service provision, and assessment of potential harm to patients, staff or public, together with the Trust's obligations in relation to legislation, regulation, standards or targets. At a corporate level, the Board of Directors utilise risk reports and other sources of information to consider their risk appetite.

The major risks facing the Trust are:

In-year: Impact of a failure to meet Emergency Services 4-hour waiting target which will be managed and mitigated by service developments such as the Surgical Assessment Centre, reconfiguration of Acute Medicine, planned A&E Consultant expansion; partnership working with local commissioners, care trust and ambulance service, and improved monitoring and performance management via the Chief Operating Officer.

Future: Failure to maintain financial balance in future years (2010/11 onwards) which will be managed and mitigated by detailed annual planning; an active productivity and efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.

All major risks are directly managed or operationally led by an Executive Lead. Progress against the action plan to mitigate the risk is updated in the Top Risk Report by the Executive Lead. The Top Risk Report is reported and reviewed by the Trust Executive Group and the Board of Directors on a quarterly basis. Outcomes are assessed by monitoring the progress reports against the action plan and by comparing the current residual risk with the target residual risk (which may be to eliminate the risk or to reduce the risk to a reasonable level, as agreed by the Board)

There are robust and effective systems, procedures and practices to identify, manage and control information risks.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Committee which is accountable to the Healthcare Governance Committee, a committee of the Board. The Information Governance Committee is chaired by the Medical Director who is also the Caldicott Guardian. The Director of Service Development was appointed by the Board as the Senior Information Risk Owner and in that capacity is the Deputy Chair.

The Information Governance Strategy (reviewed and approved by the Trust Executive Group in March 2009) outlines a framework which brings together all the statutory requirements, standards and best practice in information governance. Underpinning the strategy is the Information Governance Policy (reviewed and approved by the Trust Executive Group in March 2009) and a risk-based Annual Plan which is used to drive continuous improvement in information governance. The development of the Annual Plan is informed by the results from the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Framework Programme.

Supported by the policies and Procedures for the Transfer of Person Identifiable Data (PID) and other Sensitive and Confidential Information and the Confidentiality – Staff Code of Conduct (approved by the Trust Executive Group in September 2009), the Trust has an ongoing programme of work to ensure that PID is safe and secure when it is transferred within and outside the organisation.

All Trust laptops are now encrypted and the introduction of port control and an approved list for removable media is planned to be introduced shortly. Work is underway to populate a centralised information asset register, (supporting the role of the information asset owners), which will be reported to the Senior Information Risk Owner. 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 Director or manager within the Trust.

There were no serious data security incidents in the past year.

The Assurance Framework identifies the Trust's principal objectives and the high level risks to their achievement along with key controls and sources of assurance. Underpinning the Assurance Framework is the Trust's Risk Register which includes those strategic risks identified by the Trust Executive Group and reported via the Top Risk Report and operational risks identified by clinical and corporate directorates. The Assurance Framework is reported to the Board every six months and the Top Risk Report is reported each quarter. Both reports inform and update the Board of Directors and the Trust Executive Group on key strategic risks and allows progress against Executive Director-led action plans to be effectively monitored.

The integration of the Assurance Framework and the Risk Register into the business planning process ensures that risk-based decisions can be made in relation to service developments and capital allocation.

Risk management is firmly embedded into the activity of the organisation and operational responsibility is delegated to the individual directorates' management teams. Each directorate is responsible for identifying, assessing, scoring and registering its own risks. It is also responsible for maintaining the local risk register and for developing and monitoring plans to mitigate unacceptable risks or escalating the risk management within the organisation, as appropriate.

Supplementing the work of the Board and its committees, there are a number of specialised committees within the Trust with a remit to oversee specific risks: Safety and Risk Management Board, Blood Transfusion Committee, Control of Infection Committee, Emergency Preparedness Operational Group, Information Governance Committee, Medical Equipment Management Group, Medicines Safety Committee and Radiation Safety Steering Group.

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

- NHS Sheffield (PCT)
- Yorkshire and Humber Strategic Health Authority
- Yorkshire and Humber Specialised Commissioning Group (South)
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- Neighbouring Trusts in South Yorkshire and North Derbyshire
- Sheffield City Council
- Sheffield and South Yorkshire Overview and Scrutiny Committees

- Sheffield First and more specifically Sheffield First for Health

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 core standards for better health. From 1 April 2009, the Trust was registered with the Care Quality Commission for the control and prevention of healthcare-associated infections. In January 2010, the Trust applied to register with the CQC and declared compliance with the CQC essential standards of quality and safety for all its regulated activities across all its locations.

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 has an established Equality and Human Rights Steering Group, (chaired by the Trust Secretary) and an Operational Group. The Policy for the Development, Approval, Management and Dissemination of Trust Controlled Documents (reviewed and approved by the Board in August 2009) requires all new and reviewed controlled documents, such as policies, strategies, procedures and guidelines, to have an equality impact assessment completed before approval and dissemination. A programme of equality impact assessments against existing services is underway.

