Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2012-13

Incorporating the
Annual Quality Report




proud to make a difference

Sheffield Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2012-13

Incorporating the Annual Quality Report

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

Welcome

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS foundation trusts. We provide a full range of local hospital and community services for people in Sheffield, as well as specialist care for patients from further afield, including cancer, spinal cord injuries, renal and cardiothoracic services. In addition to community health services, the Trust comprises five of Yorkshire's best known teaching hospitals. The Trust has a history of high quality care, clinical excellence and innovation in medical research.

The Northern General Hospital is the home of the City's Accident and Emergency department which is also now one of three Major Trauma Centres for the Yorkshire and Humber region. A number of specialist medical and surgical services are also located at the Northern General Hospital including cardiac, orthopaedics, burns, plastic surgery, spinal injuries and renal to name a few.

A new state-of-the-art £16 million laboratories complex has also recently been built to provide leading edge diagnostic services. The hospital also provides a wide range of specialist surgery such as orthopaedic, spinal cord, hand and kidney transplantation.

The Royal Hallamshire Hospital has a dedicated Neurosciences department including an intensive care unit for patients with head injuries, neurological conditions such as stroke and for patients that have undergone neurosurgery. It also has an award winning Gastroenterology department, a large Tropical Medicine and Infectious Disease Unit as well as a specialist Haematology centre and other medical and surgical services.

Sheffield Teaching Hospitals is home to the largest dental school in the region, a women's hospital with a specialist neonatal intensive care unit and a world renowned Cancer hospital. The Trust has also recently integrated with the City's NHS community services to support our work to provide care closer to home for patients and preventing admissions to hospital wherever possible.

We have a long tradition of clinical and scientific achievement, including the development of one of the UK's first Academic Health Sciences Networks.

Through our partnerships with the University of Sheffield, Sheffield Hallam University, other health and social care providers and industry we remain at the forefront of advancements in clinical services, teaching and research.

We have around 15,000 employees, making us one of the biggest employers locally. We aim to reflect the diversity of local communities and have spent time over the year developing new and existing partnerships with local people, patients, neighbouring NHS organisations, local authority and charitable bodies and GPs.

We strive to recruit and retain the best staff: the dedication and skill of our employees are what make our hospitals and community services successful and we continue to keep the health and wellbeing of staff as a priority.

Our vision is to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city. During 2012/13 we began this journey with our staff, partners and patients and over the coming year we will continue to explore every aspect of our business to ensure we are doing our very best to achieve our vision.

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

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We are here to improve health and wellbeing, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

We aim to work at the limits of science - bringing the highest levels of human knowledge and skill to save lives and improve health. We touch lives at times of basic human need, when our care and compassion are what matter most to people.

1 Chairman's statement

Delivering the highest quality care for our patients is always the top priority for all of us at Sheffield Teaching Hospitals FT. Hence, it is pleasing to be able to report that in 2012/13, despite a challenging year, with increased emergency admissions and a testing financial environment, we have made significant improvements in the areas of safety, quality of care, waiting times, cleanliness of our hospitals and how responsive we are to our patients' differing needs while in hospital and in the community.

There is much detail in the following pages and I would highlight just a few issues. We have driven down waiting times to an all-time low. A large number of non-urgent patients now have their operation or treatment within six weeks or less from a GP referral. Our mortality rates are low and our clinical outcomes are some of the best in the NHS. Disappointingly, we saw a slight increase in Never Events in 2012-13. However, prompt action has been taken to limit the chance of such incidents recurring. Our relentless focus on the cleanliness of our hospitals and preventing infections has remained a particular priority and as a result we have further reduced the levels of hospital acquired infections. More detail on these important areas can be found in our Quality Report.

However, we are never complacent and in particular we have reflected on the tragic events which occurred at Mid Staffordshire Hospital. In conjunction with staff and Governors we have reemphasised the need to continually review all our activities, our 'Making a Difference' strategy and our PROUD values to ensure we never get deflected from a clear focus on the fundamentals of care and compassion. Whilst mindful of the need to protect confidentiality at all times, operating in an open and transparent way is an important element of reassuring our patients, staff, Governors and local communities about our standards of care, our services and our future plans. Hence we continue to keep this very much in mind with regard to the appropriateness of all our governance processes.

The integration of community and hospital services, alongside existing partnerships with GPs, Social Services and voluntary teams has continued to develop positively. This is a key feature of the future direction of health provision and is aimed at ensuring that patients always receive the best treatment in the most appropriate location, possibly avoiding or reducing spells in hospital.

During the year we also gave much attention to our activities in academia, research and partnerships with industry. As well as ensuring that we continue to seek improvements in patient care, this work is also a valuable contribution to closing the gap in health, wellbeing and life expectancy that is experienced across South Yorkshire.

I referred above to the financial environment and pleasingly, despite the pressures which affected all areas of public service in 2012-13 and the activity we have undertaken, we achieved a positive financial outturn, recording a small surplus to invest in future developments.

Of course none of the achievements described here or in the attached reports would be possible without the dedication of our excellent staff who perform above and beyond the call of duty to ensure the needs of our patients are at the centre of everything we do. We are also fortunate to be supported by active and committed Governors, dedicated volunteers and exceptional charities. On behalf of the Board, I would like to thank each and every one of them for their tireless work which makes such a difference to our patients.

And finally, as we move into 2013/14, I am confident that we will continue to build on our strong foundations to ensure those people who choose us for their care continue to receive excellent clinical outcomes, that their experience of our services is as personal as possible, and that our staff feel supported and able to continue to give of their best.

Tony Pedder
Chairman

Our aim: to provide patient centred services

2 Directors' report 2012/13

Sheffield Teaching Hospitals NHS Foundation Trust is home to many internationally renowned specialists and researchers achieving some of the best clinical outcomes in the NHS.

During the year patient safety and experience remained our highest priorities. The commitment of our staff, the excellence of our clinicians and academics, the quality of our partner organisations, and the support we have from our patients and local community have enabled us to continue to deliver the highest quality care for our patients.

The Dr Foster Summary Hospital Mortality Indicator provided independent confirmation that our mortality rates remained significantly lower than expected, given the nature and complexity of the patients we treat. This is a measure that is widely regarded as an indicator of clinical excellence overall and one of the reasons why patients continue to choose us for their healthcare needs. Two separate Care Quality Commission inspections found we are meeting all of the essential quality and safety standards.

We worked hard to keep waiting times as short as possible, continued our zero tolerance approach to hospital acquired infections and focused as much on patient experience as clinical outcomes. It is because of this that 98% of inpatients in Sheffield's adult hospitals said they were treated with respect and dignity during their stay, according to the 2012 National Inpatient Survey by the Care Quality Commission.

Yet again in 2012/13 Sheffield Teaching Hospital NHS Foundation Trust was highlighted as one of the top NHS Trusts in the Good Hospital Guide.

We have also pioneered new treatments for multiple sclerosis, cancer and many long term conditions through innovative translational research trials. Our joint research project with the University of Sheffield on the virtual physiological human being brings new futuristic advancements into healthcare right here in the heart of the UK.

Adult Community Services became part of Sheffield Teaching Hospitals NHS Foundation Trust from 1st April 2011.

The integration of community services with acute hospital services is proving to be a unique and exciting opportunity to harness the skills and expertise of both acute and community staff and develop new ways of delivering services for the patients we serve.

Quality counts

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

The major financial concern for the Trust in 2012/13 was to maintain financial stability, while meeting the demands of increasing numbers of patients and more stringent operational targets. In the last 12 months, through our Quality and Efficiency programme, we have been reviewing our costs and the way in which we work in order to become more efficient and deliver better value at a much greater pace. Our focus is on doing more of what adds value; improving the productivity of our clinical areas - using our operating theatres, outpatient clinics and inpatient beds more efficiently; streamlining procurement, and generating more income. Delivering higher quality at lower cost is the only way we will achieve our ambition to continue to deliver care to the highest standards.

This has culminated in services being further improved in the areas which really matter to patients:

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

Five year strategy 'Making a Difference'

Whilst we have been able to make significant improvements over the past 12 months we believe that we can still do much more to offer consistently high quality services, the best outcomes and, in partnership with our academic partners, excellence in education and research. To this end, we formally launched our new five year corporate strategy titled: 'Making a Difference' in 2012.

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

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

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

Right care, right time, right place

Our strategic mission is to help our local population achieve the highest physical and mental health status possible and by strengthening existing partnerships and forming new alliances, we want to play a leading role in closing the gap in health, wellbeing and life expectancy that is experienced in different parts of South Yorkshire.

One of the ways we are trying to achieve this is through the Right First Time Programme. 2011/12 saw the City's partners in health and social care come together to form the partnership which aims to set aside organisational boundaries to ensure 'the right care is delivered at the right time, in the right place, by the right person and in a way which is as efficient as possible.

The partnership comprises Sheffield City Council, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust and Sheffield Clinical Commissioning Group.

The vision of the Programme is to:

'*Ensure all Sheffield's residents live longer and healthier lives, and are supported in their local community wherever possible by joined up, high quality, responsive, health and social care services which offer continuity of care, shared decision making, and a lifelong, personalised, preventative approach to health and wellbeing*'.

The main achievements of the programme in 2012/13 have been:

- Development of 16 GP associations, across the city. Most of the population has been risk stratified, potentially enabling GPs to target support, self-care support and supportive technology
- Aligning health and social care services in the community so that it is easier to integrate the services offered. Investment in community falls prevention and other crises response teams.
- A new Frailty Unit was opened at the Northern General Hospital to enable older patients to be cared for, in many cases, without the need to admit them to hospital. This was established in May 2012 and has seen a 16 per cent reduction in readmissions and a 13 per cent reduction in crude mortality. In readiness for this new development we increased the number and range of community health professionals available to provide support particularly for older people and those suffering from long term conditions such as diabetes or chronic lung disease.
- Standardising the discharge process for patients with complex needs and aligning community resources to begin reducing the delays that can occur with such discharges

The second phase of the programme in 2013/14 will build on these foundations and look to move further towards turning the Right First Time vision into reality.

Investing in new facilities

Throughout the year we continued to invest in the very latest medical treatments as well as state-of-the-art equipment. We also continued to refurbish our wards and departments to enhance patients' experience of visiting our hospitals.

One example is the improvements made to the Outpatients Department at the Royal Hallamshire Hospital to better meet the needs of patients

who have dementia. The new area is light and spacious with carefully selected furniture and artwork to create a less confusing, relaxing space in which patients feel more comfortable.

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

Improving the patient experience

We believe the experience our patients and their visitors have with us should be as positive as possible .

For example our Outpatient Transformation Programme aims to make improvements in all aspects of a patient's journey through the service. From making an appointment, to attending the clinic, through to discharge and follow-up care in the community.

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

Promoting a culture of openness

We are open to scrutiny from our patients, commissioners and partners. It is this challenge and feedback which enables continuous improvement of our services.

When our services do not meet the required standards, we take immediate action. During 2012/13 we introduced the new Friends and Family Test (FFT) across all inpatient wards and in the Accident and Emergency Department. This simple test gives patients the opportunity to tell us how likely they would be to recommend the ward or A&E department in which they had just been cared for to their friends or family if they needed similar care or treatment. This is an ambitious and far-reaching national survey which was introduced across all trusts from 1 April 2013.

From October 2013, FFT will be extended to cover maternity services, and from April 2014 it will be extended to other services. We have embraced FFT as another important way in which we can ensure we meet our patients' needs. We will publish the results for each ward and department to enable those people who need our care to see how we perform and how we are responding to areas in need of improvement.

As well as actively seeking patients' views, we also have an active programme to encourage our staff to raise concerns should they need to. Our new Proud values and behaviour programme was also launched in 2012. We encourage a culture of openness and our Let's Talk programme encourages staff to share their views and ideas. We acknowledge when we get things wrong and share our learning with our staff, patients and the wider NHS, where appropriate. We are open about the challenges we face as well as our successes. This is reflected in our annual Quality Report, which details our performance against our priorities and national standards.

At the forefront of healthcare research and innovation

Sheffield Teaching Hospital NHS Foundation Trust is one of the UK's largest NHS healthcare research institutions. The Trust, together with the University of Sheffield and Sheffield Hallam University, has formed a partnership to promote, host, facilitate and implement the findings of clinical and healthcare research in Sheffield.

Promoting excellence in research and innovation is one of the main aims of our Making a Difference strategy and although the Trust performs well against national research targets, there is room for improvement particularly in the type and number of studies and the breadth of research portfolio.

A more coordinated approach to deliver integrated innovation, research, adoption and spread will be developed over the next five years. New Academic Health Science Networks are targeted at closing the so called second translational Research and Development gap. During 2012/13 we have therefore been working closely with local partners and the Department of Health to ensure that Yorkshire and the Humber is well placed to be part of this important national policy development. You can read more about our research and innovation activities on page 83.

Governance Code

The Board of Directors has considered the NHS Foundation Trust Code of Governance published by Monitor and is compliant with the principles and provisions of the code apart from the Terms of Office for Non-Executives. Following an extensive review of the Trust's Constitution, it was decided to maintain the term of office for Non-Executive Directors at four years, rather than three years as recommended in the Code. The Trust believes this provides the Board with additional stability and continuity without compromising independence. The revised Constitution was approved the Board of Directors and the Council of Governors.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors and members of the Board take all necessary steps to make themselves aware of relevant information and to ensure that this is disclosed to the auditors where appropriate.

The Trust has complied with the principles outlined in the cost allocation and charging requirements set out in HM Treasury Guidance.

Countering fraud and corruption

The Board of Directors remains committed to maintaining an honest and open atmosphere within the Trust; ensuring all concerns involving potential fraud have been identified and rigorously investigated. The Audit Committee receive an Annual Report and quarterly Progress Reports from the Trust's Local Counter Fraud Specialist (LCFS). The LCFS has been instrumental in creating an anti-fraud culture and provides specialist advice in keeping corruption policies up to date.

In all cases of fraud, where guilt has been proven, appropriate civil, disciplinary and/or criminal sanctions have been applied. By maintaining fraud levels at an absolute minimum the Trust ensures that more funds are available to provide better patient care and services.

And finally...

We are very proud of all our staff and volunteers for their tremendous achievements, which are the basis for this organisation's success and for the excellent quality of care provided to patients. We are also very grateful for the support of our local community through our membership and Council of Governors. Our members have grown in number and the work of the Governors continues to make a positive impact on services. Last but by no means least our fundraisers deserve a special mention for continuing to raise significant sums of money to enhance patient facilities and care. Given the tough financial climate we are yet again staggered at the generosity of those who support us and the tireless work of our charities.

Finally 2013/14 promises to be one of our most challenging years yet but we intend to rise to that challenge and deliver the best possible clinical outcomes, provide a high standard of customer services, employ caring and cared for staff, spend money wisely and deliver excellent research, innovation and teaching.

Sir Andrew Cash OBE

On behalf of the Board of Directors

Our aim: to deliver the best clinical outcomes.

3 Operating and financial review

Sheffield Teaching Hospitals NHS Foundation Trust is one of the largest and busiest trusts in the country; over the past year we have seen and treated **958,783** outpatients, **107,007** inpatients, **98,861** day case patients and **143,160** accident and emergency attendances. We have also had **831,216** contacts with community patients.

Our performance

Our performance is externally assessed against a range of national targets and standards.

Last year was a particularly challenging one for the NHS with all trusts expected to provide the highest standards of care while achieving demanding efficiency savings. Despite this and thanks to the hard work of all our staff we continued to provide safe, high quality care, with excellent clinical outcomes and a high level of patient satisfaction.

Activity levels increased significantly last year. Not only did we treat around 2.5% more inpatient and day cases, but we also saw a significant rise in the number of emergency admissions and a smaller rise in A&E attendances. This rise in emergency demand coupled with the extreme weather experienced in Winter 2012, and an increase in Flu and Norovirus cases put significant pressure on our services. Despite our staff working exceptionally hard, we narrowly missed the national target for diagnosing, treating and discharging or admitting 95% of patients within four hours from the Accident and Emergency Department.

We are currently reviewing in detail how patients move through the City's urgent care services to allow us to meet future patient demands and to further improve services for our patients. This includes developing a new Urgent Care Centre at the Northern General Hospital.

This work complements the city wide Right First Time transformation programmes which are focusing on reducing avoidable hospital admissions, creating integrated community teams and exploring the future model of urgent care across the city. We are confident that this work will have significant benefits for our patients and those who provide their care.

We have continued to work hard so that the majority of our patients are seen within 18 weeks from the date their GP refers them for a hospital consultation. 64% of our patients were treated within 8 weeks and we are currently treating over 90% of our admitted patients within 18 weeks. The national standard is 90%.

Last year we also met or exceeded all of the waiting time standards for patients requiring cancer care. This included the target of seeing patients within two weeks after urgent GP referral. As well as ensuring patients were able to receive care as soon as possible, we work hard to ensure the experience our patients have is of a high standard. We were therefore pleased that 97% of patients rated their overall care at the hospital as either excellent or very good in the national Radiotherapy Patient Satisfaction Survey.

We continue to have very low levels of hospital acquired infections, including MRSA, *clostridium difficile*, Norovirus and surgical site infections.

However, we are never complacent and remain committed to reducing the levels of hospital acquired infections even further. Reducing the rate of MRSA infections is a key national target and is indicative of the degree to which hospitals prevent the risk of infection by ensuring cleanliness of their facilities and good infection control compliance by staff. During 2012/13 we had 3 cases of MRSA bacteraemia recorded which was below the target set by our Commissioners but exceeded the target set for us by the Department of Health which was to have no more than 1 case.

We were also set a target of no more than 134 cases of *C.difficile* by our Commissioners. We had 104 cases in 2012-13. The reduction reflects the introduction of an enhanced deep cleaning programme on our wards, careful use of antibiotics, a rigorous approach to hand hygiene and the introduction of stronger cleaning agents.

Commissioners hold the NHS budget for their area and decide how to spend it on hospitals and other health services. Our Commissioners set us goals based on quality and innovation: a proportion of our income is conditional on achieving these goals. This system is called the Commissioning for Quality and Innovation or the CQUIN payment framework.

Last year, 2.5% of our clinical income was conditional upon achieving quality improvement and innovation goals agreed with our main Commissioners of services through CQUIN.

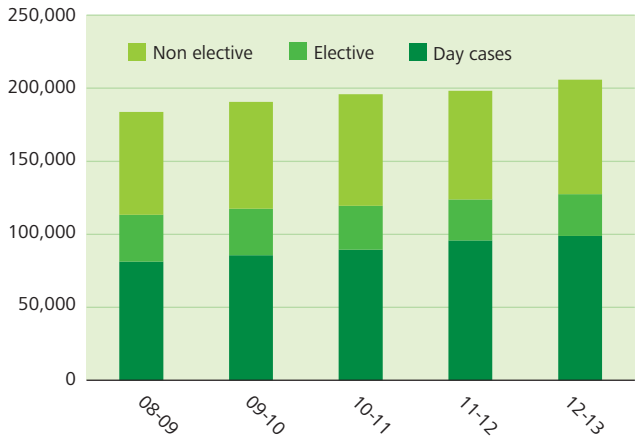
This equates to more than £16.1 million of our total Income. The Trust delivered all of its CQUIN targets for specialised commissioners in 2012/13 and the vast majority of its CQUIN targets for local Commissioners..

For further details of the Trust's performance see the tables on this page.

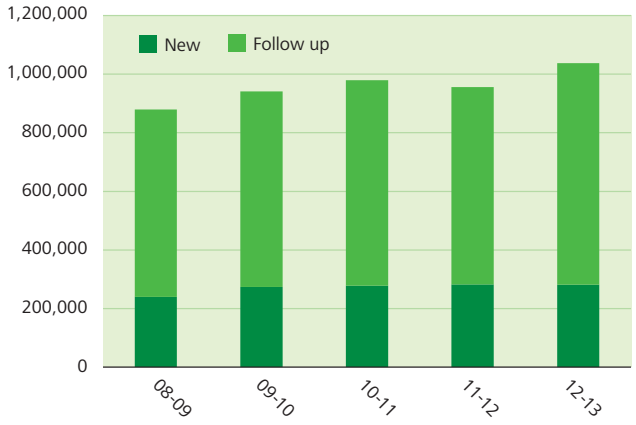
The Trust's Annual Quality Report is also included in this document on page 30. It is also available online at NHS Choices (**www.nhs.uk**).

Activity trends

Number of completed inpatient spells

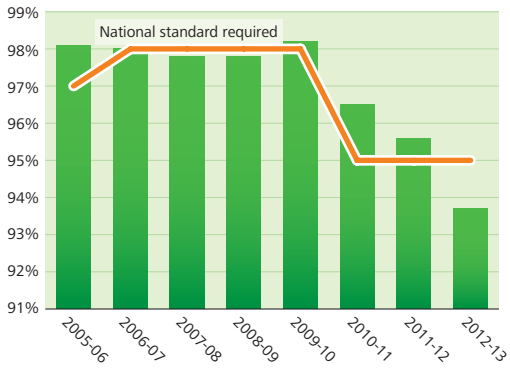


Number of outpatient attendances

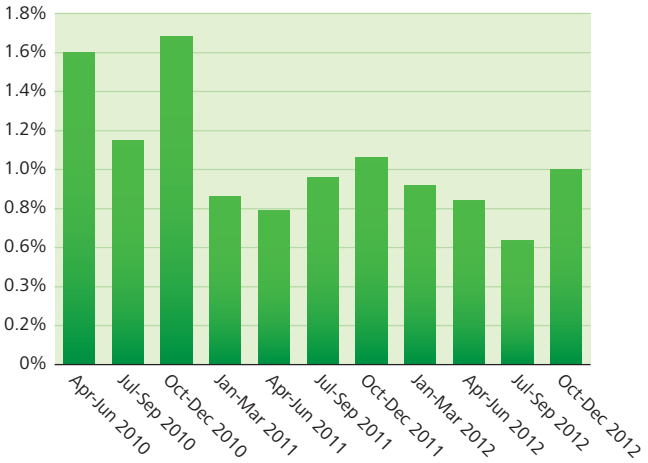


Our performance against national and core quality standards

Percentage of patients treated within four hours in A&E



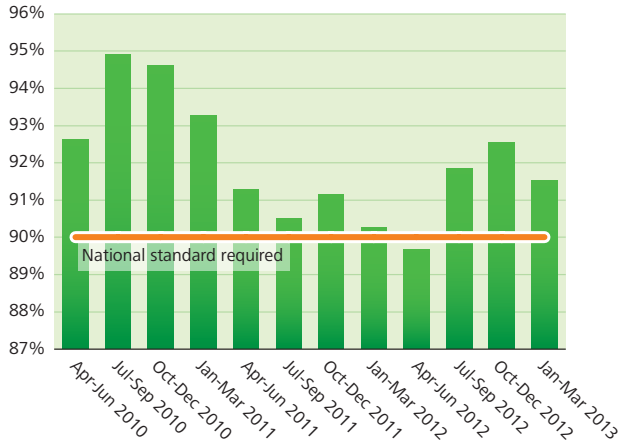
Percentage of operations cancelled on the day