The Trust aspires to be an organisation of best practice for positively encouraging equality and diversity in the workplace and providing services which take account of the diverse needs of service users. An independent Equality Review was commissioned to identify current strengths and good practice within the Trust and opportunities for improvement and development to help the organisation exceed minimum standards and achieve excellence.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has established a Sustainable Development Strategy Group, (which I chair as Chief Executive) and an Implementation Group. A Sustainable Development Manager has been appointed to provide an operational lead on specific carbon reduction projects as detailed in the Trust's Sustainable Development Action Plan.

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

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plans for improving productivity and efficiency in order to offset income losses, meet the national efficiency target applied to all NHS providers and fund local investment proposals. The financial plans reflect organisational-wide plans and initiatives but are also translated into Directorate budgets and productivity and efficiency plans. Financial planning at all levels is influenced by income assumed from national tariffs and local prices agreed with Commissioners. Financial plans are approved by the Board, supported by its Finance Committee. An Annual Plan is submitted to Monitor, reflecting finance and governance (including service and quality aspects), each of which is ascribed a risk rating by Monitor. This plan incorporates projections for the following two years, which facilitates forward planning by the Trust. In particular, the Trust has sought to develop capital investment and productivity and efficiency plans over a number of years.

The in-year use of resources is monitored by the Board and its committees via a series of detailed monthly reports, covering finance, activity, capacity, human resource management and risk. These documents are a consolidation of detailed reports that are provided at Directorate and Department level to allow active management of resources at an operational level.

Quarterly monitoring returns are submitted to Monitor from which a risk rating is again attributed to the finance, and governance elements.

The Trust continues to drive enhanced productivity and efficiency through targeting areas for improvement and developing capability and capacity to deliver the required change. A key principle of the programme is to seek improvements to patient care alongside productivity and efficiency gains.

The development of information and performance management systems are also key elements of the Programme.

The Trust employs a number of approaches to ensure best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service re-design leading to improvements in the quality of services and patient experience as well as financial performance. External consultants are commissioned to undertake reviews where the Trust believes economy, efficiency and effectiveness can be improved. The Trust is developing and rolling-out to Directorates a Service Line Reporting and Patient Level Costing System to enable better understanding of income and expenditure at various levels and, therefore, to facilitate improved financial and operational performance. 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 rating and the Care Quality Commission's Annual Healthcheck. Such reviews are reported to the Board of Directors and its relevant committees.

All the above is underpinned by the Trust Scheme of Delegation, Standing Orders and Standing Financial Instructions, which allow the Board to ensure 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 Management Audit Committee as appropriate.

Annual Quality Report

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

In the light of recent guidance and building upon the successful 2008-09 pilot Quality Report, the Trust has established a sound process for preparing this year's Quality Report. The process is project managed under the leadership of the Medical Director. 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, a number of quality priorities were identified during informal discussions with senior managers, clinicians and Governors in the Trust. From these, the Board finally agreed three priorities for 2010-11 which relate to Patient Safety, Effectiveness and Patient Experience. 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. The comments have been received and incorporated into the final report which has been approved by the Board.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Management 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 have been reviewed.

The Management Audit Committee continues to receive and monitor the Assurance Framework and relevant internal audit reports. It plays a central role in performance managing the action plans to address the recommendations from audits which have identified the presence of medium to high risks or weaknesses in internal control.

The preparation and publication of the Quality Report has been informed by an in-depth review of last year's process and by scrutiny of further guidance. All data incorporated into the Quality Report is from established sources which are subject to routine and regular audit of data quality. The comments from the Overview and Scrutiny Committee, the LINk and NHS Sheffield provide external assurance of the effectiveness of internal controls. The dry-run on external assurance undertaken by our external auditors which will report to the Board and to the Governors Council will provide enhanced assurance.

The Trust is committed to continuous improvement of its risk management and assurance systems and processes to ensure improved effectiveness and efficiency.

My review is also informed by:

- Opinion and reports by Internal Audit who work to a risk-based annual plan with topics that cover Governance and Risk Management, Service Delivery and Performance, Financial Management and Control, Human Resources, Operational and Other Reviews.
- Opinion and reports by our external auditors (Audit Commission) and specifically the Annual Governance Report, ISA 260.
- Quarterly performance management reports by Monitor.
- DH reports such as Performance Indicators.
- Care Quality Commission reports such as Control and Prevention of Healthcare-associated Infections Inspection Report and the National Review of Safeguarding Children.
- The Board of Directors' declaration of full compliance against Core Standards for Better Health and declaration of full 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.
- Achievement of Improving Working Lives - Practice Plus.
- NHSLA assessments against Risk Management Standards and CNST for Maternity.
- Information Governance Assurance Framework and the Information Governance Toolkit
- Results of national Patient Surveys and the National Staff Survey.
- Investigation reports and action plans following Sudden Unexpected Incidents.
- User feedback such as Picker real-time monitoring of patient experience, complaints and claims.
- Governors Council reports.
- Clinical Audit reports.

The Trust was subject to Monitor's escalation process in relation to performance on the Emergency Services target. The Trust was required to provide Monitor with monthly updates on it's the action plan but was not found to be in significant breach of its Terms of Authorisation.

Conclusion

No significant internal control issues have been identified.

Sir Andrew Cash
Chief Executive
Date: 27 May 2010

This annual report and accounts has been produced by Sheffield Teaching Hospitals NHS Foundation Trust.

For further information on any aspect of this report or enquiries regarding our services, please visit www.sth.nhs.uk or write to:

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