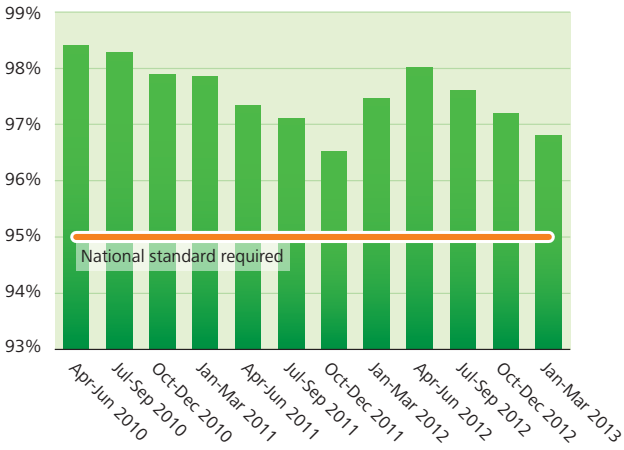
2012/13 - Community Performance

Service measure	Target	Q1	Q2	Q3	Q4 (projected)
Intermediate Care Community Beds - number of admissions	317	325	271	336	338
Intermediate Care at home - patients assessed within required timescales	99%	94%	97%	96%	97%
Intermediate Care - number of packages of care delivered at home	1272	1115	1270	1332	1344
Community Nursing Referrals	5757	5738	6078	6320	6221
Community Nursing Contacts	N/A	109,988	110,157	111,720	105,449
Average Stroke Length of stay	35 days	48	42	39	37
Average Orthomedical length of stay	35 days	48	41	33	38

Percentage of patients starting admitted treatment within 18 weeks of referral (English Commissioners only)

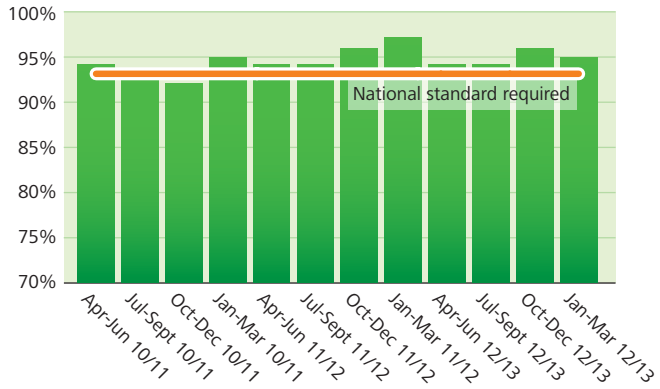


Percentage of patients starting non-admitted treatment within 18 weeks of referral (English Commissioners only)

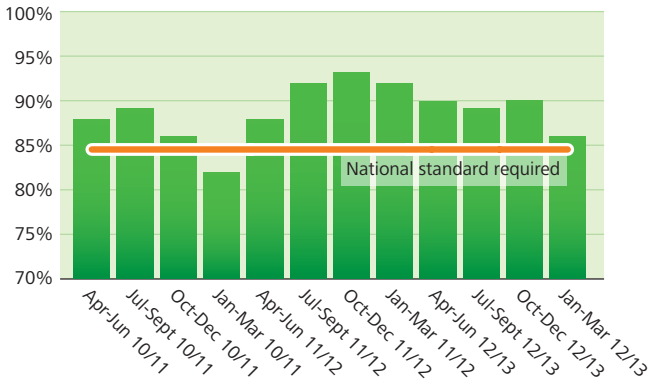


Performance against cancer access targets

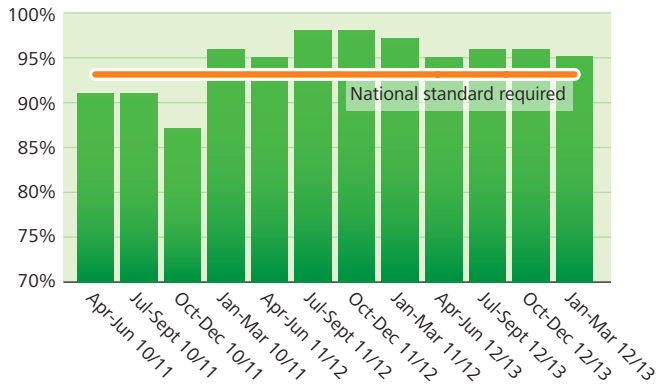
Urgent GP referrals seen within 2 weeks



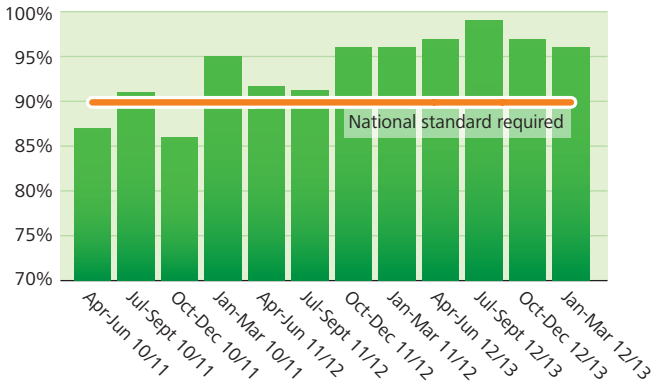
Treatment within 62 days of an urgent GP referral



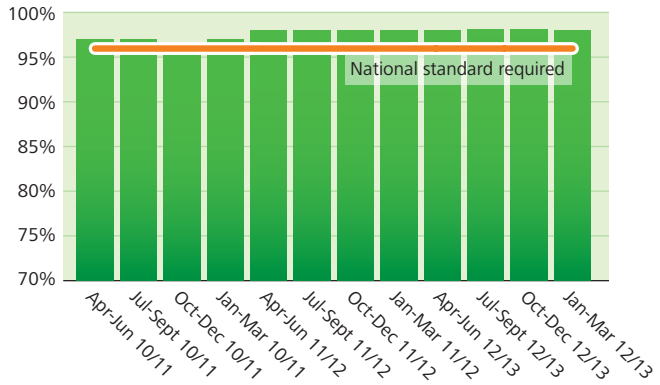
Breast symptomatic referrals seen within 2 weeks



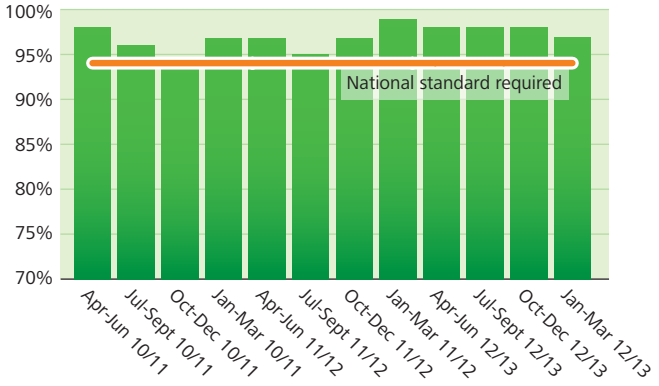
Treatment within 62 days of referral from screening



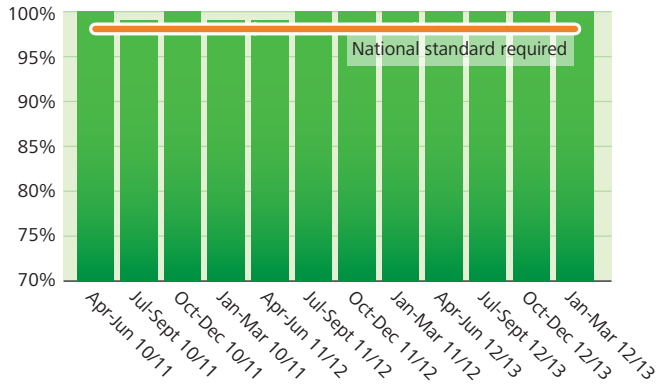
First treatment within 31 days



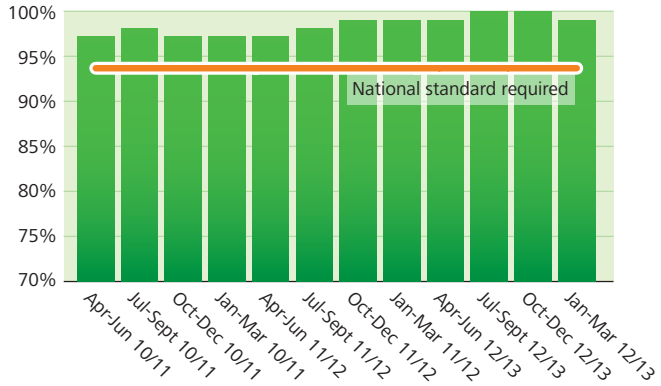
Subsequent treatment (surgery) within 31 days



Subsequent treatment (chemotherapy) within 31 days



Subsequent treatment (radiotherapy) within 31 days



Quality

As already described within this document, quality of care is our top priority and we have seen some very positive improvements in the quality of care provided over the last year such as the reduction in healthcare associated infections, the development of integrated services and improved clinical outcomes in several conditions. We are continually looking at our internal systems and learning from national assessments which examine the services we provide and how we use our resources and expertise.

Our Quality Report is included within this publication and can be found on page 30. The Quality Report contains details of our 2012/13 performance against clearly defined priorities and also sets out the priorities for 2013/14. The priorities have been developed in partnership with our Governors, Commissioners, Sheffield Local Involvement Network (LINk) and Sheffield City Council Overview and Scrutiny Committee.

Sustainability and climate change.

The Trust has made very good progress towards achieving its sustainability targets. We are on target to cut our carbon emissions by 20% by 2015, 34% by 2020 and 80% by 2050. We are ahead of other neighbouring Foundations Trusts in both the progress we have made and the systems established. Trust continues to implement its Board approved Sustainable Development Action Plan and the objectives / measures are monitored and progressed to enable the trust to become good corporate citizen.

The "Be Green" initiative has been used extensively to publicise the sustainability development. Trust provides induction training to all new starters on the initiatives that are currently underway and those planned for future introduction. Our network of over 160 'Be Green' local representatives have helped save energy, water and waste, and awareness of sustainability amongst staff members has increased further 7% to now over 44%, thus engage staff and act as the eyes and ears of our sustainability campaign.

Trust is linked with Sheffield University's School of Health and Related Research (ScHARR) to investigate various ways to reduce NHS carbon emissions by modelling the relationship between financial, carbons, healthcare and operational considerations linked to the patient-pathway. The Centre for Energy, Environment and Sustainability (CEES) is to be a leading world class centre of excellence in multi-disciplinary research, development and deployment of innovative ways to advance the understanding of energy, environment and sustainability for a low carbon future.

Environmental impact performance indicators 2012/13

Area		Non-financial metric	Non-financial metric		Financial data (£,000)	Financial data (£,000)
		2012/13	2011/12		2012/13	2011/12
Waste minimisation and management	Clinical HTI		142 tonnes	Total Waste Cost	£1,201*	£1,065
	Clinical - Alternative		1374 tonnes			
	Landfill disposal		360 tonnes			
	Recycling / Recovery		2791 tonnes			
Finite Resources	Water / Sewerage	318,198 m^3	374,976 m^3	Water / Sewerage	£781*	934
	Electricity	53.56 GWh	55.21 GWh	Energy	£9,127*	£8,766
	Gas	111.35 GWh	103.19 GWh			
	Heat and power	4.21 GWh	4.35 GWh			
	Oil					

* Where invoices have not been received in 2012/13 we have used estimates.

The Trust continues to show good progress with energy and carbon reduction, the following lists some of the projects completed in 2012 which contribute toward this.

Cystic Fibrosis service: Three big sustainability ticks were achieved: 1, Sustainable Transport (electric vehicle), 2, Sustainable Energy (solar panels to charge the car), and 3, Sustainable Healthcare (making visits to patients, reducing need for patients and potentially cars to visit the hospital).

New Laboratory Building: The Northern General Hospital has Photo voltic panels, Green Roof, Bicycle parking and has achieved BREEAM Excellence 'A' rated standard for best practice in sustainable building design, construction and operation.

An electric Courtesy bus has been provided by League of Friends and now operating around the Northern General Hospital.

Teleconferencing can allow people to hold interactive business meetings between people in different geographical locations without the inconvenience of travel time and cost.

Replacement of five power transformers at the Royal Hallamshire Hospital and Northern General Hospital (due to age and maintenance) provided an ideal opportunity for energy savings and as such the transformers have been replaced with high efficiency equipment and with the ability for voltage reduction. Savings of between 6-10% have been achieved in doing this.

NGH food Central Processing Unit upgrading and refurbishment provided an opportunity to review energy consumption and as a result a heat recovery system has been installed which recovers heat from refrigeration equipment and uses this to heat incoming water for pot washing and also space heating.

Conversion of lighting systems to high efficient/ low energy LED light fittings to Brearley, Nurses Home, Huntsman & Firth Corridor, and Jessop Wing will improve lighting levels, reduce maintenance and heat gains while reducing energy consumption by typically 85%.

Conversion of steam infrastructure to low temperature hot water will benefit reduced boiler house stack losses and steam distribution losses, reduced backlog and maintenance, modernised infrastructure, improved

hygiene to domestic hot water systems; which provides opportunities to use low carbon technologies and hence maximises strategic opportunity and energy resilience, whilst reducing energy cost and carbon emissions and meets some of the Trust's sustainability agenda objectives.

The Trust has achieved notable reductions in energy consumption and hence associated carbon emissions to atmosphere during the period 2012/13 when compared with the same period last year.

We reduced electricity consumption by 3% (over 1.65 GWh), and there was increase in gas consumption by 6%. Both figures are impressive considering the weather in 2012. Analysis of Degree Day data shows that 2012 was 18% colder than 2011 and 20% colder than the 20 year average.

Based on the above figures the Trust reduced associated carbon emissions by 5% (2,587 tonnes CO_2) when compared to previous Year.

We reduced water consumption by 15% during 2012, comparable with 12.5 million gallons of water or 350,000 average baths.

The reductions in consumption are attributed to the efforts of all staff and every contribution helps to achieve such targets which has an impact on the local environment and reduces costs.

Future focus will need step change in sustainable development and will include further improvements to water efficiency, waste reduction and recycling; active and sustainable travel; improve the environmental impact of our supply chain (accounts for 57% of total carbon footprint for whole of NHS) and adapting models of care to improve efficiency.

Financial Performance

The financial results for 2012/13 are very satisfactory in the context of the challenging period of very constrained funding for public services.

	2012/13 Plan £M	2012/13 Actual £M	Variance £M
Total income	856.1	909.5	53.4
Expenses excluding depreciation	-809.0	-862.1	-53.1
Depreciation	-27	-31.7	-4.7
Operating surplus	20.1	15.7	-4.4
Public Dividend Capital dividend	-10.2	-9.9	0.3
Financing Costs (net)	-3.2	-3.3	-0.1
Surplus for the year	**6.7**	**2.4**	**-4.3**

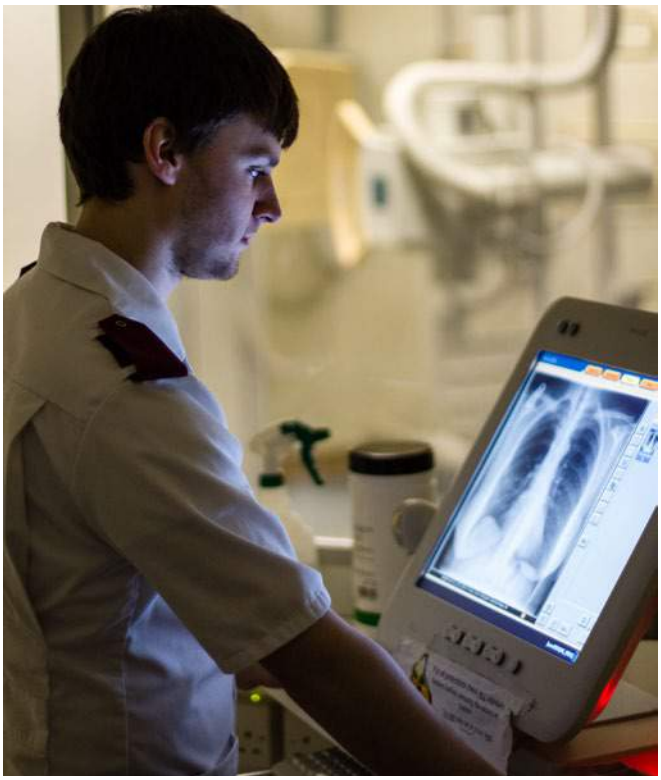
The Trust achieved a surplus from continuing operations of £2.42m (0.27% of turnover). This is below the Trust's 2012/13 Financial Plan surplus of £6.7m but the actual surplus is after absorbing net non-cash costs of £5.47m from asset impairments, impairment reversals, accelerated depreciation and charitable donations used for capital investments. The cash benefit, therefore, slightly exceeds the target in the Financial Plan. The funds generated from the planned surplus will be invested in the Trust's 2013/14 Capital Programme. Overall, therefore, the results represent a very satisfactory position with continued financial stability alongside some investment and significant service achievements.

The Trust's income position for 2012/13 was as below:

	£m	% increase over 2011/12
Income from patient services	749.8	4.6
Other operating income	159.7	10.3
Total income	**909.5**	**5.5**

The growth in income from patient services is due to activity being significantly higher than planned, particularly for non-elective patients and cost per case episodes, plus additional non-recurrent funding received for things such as winter pressures. Private Patient income was marginally less than in 2011/12 at £3.8m. The increase in other operating income is largely due to the requirement to account for reversed asset impairments as income (£15.4m). Charitable donations at £2.7m were also significantly higher than in 2011/12 but income for Research and Development reduced by £2.6m following the loss of funding for Biomedical Research Units.

Pay costs rose by just 1.2% over 2011/12 levels, despite the activity increase, reflecting the pay freeze within the NHS. Drugs costs increased by 7.9%, clinical supplies and services by 9.5%, premises by 11.1% and clinical negligence by 7.6%. The combined depreciation, loan interest and PDC dividend charges increased by around 12% due to accelerated depreciation charges, largely on old buildings which will be demolished in the coming years. There were impairment charges of £18.8m following the revaluation of the Trust's land and buildings during the year.



Efficiency Savings

The Trust again faced a major challenge to deliver the 4% national efficiency requirement. For 2012/13 this was around £24m bringing the cumulative requirement for the 7 years up to 2012/13 to nearly £200m. The Trust broadly delivered this savings requirement but fell short of the plan which was to deliver further efficiency savings to offset underlying pressures in Directorate budgets. The shortfall in savings was largely offset by the income from additional activity. The Trust continued to seek efficiency savings through its Efficiency Programme, with work streams under the broad headings of Clinical, Workforce, Corporate and Commercial, and by supporting Directorates to identify savings opportunities and deliver them. This will continue to be a key area in the future.

Capital Investment

The Trust's capital expenditure in 2012/13 amounted to £36.6m. This was an underspend of £7.7m due to slippage on planned schemes. The unspent resources are carried- forward into 2013/14 and will be used to complete the relevant schemes. The 2012/13 capital expenditure is analysed below and demonstrates a significant investment in new service developments whilst maintaining investment in existing infrastructure, information technology, medical equipment and statutory and regulatory needs.

	£,000	£,000
Service Development	**£19,144**	
Chest Clinic/Respiratory Outpatients		2,724
A&E Expansion		2,346
Additional Theatres x 2 (RHH)		2,109
Royal Hallamshire Hospital new Critical Care Unit		1,983
B&C Floor Medical School (University of Sheffield)		1,901
Royal Hallamshire Hospital new Endoscopy/Decontamination Suite		1,747
New Laboratory Medicine Facilities at the Hallamshire Hospital		1,648
New Laboratory Medicine Facilities at the Northern General		1,514
New Pharmacy Robot		794
Other smaller schemes/adjustments		2,378
Infrastructure	**£7,033**	
Ward Refurbishments		2,329
Catering Infrastructure		2,635
Hotel Services Equipment, e.g. Catering, Laundry and Transport		304
LTHW Expansion to Spinal Injuries		238
Jessop Wing Medical Air & Vacuum Upgrade		232
Other		1,295
Medical Equipment	**£5,327**	
Linear Accelerator		1,957
Equipment replacement programmes e.g. Patient monitors, ultrasounds, stack systems, Scopes and dental chairs		872
Radiotherapy Innovation Fund		372
Neuro Navigation System		241
Vitoretinal/Cataract Simulator		179
Other		1,706
Information Technology	**£4,945**	
Wi-Fi Project		2,407
ICE E-discharge		351
New Corporate Desktop project		279
Case Note Tracking		208
Other		1,700
Statutory Compliance	**£170**	
Fire Safety		107
Moving and Handling Equipment		41
Other (e.g. Road Safety and DDA compliance)		22
Total Expenditure	**£36,619**	

Total capital funding available for the year was £44.4m. This can be analysed as follows:

	£,000
Internally Generated Resources	41,571
Other Donations/External Income	2,787
Total income	**44,358**

Cash Flow and Balance Sheet

The Trust's net assets employed at 31 March 2013 were £385.9m compared with £376.2m at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2013 was £420.6m. As stated above, the Trust had its land and buildings independently valued during the year. Outstanding 'borrowings' relating to Foundation Trust Financing Facility loans, a PFI contract and a Finance Lease totalled £54.0m at the year-end.

Net current assets at 31 March 2013 were £14.2m but there is around £15m of resources committed to capital schemes in 2013/14. The cash balances of £71.1m are healthy but in addition to the capital funding commitment referred to above there are many other liabilities. The cash position has been improved by a major focus on reducing outstanding debts, particularly with other NHS organisations. The Trust has had a strategy for some time of gradually improving its working capital position in order to provide a degree of financial security in the difficult years ahead. This seems likely to be an important factor in Monitor's new Risk Assessment Framework for assessing risks around provider continuity of services.

On Monitor's 2012/13 Financial Risk Rating of one to five, where one represents very high risk and five very low risk, the Trust planned and comfortably achieved a risk rating of three. The Trust was at all times compliant with its Prudential Borrowing Limit and private patient income was well within the statutory Cap for the part of the year it applied to.

Conclusion

Overall, therefore, the Trust's 2012/13 financial results are very satisfactory, particularly when set alongside excellent service performance and the challenging financial environment. However, it is clear that the Trust, along with the rest of the NHS, faces an immensely difficult future as demands on services continue to grow and major national efficiency targets continue. The Trust also faces cuts to Education and Training funding following the Department of Health's MPET Review, although these are being phased in over several years. In addition to this, commissioners continue to seek savings through reduced use of hospital services and national contracts/business rules become ever more challenging for providers given the overall NHS financial position. The new and fragmented commissioning arrangements from 1 April 2013 also bring new issues and challenges. However, despite the major challenges, the Trust remains committed to delivering high quality services and to achieving real efficiency savings to address the future financial pressures and to protect and invest in our services.

Changes to commissioning arrangements and for clinical services

The Trust developed close working relationships with the new commissioning organisations during 2012/13, in particular NHS Sheffield Clinical Commissioning Group, NHS England and Sheffield City Council.

NHS Sheffield CCG shared its commissioning intentions for 2013/14 with the Trust which has informed the contract negotiations for the forthcoming year. The commissioning intentions have four aims:

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

To achieve these aims, the CCG intends to achieve a major shift in care to a community setting, working with our current and potential providers to establish properly funded primary care and community based services to

- Transform the way outpatient services are used
- Reduce emergency admissions and the average length of stay for people who do need a hospital bed
- Redesign mental health services, and
- Release resources to invest in quality improvements and actions to reduce health inequalities

NHS England published its commissioning intentions for prescribed specialised services in December 2012. The Trust welcomed the emphasis on improving quality and outcomes and will review all specialised services against the draft Commissioning Specifications in the summer of 2013.

A range of Public Health services are now commissioned by Sheffield City Council, including a range of community services and Integrated Sexual Health services.

Commercial Opportunities

In September 2012, the Trust Board approved the development of a small commercial team within the Strategy and Planning Directorate to focus on diversifying our income base and to provide expertise on commercial opportunities. The Commercial Unit will also lead on the development of the market by NHS Commissioners, in particular the Any Qualified Provider Initiative.

The Trust was successful in 2012/13 in securing a contract for foot and ankle surgery in the community, Direct Access Cardiology and Direct Access Flexible Sigmoidoscopy for Sheffield CCG and Direct Access Audiology in Derbyshire.

Partnerships to improve health care

Transfer of acute services to a community setting

We have worked closely with local commissioners on a number of schemes which will see services transfer from the acute hospital into the Trust's Community Services - in 2012/13, this included the development of foot and ankle surgery by podiatric surgeons based in the community.

Radiotherapy

Work is on-going to maintain the improvement in Intensity Modulated Radiotherapy rates enabled by the Radiotherapy Innovation Fund monies and in line with this to improve the uptake of Image Guided Radiotherapy which is likely to be a CQUINS target in the coming 12 months. In addition, we now need to build on the detailed work to date to understand radiotherapy demand and, with the opportunities provided by the introduction of the radiotherapy tariff, we are progressing plans to build satellite radiotherapy centres in neighbouring hospitals in order to increase capacity and provide treatment closer to home and thus improve the patient experience.

Macmillan One to One Pilot

The Trust continues to build on its partnership with Macmillan Cancer Support and has successfully secured funding from Macmillan to run a two year pilot to support patients who are living with cancer and other complex health and social care needs along their cancer pathway, tailoring support to individual needs. This will give patients the opportunity of effective support, to live well for longer and to take an active role in their own care, throughout their cancer treatment. The project will be delivered by two newly created Macmillan Complex Case Manager posts.

They will work to minimise the risk of crises and inappropriate hospital admissions. In addition, the Case Managers will help patients and their carers to spot signs of deterioration or recurrence of illness along with any long-term side effects of treatment and put systems in place for them to re-access specialist care without delay. This is an exciting opportunity for the Trust and Macmillan Cancer Support to test out a new and innovative way of working between hospital and the community to deliver seamless care to patients in their own home.

Stroke Services

The Trust's stroke pathway has developed significantly since its redesign in 2010. The pathway has been awarded Level 1 accreditation as a comprehensive stroke service which is the highest level that can be awarded in the national Peer Review process. The Trust is part of the North Trent Comprehensive Stroke Network and has successfully introduced telemedicine across the regional network which allows specialist stroke consultants to connect into hospitals across the region to allow thrombolysis to be given to suitable stroke patient 24 hours per day, 7 days per week. There is a strong research activity stroke team in Neurology. We have research active consultants and stroke research nurses funded though the NIHR Stroke Comprehensive Local Research Network. Our accrual figures for recruiting into stroke research trials are excellent, we were first in the Trent Stroke Research Network league table for accrual numbers in both January and February 2013 and we are the top performer in the achievement of accrual targets (the league table includes 21 stroke sites across South Yorkshire, Nottinghamshire, Lincolnshire, Leicestershire, Norfolk, Suffolk).

Improving Emergency Care for Heart Attack - the Heart Attack Centre for North Trent

The Cardiac Directorate worked in close partnership with Yorkshire and East Midlands Ambulance Services and colleagues at our surrounding hospitals to develop a modern system of care for patients suffering a major heart attack. The Primary Angioplasty Service (PPCI) at the Northern General Hospital serves the populations of Sheffield, Doncaster, Barnsley, Rotherham, Bassetlaw and North Derbyshire. The service involves rapid diagnosis of a heart attack by ambulance paramedic crews. The paramedics alert the Cardiology Team at the Northern General Hospital via a dedicated phone line that a patient suffering from a heart attack is being brought to the hospital for emergency treatment. The Cardiology Service then ensures that the patient is transferred to the Cardiac Catheter Suite for an emergency PPCI procedure to unblock and restore blood flow through the coronary arteries.

This system of care runs 24hrs a day, 7 days a week and ensures that patients receive the best, modern, emergency treatment. PPCI is a significant development in the treatment of heart attacks, improving survival, reducing disability and shortening the patients stay in hospital following a heart attack.

Our aim: to employ caring and cared for staff.

4 Our staff, patients and partners

The Trust has just over 15,000 employees whose skills, hard work and dedication play a significant part in the success of the Trust. The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care.

Appraisal

During 2012 a performance, values and behaviours based appraisal process was piloted with senior leaders in the Trust as it is important that our staff are not only competent but demonstrate the right values and behaviours. This is based on the PROUD values which were developed in conjunction with staff and patients i.e:

Patients first
Respectful
Ownership
Unity
Delivery

Plans are also afoot to introduce assessment against the Trust values into the recruitment process and this had been piloted recently with newly qualified nurses.

Further information about PROUD and the new appraisal and recruitment system is contained in the Quality Report on page 30.

Health and Wellbeing

The importance of caring for our staff who are our greatest asset has been recognised in the corporate strategy.

Further Health and Wellbeing festivals have been held across the Trust in the last year which provide staff with a range of information on how to improve their health and wellbeing. Staff views have been sought to identify what support they would like to see and in response to this a number of initiatives have been held on site, including exercise classes, smoking cessation advice and weight management classes run by dieticians.

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we are looking to expand this service across the whole Trust and link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety and depression.

The intention is to develop a seamless service between Occupational health, physiotherapy and mental health practitioners to support staff who are absent and in time be able to provide a preventative service which will reduce sickness absence rates within the Trust and improve staff engagement overall.

The outcome of research undertaken in conjunction with Sheffield Hallam University regarding the provision of staff health checks proved promising but consideration is being given to undertaking a larger scale pilot programme across the Trust to determine the efficacy of the service.

Staff Involvement

During 2012 the implementation of the Trust Staff Engagement Strategy has been ongoing. A number of 'Let's talk' events and timeouts have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements. The Chief Executive undertook a wide consultation exercise on the corporate strategy visiting a number of staff in their work areas. In addition regular meetings with the Chairman of the Trust and the Staff Governors have been introduced.

Throughout the year we seek staff views in a variety of ways e.g. via team meetings, use of survey monkey and all clinical areas participate in the e- CAT staff survey. In addition we participate in the NHS annual staff survey ever year which provides a valuable snapshot of staff views.

The Trust's progress on staff engagement is measured every year via the annual NHS staff survey which includes an overall score for staff engagement and it was encouraging to note that this was maintained during 2012 despite a period of change in the NHS.

It was pleasing that the survey showed that 78% of the staff are satisfied with the quality of work and patient care they are able to deliver. 70% of staff would also recommend the trust to their families and friends for treatment which compares favourably to the NHS average for acute trusts of 60%.

Equality and Diversity

We believe in fairness and equality and aim to value diversity and promote inclusion in all that we do. We are committed to eliminating discrimination, promoting equal opportunity and doing all that we can to foster good relations in the communities we provide services in and within our staff teams. In doing this we take account of gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion or belief, disability, age, domestic circumstances, social class, sexual orientation, marriage or civil partnership and trade union membership. Everyone who comes into contact with our organisation can expect to be treated with respect and dignity and to have proper account taken of their personal, cultural and spiritual needs.

If unjustified discrimination occurs it will be taken very seriously and it may result in formal action being taken against individual members of staff, including disciplinary action.

We aim to ensure that we employ and develop a workforce that is diverse, non-discriminatory and appropriate to deliver modern healthcare. Valuing the differences of each team member is fundamental to enable staff to create respectful work environment and deliver high quality care.

The requirements of the Equality Act 2010 support these aims and in 2012/13 the Trust undertook a range of activities and actions to support the Trust to:

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

The Trust produces an Equality and Human Rights Report each year which is published on the Trust web site; this includes details of these actions and activities and includes data and information about our staff and people who use our services these reports can be found on the Trust website.

We also believe that Equality and Human Rights should be integrated into all activities of the organisation and examples of mainstream activity in 2012/13 included; ongoing implementation of PROUD, delivery of Equality and Diversity training to leaders through the Trust leadership and development programme and a sharing good practice seminar delivered with partner organisations focused on domestic abuse.

In 2012/13 we identified and published Equality Objectives for the first time and made good progress against annual milestones which were agreed to support these objectives. This progress included; working in partnership with Sheffield Hallam University to review why people from some groups miss appointments, identifying areas for action through membership of the Sheffield Equality Engagement Group and achieving improvement in the quality of information we have about the diversity of staff in the organisation and using this to identify areas for action.

Volunteering

The Trust is very grateful to all of our volunteers who carry out a variety of roles across the Trust, helping to enhance the patient experience of our services. The Voluntary Services Team recruited over 200 new volunteers during 2012. There are now over 800 volunteers across the Trust.

Recruitment to the Volunteer Nutrition Assistant Programme continues to grow. There are now 68 volunteers involved in this programme and this figure will grow as the programme is rolled out during 2013 to other wards including Robert Hadfield wards 3 and 4 at the Northern General Hospital and wards Q3 and Q4 at the Royal Hallamshire Hospital.

New volunteer roles developed in community services over the past 12 months include roles in Speech and Language Therapy, Community Midwifery and Adult Hearing Services. New volunteer roles planned over the next 12 months include a role promoting Stop Smoking information across the hospital. This will be piloted on the Chesterman Wing.

A new Volunteer Database is now operational, which will allow more detailed analysis and reporting of volunteer activities and will provide valuable information on the profile of our volunteers, helping us to carry out targeted recruitment programmes to ensure we have a vibrant and diverse team of volunteers.

Patient Information

Sheffield Hospitals Charity has kindly supported the implementation of a new patient information system, Interlagos. This new system will improve the production, quality and access to patient information resources.

A 'test internet site' is being developed. This will enable the public to access patient information leaflets via the Trust website.

Patient Experience Reporting

Quarterly Trust wide Patient Experience Reports are now routinely reviewed by the Trust Board of Directors at their monthly public meetings. The reports continue to bring together a range of patient experience information from across the Trust. This ensures that key patient experience monitoring information is routinely considered at the most senior level.

These Trust reports were reviewed by the Patient Experience Committee in April 2012 and a number of key changes were made, including reducing the size of the reports whilst maintaining their highly visual presentation. The reports are accessible for those staff who are best placed to understand the feedback and implement changes where necessary. Group, directorate and ward level reports were developed in April 2012 and these are now provided quarterly.

Zest Arts in Health

The Sheffield Hospitals Charitable Trust continues to support the Trust's Arts in Health Scheme called Zest, to bring a range of projects across the Trust that has a very positive impact on overall patient experience.

A weekly calendar of music performances has been supported by the League of Friends to continue on the current wards for a further two years, and also expand to new areas including wards L1, L2 and the stroke unit at the Royal Hallamshire Hospital, and two community rehabilitation centres. These music sessions continue to receive very encouraging feedback and support from ward staff and induce some remarkable responses from patients, particularly those who are quite anxious or struggling with their memory. Therapists on several wards have noted how patients often respond more positively to their therapy sessions following a music session.

Zest have been involved in several environmental improvement projects. Following the success of the Enhancing the Healing Environment project which brought changes to A floor Outpatients entrance at the Royal Hallamshire Hospital, the Trust was involved in supporting improvements to the Huntsman main entrance at the Northern General. Using a similar approach with service user involvement a much more comfortable and welcoming environment has been created.

Zest worked with staff and user groups, on the new Critical Care Unit at the Royal Hallamshire Hospital to develop a vibrant art scheme to complement the interior design whilst working in harmony with the very busy and technical environment of critical care. Using bright images of natural scenes has helped to soften what could otherwise be a rather austere and clinical environment.

The stereotactic department at the Royal Hallamshire Hospital contacted Zest to help put some finishing touches to their recent refurbishment. As they had no windows, views or natural light we worked together to create an art scheme which provided patients and visitors with something to look at and get lost in whilst waiting for their appointment.

Brearley 7 were due to have a small refurbishment as part of the Trust's essential maintenance scheme. Zest worked with the Matron and Ward manager to make wider environmental improvements to make this ward a pioneering area for people living with dementia. Zest were fully involved with the interior design and decoration of the ward to ensure it went beyond general maintenance to a full ward redesign based around the needs of people living with dementia.

Zest continue to manage the patient and visitor information posters which are on display on every ward across the Trust. As part of the Trust's work to ensure the provision of relevant and professionally presented information, Zest worked with patients and staff to design the poster providing a welcome, and key information individualised to each ward. These posters are updated every 4 months to ensure patients and visitors have access to up to date meaningful information.

Commitment to Customer Care

Following the success of the customer care guidelines for Reception staff, a programme of customer care workshops is now being rolled out. Staff groups participating in the workshops during 2012-13 included:

- 60 orthopaedic administration staff
- 120 Hotel Services staff including porters and car park attendants
- 90 Therapy Services staff

This training has been funded through regional patient dignity money for which the Trust made a successful application. The training is highly participative and is specifically tailored to each individual group of staff. In order to evaluate the impact of the training, staff and patient surveys were carried out before the training, along with a mystery shopping exercise, including mystery telephone calls to the orthopaedic enquiry line. These will be repeated three months after the training is complete.

Friends and Family Test

The new Friends and Family Test (FFT) has been implemented across all inpatient wards and in the Accident and Emergency Department. This simple test gives patients the opportunity to tell us how likely they would be to recommend the ward or A&E department in which they had just been cared for to their friends or family if they needed similar care or treatment. This is an ambitious and far-reaching national survey which was introduced across all trusts from 1 April 2013. From October 2013, FFT will be extended to cover maternity services, and from April 2014 it will be extended to other services. Results will be reported each month, showing our scores at both Trust and ward/department level. Our wards and the A&E Department will receive monthly reports including any comments respondents have provided.

This will enable us to gather feedback from high numbers of our patients and to take actions at ward/department and Trust level to improve services where patients feel improvements can be made.

National Survey Programme

The 2012/13 national inpatient, accident and emergency (A&E) department and cancer surveys were completed, and the Trust scored well in all three surveys.

High scoring questions include:

- Doctors and nurses working well together (A&E Survey)
- Clinical Nurse Specialist listens carefully (Cancer Survey)
- Confidence and trust in doctors and nurses (Inpatient Survey)

Lower scoring questions include:

- Not being given written information about the condition (A&E Survey)
- Staff asking patients what name they prefer to be called by (Cancer Survey)
- Discharge delayed by 1 hour or more (Inpatient Survey).

Overall ratings of care

- Inpatient Survey: 94% of patients rated their care as excellent, very good or good
- A&E Survey: 74.9% of patients rated care as 7 or above (0= very poor experience, 10= very good experience)
- Cancer Survey: 91% of patients rated care as excellent or very good

Results from the surveys have been shared widely and actions have been agreed to make improvements where scores were lower. During 2012/13, the national inpatient, maternity and cancer surveys are being undertaken, along with a number of specialised cancer surveys in radiotherapy and chemotherapy. The results will be reported in the 2013/14 Annual Report.

Frequent Feedback Survey Programme

Since the introduction of the Frequent Feedback system, over 9,000 patient interviews had been undertaken across the Trust. Two waves of the inpatient survey have been carried out with each wave capturing at least 20 patient interviews from every ward across the Trust.

Survey results are provided to each ward within 2 weeks of the survey taking place. This enables staff to consider service improvements in a more responsive way.

The Trust set a target to increase the number of Frequent Feedback surveys this year by 20%. This target has been achieved with 4,824 surveys completed during 2012/13. This compares with 2,484 for 2011/12.

From October 2012, questions on staff attitude have been included, following an in-depth analysis of all patient feedback relating to staff attitude. The inclusion of specific 'attitude' questions in the Frequent Feedback survey will allow ongoing reporting of feedback at ward level.

There is now a free text facility in the survey which allows comments from individual patients and provides more qualitative data for the wards. Results from all Frequent Feedback surveys are fed back to individual wards and departments and action plans are agreed.

Website and Comments Card Feedback

The Trust set a target to increase the number of completed comments cards by 50% this year. In 2011/12 575 comments cards were received, the target for this year being 861.

During 2012/13, 2,857 comments cards have been received. Initiatives which have helped to achieve this excellent result include the following:

- Since 1st July, all volunteers conducting patient interviews for the Frequent Feedback programme offer comments cards to patients.

- In addition, Trust Governors and the voluntary services team now routinely promote comments cards at external events and Foundation Trust recruitment events. In recent months these have included events at the Sheffield Wellbeing Festival, Sheffield Disability Awareness and Sheffield Pride.

Websites remain an important method of feedback, with 100 comments regarding the Trust being posted over the last 12 months on the 2 main patient feedback websites, NHS Choices and Patient Opinion. In addition to this, a new feature has been made available where comments can be submitted directly through the Trust website.

During 2012/13, 160 comments have been received using this method. All comments are fed back to relevant staff for action and a quarterly report is provided summarising key themes.

Regular analysis of themes shows 'staff attitude' and 'communication' to consistently be two of the aspects of care which patients most comment on, highlighting the importance of these issues to the patient's overall experience.

A number of current work streams aim to ensure that we are continually improving these aspects of care. These include a new customer care training programme which commenced in January 2013.

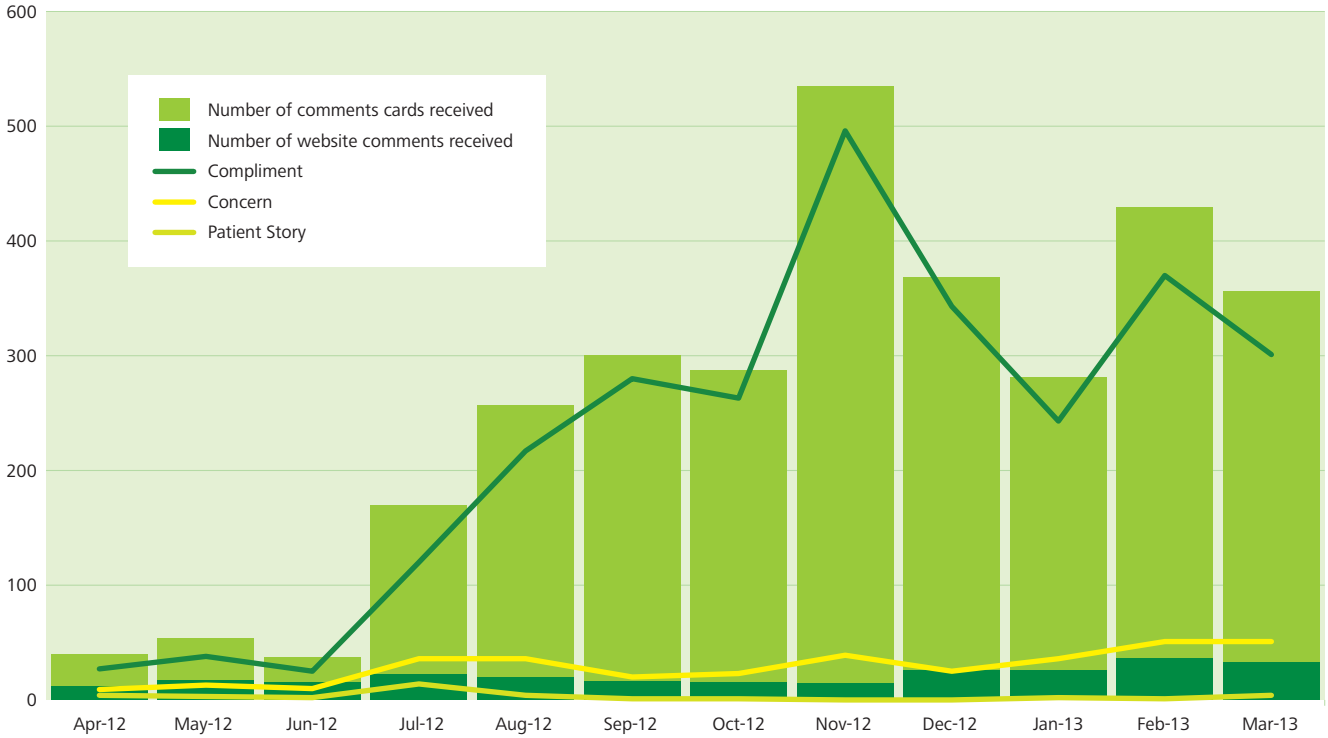
Action Planning for Improvement

A new patient experience action planning process was piloted in 2011. This has been reviewed and further developed in 2012. The aim of the new process is to ensure a co-ordinated approach to taking actions to improve services, based on feedback from patients.

Guidelines, along with a standard action plan template for wards and departments have been developed. Training workshops for staff have also been held to ensure that staff have the support and information needed to help them to review patient feedback from their ward or department and to identify actions to make improvements to services.

Website feedback and comments cards

The graph below shows the number of comments cards and website feedback received by month over the past year and the type of feedback (compliment/concern/story):



103 ward and department level patient experience action plans were agreed for the period 2012/13. These plans highlight the key patient experience issues in each area and define the improvement priorities and actions agreed at clinical team level.

Examples of recent actions identified at individual ward level through the annual action planning process include:

- A noise reduction strategy on Brearley 6 to ensure that the environment is as quiet as possible and conducive to patient rest and recovery.
- Education sessions for all members of the multi-disciplinary team on the Cardiac Catheter Suite so conversations take place in an appropriate setting.
- A new handover sheet was implemented on Chesterman 1 following comments from patients regarding lack of involvement in discharge planning.

Quarterly Group, Directorate, Ward and Department Patient Experience Reports will enable staff at local level to monitor the impact of their action plans and continue to identify new areas for improvement.

Charitable Funds

2012/13 has seen an increase in the number of enquiries received with regards to accessing charitable funds. This is partly due to a simplified application process which clearly outlines the necessary steps required and at which stage applicants need to involve other Trust groups such as the Medical Equipment Management Group.

Support is provided to all applicants to ensure that charitable funds are being used to support projects that are considered to give the greatest benefit to patients and that anything purchased is considered good use of the funds.

Examples of projects funded through charitable funds in 2012 include:

- Ward Brearley 7 refurbishment which was generously supported by the WRVS to make the ward more appropriate and comforting for patients suffering from dementia.
- In September 2012, the new internal Courtesy Bus Service that runs around the Northern General Hospital site was started. This service is extremely valuable to the elderly, infirm and the generally less mobile. The new vehicle produces zero levels of CO_2 emissions, all of which is positive for the environment and the level of air pollution in Sheffield.

Complaints

The Trust places a high value on complaints as a resource to provide assurance that the care and treatment provided at our hospitals meets the needs and expectations of patients and the public in terms of quality, outcome and safety. We recognise that complaints can provide us with valuable insight into where further improvements can be made.

Therefore during 2012/13 the Trust has worked hard to ensure that patients and families are easily able to provide feedback, including raising concerns. Concerns or complaints are always fully investigated in order to ensure that lessons are learned. The Trust's system of risk assessing and scoring all new complaints ensures that any serious issues receive attention quickly.

The total number of complaints received during 12/13 was 1444.

This is an increase of just over 5 % on the number received in the previous year. We have achieved our target of responding to 85% of complaints in 25 working days or to a timescale agreed with the complainant.

During 2012/13 we have produced guidance for staff on holding meetings with complainants as we feel that meetings between staff and complainants can be useful in resolving issues and supporting complainants in a way that is beneficial and helpful to all.

All information obtained from complainants is carefully recorded, analysed and monitored to ensure the Trust is able to pick up any common issues of concern or trends as they emerge.

The Patient Experience Committee which is accountable to the Trust Healthcare Governance Committee (a committee of the Board of Directors) receives a monthly monitoring report on complaints. The report details numbers of complaints received, confirms that the performance standards required of the complaints management system are being met and identifies by exception any trends or issues of concern that require more in depth investigation or review.

Examples of some of the actions taken by different wards and departments as a result of complaints during 2012/ 2013 are listed below;

- A new telephone system was introduced at the Charles Clifford Dental Hospital after complaints were received about the fact that patients were not able to speak to staff about appointments over the telephone as the telephone numbers were often engaged.
- The Catering Department has developed a nut free menu as a result of a complaint about the availability of balanced healthy choices for nut allergy sufferers.

- Following a complaint, a protocol has been introduced to ensure that all new patients with hip fractures are cared for on a specialist air flow mattress from the time they are admitted until they have recovered sufficiently to be moved to a non-specialist mattress.
- As a result of a complaint about inadequate provision of therapy for hospital continuing care patients in nursing homes, the frequency of Physiotherapy and Occupational therapy sessions for patients has been increased.
- Information for patients undergoing radiotherapy treatment for cancer has been improved. Radiotherapy information booklets now contain contact details for the Clinical Specialist Radiographer and include advice on what to do once treatment has finished.

Safeguarding Vulnerable People

Care Quality Commission (CQC) inspectors visited the Northern General Hospital in December 2012 to ensure that people who use our services were protected from abuse. Visits to adult clinical areas, including an unannounced inspection and discussions with staff and patients took place. Structures, policies and procedures, and staff training, were reviewed. The CQC gave a positive response and had no concerns.

The Trust has good working relationships with the Sheffield Safeguarding Adults Board, the Sheffield Safeguarding Children Board, the Sheffield Domestic Abuse Partnership, and the Learning Disability Partnership Board.

Representatives from the Trust's Safeguarding Adults Team have worked with multi agency partners to introduce the Vulnerable Adults Panel, which aims to improve the outcomes for vulnerable adults who frequently and inappropriately use health and other services across the city.

The Trust has improved information sharing with Sheffield Safeguarding Children's Service to identify those children in the city at the greatest risk of abuse or harm.

Actions from Serious Case Reviews and Domestic Homicide Reviews have been implemented including the review of policies, procedures and clinical guidelines to reflect the recommendations and learning identified from the Overview reports.

A training programme has been implemented to raise awareness of Prevent (the Governments Anti Terrorism strategy) which highlights the need for early identification of vulnerable people who may be at risk of being targeted by extremist groups or radicalised into terrorist activities.

The Trust has employed a Practice Development Facilitator to facilitate the embedding of the principles of the Mental Capacity Act into practice and to advise practitioners upon best interest decision making processes and Deprivation of Liberty Safeguards (DoLS) applications.

In Collaboration with Sheffield's Community Youth team the Trust has introduced a referral process for 16-18 year olds presenting in Accident and Emergency with drug, alcohol and antisocial behaviour problems.

Sickness absence

Our Regulator called Monitor requires us report our staff sickness absence rate. In 2012-13, this was 4.61%.

High quality patient care and a positive patient experience is dependent upon the education and training of all our staff.

5 Education and training

High quality patient care and a positive patient experience is dependent upon the education and training of all our staff to ensure they have the knowledge and skills to undertake their roles effectively. It also depends on high quality practice placements for all our students and good relationships with our education partners.

We have a good track record in delivering education and training. Our partnership with Sheffield college allows us to deliver everything from apprenticeships to NVQs. This is underpinned by a central induction programme for all new starters to ensure they have the essential information and training they require before taking up post. Our partnerships with Sheffield Hallam University and Sheffield University ensure our students are well supported and staff can meet their Continuing Professional Development requirements. There is also an extensive portfolio of further learning opportunities for all staff.

However the world is changing which brings new opportunities and challenges. Regulators want to see comprehensive evidence of mandatory training which requires us to review our systems of training delivery and how we report this information. A significant amount of mandatory training is now delivered by e-learning. Community staff had a different model of training delivery and we need to ensure that the model we put in place now they are part of the Trust not only meets their needs but opens up opportunities that were not previously available.

Leadership is at the heart of high quality patient care. The Trust has invested heavily in leadership development in 2012/13. Most staff in leadership roles will undertake some form of leadership development in the next three years. Ensuring we have high calibre clinical and non-clinical leaders will be critical in light of the challenges we are facing.

The creation of Health Education England and provider led Local Education and Training boards (LETBs) will make Trusts more accountable for the education and training of their workforce. As a major Trust in Yorkshire and the Humber it is important that the Trust is at the forefront of these reforms. We have developed a model for Training needs analysis (TNA) which is currently being piloted and will ensure our education commissions are based on evidence of service need.

Postgraduate Medical and Dental Education

Our Trust is Lead Employer for most specialities within the South region of the Yorkshire and the Humber Deanery. We lead on the delivery of training to 730 trainee doctors and have two dedicated Medical Education Centres providing state of the art facilities incorporating simulation and procedural skills. The Medical Education Centre on the Central Campus was officially opened by Sir Bruce Keogh in 2012.

Experienced staff deliver training in procedural skills across all curriculums, engaging faculty from across the specialties, leading to demonstrable improvements in the quality of medical education in the region. The Trust and Deanery continues to invest in simulation facilities. Through simulation we can bridge the gap between classroom learning and real life clinical experiences.

We have been successful in attracting funding in support of a number of Clinical Fellowships in medical leadership, simulation and medical education and we are continuing to expand these programmes. We continue to support and provide a structured continuing professional development programme for Specialty and Associate Specialist Doctors.

Undergraduate Medical Education

Our Trust is a major contributor to the training of student doctors who are undergraduates with the University of Sheffield. In all we provide approximately 10,000 student weeks of clinical placements per year. In addition to clinical experience, our staff contribute to the lecture programme, tutorial teaching, clinical examinations, clinical skills teaching and academic and pastoral student support.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Quality Report 2012-13




proud to make a difference

Contents

We want to make a difference to the lives of those who rely on our care, compassion and skill at a time when they are at their most vulnerable.

Foreword

This Quality Report details the quality improvement priorities taken forward during 2012/13 and describes the quality improvement priorities for the year ahead.

It also reviews the quality of services provided by the Trust and includes comments from the Trust Commissioners (NHS Sheffield Clinical Commissioning Group); Trust Governors and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee for Sheffield City Council. This version includes comments from Sheffield Healthwatch although the earlier consultations were undertaken in collaboration with Sheffield Local Involvement Network (LINk).

This report is written in the way required by Monitor, the Independent Regulator of Foundation Trusts and the Department of Health.

A second more accessible version will be produced for patients and public. Both versions will be available on the Trust's website (www.sth.nhs.uk) or from the Head of Patient and Healthcare Governance (details below).

We hope this Quality Report tells you what you want to know about the services provided by Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). If you have any comments on the contents of the Quality Report, or how it is written, please contact:

Mrs Sandi Carman
Head of Patient and Healthcare Governance

Telephone: 0114 226 6489

Part 1

1.1 Statement on quality from the Chief Executive

At Sheffield Teaching Hospitals we are firmly committed to providing you with the highest quality of care. Thanks to the professionalism and dedication of our staff, we continue to provide high quality services to our patients in our hospitals and in the community. We have seen some very positive improvements in the quality of care provided over the last year such as the reduction in healthcare associated infections. We will continue to make improvements this year so our patients can be sure they are receiving the very best clinical care and outcomes.

Having welcomed our colleagues in Community Services to the Trust, we are already seeing closer working between hospitals and community services which is benefitting our patients. This has been formalised in the new corporate strategy 'Making a Difference' which is also supported by a new five-year Quality Strategy.

The Mid-Staffordshire Public Inquiry Report by Robert Francis QC denotes one of the most significant events in the recent history of the National Health Service. It is our duty to ensure that the Trust responds positively to the recommendations within the report. We are currently engaging with our staff and partners to review the report and to consider any actions in conjunction with the implementation of the 'Making a Difference' strategy. We will also report on our progress as part of our action plan in the 2013/14 Quality Report.

Our successes this year include an on-going reduction in *Clostridium Difficile* rates, improvement in our discharge information and a significant increase in the volume of feedback received from our patients.

However this year has been very challenging. The number of attendances at our Accident and Emergency Department remains high and the number of very sick patients requiring emergency admission to hospital has steadily risen. This has had a significant impact on the number of beds needed and the number of operations cancelled on the day of surgery. The cancelled operations issue is a consequence of the rise in emergency patients who had to take priority over non-urgent patients and therefore operating time and available beds had to be used for emergency patients. We will continue to work to address these challenges. A capital plan to expand the clinical area of the Accident and Emergency department is underway and we have in place a number of improvement initiatives focusing on patient flow into the wider hospital.

As a result of the Health and Social Care Act (2012) a number of changes have been made to the way our services are commissioned, regulated and delivered. We are therefore committed to working closely with our partners to ensure that the changes are effective and have a beneficial impact on the services we provide to patients. The city wide health and social care transformation programme - Right First Time, is an excellent example of this commitment to develop services which deliver the right care, in the right place, at the right time and in the most efficient way. In summary, patient care is, and will continue to be, our highest priority.

To the best of my knowledge the information contained in this quality report is accurate.

Sir Andrew Cash OBE
Chief Executive
23 May 2013

1.2 Introduction from the Medical Director

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of care patients received during 2012/13. Whilst it is impossible to include information about every service the Trust provides in this type of document, it is nevertheless our hope that the report we present here will give you confidence in our ability to deliver safe, effective and high quality care.

We have consulted widely on which quality improvement priorities we should adopt for 2012/13. As with previous Quality Reports we have developed the quality improvement priorities in collaboration with representatives from NHS Sheffield Clinical Commissioning Group, the Local Involvement Network (LINk) and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. Once again, this year the Trust has held several meetings with LINk. This partnership approach has enabled feedback from LINk to be considered in the production of this Quality Report.

The Quality Report Steering Group, whose membership includes Trust managers, clinicians and Trust Governors, oversees this work.

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

In the production of this report we have also taken into account the comments and opinions from internal and external parties on the 2011/12 Quality Report. The proposed quality improvement priorities for 2013/14 were agreed by the Trust's Board of Directors on the 17 April 2013. The final draft of the quality report was sent to external partner organisations for comments in April 2013 in readiness for the publishing deadline of the 31 May 2013.

Dr David Throssell
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

2.1.1 Priorities for Improvement 2012/13

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

	Achieved	Almost achieved	Behind schedule
Clinical Effectiveness **1. Optimise length of stay** Through a systematic process of review identify areas for improvement across the organisation. Establish improvement plans to achieve necessary reductions in length of stay compared to national benchmarks (Dr Foster benchmark comparators).			✔
Patient Experience - communicate better **2. Discharge letters for GPs** Improve the quality of immediate discharge letters sent to General Practitioners (GPs) by auditing the content of letters within each Directorate against parameters agreed with NHS Sheffield. Deficiencies identified during this process will be addressed by actions at Directorate and Trust level.		✔	
Patient Experience **3. Giving patients a voice - Make it easier to communicate with the organisation** Making what we've got work well - to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by promoting the processes and demonstrating effectiveness, for example through case studies and actively communicating feedback (e.g. 'you said - we did').	✔		
Safety - deliver harm free care **4. Review Mortality rates at the weekend** Review in detail the Trusts position with regard to Mortality at the weekend and identify any significant differences, review causes and implement improvements as required.	✔		
Quality: Holistic Care - to promote a good experience for patients who have Dementia **5. Improve Dementia awareness** Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Link to the Kings Fund Dementia work and ward essential maintenance programme).	✔		

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.2 Clinical Effectiveness

Optimise length of stay

Target

Through a systematic process of review identify areas for improvement across the organisation. Establish improvement plans to achieve appropriate reductions in length of stay compared to national benchmarks (Dr Foster benchmark comparators).

Outcome

Work continues across the organisation to achieve a clinically appropriate length of stay when compared to national and local benchmarks. If achieved this would allow appropriate bed reductions across the Trust but specifically in Medical Specialties, Orthopaedics and General Surgery.

The main focus is on non-elective activity and particularly, the Medical Specialties of Geriatric & Stroke Medicine and Respiratory Medicine. These include improvements to patient discharge into community and social care services as agreed and supported through the Right First Time Programme.

Opportunities in elective services are fewer, but work continues to increase day case rates, improve processes and build on the enhanced recovery programme. The Surgical Pathways work stream is focusing on microsystems[1] work in Foot & Ankle, Gynaecology, Colo-rectal, Arthroplasty, Ophthalmology, Renal, Neurosurgery and Cardiology Catheter Laboratories.

Planning is currently underway to identify the priority activities for 2013/14 to support improved patient flow, including a Trust-wide review of emergency flow.

Case example: Geriatric & Stroke Medicine

Dr Foster Case Mix Adjusted Average: 12.5 days
Trust performance 2012/13: 15.5 days

Throughout the year the Average Length of Stay (AVLoS) was lower on a month by month basis when compared to 2011/12. The lowest AVLoS occurred in November at 13.1 days before peaking at 17.5 days in February 2013.

Trust wide performance

2011/12: 2.9 days
2012/13: 2.8 days

The Trust has improved its performance overall when compared to 2011/12 and further improvement work continues in this area. There are a number of factors which influence this performance including:

- The number of patients above 85 years of age requiring admission to hospital increased by 11% in December 2012 when compared to December 2011
- The increased admissions in the elderly population created an increased demand for supported discharges, which exceeded Community and Social Services capacity creating delayed transfers of care
- Adverse weather which was more prolonged than previous winters
- Earlier occurrence of and increased length of debilitation due to viral illnesses over the winter period

Length of stay is influenced by the integration between the hospital and the wider system (i.e. adult social care, primary and community health services); the Trust will work with its partners on the Right First Time initiative to ensure that any wider system issues are addressed. This objective will be carried over to 2013/14.

2.1.3 Patient Experience - communicate better

Discharge letters for GPs

Target

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

Outcome

The Trust completed a project on the quality of immediate discharge letters during 2012/13 across all specialties with more than 1000 inpatient spells (episodes) per annum, a total of 28 specialties.

Three audits were completed to review the quality of immediate discharge letters:

Timeframe	Number of immediate discharge letters that were audited
April to June 2012 (Quarter 1)	439 (25%)
October to December 2012 (Quarter 3)	422 (21.6%)
January to March 2013 (Quarter 4)	495 (35%)

1 http://www.sheffieldmca.org.uk/sheffields_approach

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The results for each audit in the key areas reviewed are detailed below:

Area reviewed	Q1	Q3	Q4
Documentation of patients' NHS numbers	60.1%	67.3%	64.6%
Documentation of full name of the consultant in charge of the patient's care	32%	53.4%	55.1%
Completion of the follow up arrangements	61.3%	65.2%	59.3%
Completion of the section about further advice to GPs	46.7%	58.5%	48.8%

Between July and September 2012 (Quarter 2) all 28 Directorates developed a local action plan to improve practice. The final two audits (Quarter 3 and 4) were undertaken to monitor any improvements made after the implementation of local action plans.

With the exception of the 'Documentation of full name of the consultant in charge of the patient's care' there is more work to be completed to improve the overall situation.

The Trust is currently in the process of adopting e-discharge summaries which will allow clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information sent to GPs. It is expected that the e-discharge system will be in place in all inpatient areas by the end of summer 2013. Incomplete discharge summaries will be rejected by the system which will improve overall compliance. This objective will be progressed through the e-discharge project in order to address the areas for improvement.

2.1.4 Patient Experience

Giving patients a voice: Making it easier to communicate with the organisation

Target

Making what we've got work well - to improve the response rate for frequent feedback forms by 20% and for comments cards by 50%. This has been achieved by promoting the processes and demonstrating effectiveness, for example through case studies and actively communicating feedback (e.g. 'you said - we did').

Outcome

Frequent Feedback Surveys

Target: 2976 Frequent Feedback surveys
Achieved: 4914
Increase of: 98% from 2011/12

Over the past 12 months, 33 additional Frequent Feedback volunteers have been recruited and trained in order to expand the Frequent Feedback survey programme. A detailed annual survey plan was also developed to support a new, more targeted approach which enables wards to receive their survey results within 48 hours of the survey being completed.

New areas included in the Frequent Feedback survey programme this year include Intermediate Care and the Jessop Wing (Maternity Services).

New questions included in the survey focus on staff attitudes in order to enable us to collect more detailed, ward-level feedback on this important aspect affecting patient experience.

Frequent Feedback ward-level scores and changes to services following feedback are reported on the ward information posters, which are located at the entrance to each ward. These posters are updated every 4 months.

Comments Cards

Target: 861 comments cards
Achieved: 2857
Increase of: 397% from 2011/12

Volunteers now routinely encourage patients to complete comments cards and this has had a significant impact as demonstrated by the number of responses received.

In addition to promoting comments cards through our volunteers, comments cards were also made available online in 2012.

All comments received are reported to directorates in the quarterly Patient Experience Reports and these comments are considered alongside all other patient feedback in agreeing local action plans.

Examples of actions identified within ward plans as a result of patient feedback include:

- A noise reduction strategy on Brearley 6 to ensure as quiet an environment as possible for patients
- Implementation of a new handover sheet on Chesterman 1 to ensure increased involvement of patients in discharge planning
- Awareness raising sessions for staff and creation of a quiet room on the Cardiac Catheter Suite to ensure conversations take place in an appropriate setting

For 2013 the new national Friends and Family Test will be introduced. From 1 April all inpatients and Accident and Emergency Department patients will have the opportunity to comment on our services when they are discharged. Consequently whilst the Trust comment cards will still be available for patients, the Friends and Family card will be given to patients on discharge.

2.1.5 Review Mortality rates at the weekend

Target

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

Outcome

The Trust has established a Mortality Steering Group, which meets monthly, includes a collaboration of managerial and clinical staff and aims to:

- Oversee activities related to the appropriate management of mortality and morbidity
- Promote best safety practice across the organisation and ensure that lessons learnt in one part of the organisation are appropriately shared across the wider organisation
- Develop and oversee the implementation of the Dr Foster and other tools for use when analysing mortality

To ensure consistent and accurate Mortality and Morbidity review the Trust is standardising systems in use across the organisation.

Overall the mortality ratio for the Trust remains low. Two key measures for mortality are used:

Hospital Standardised Mortality Ratio (HSMR)	
April 2012 to January 2013	**98%** This is rated as 'within expected range' (Dr Foster assessment)
April 2011 to March 2012	**98%**

Summary Hospital-level Mortality Indicator (SHMI)	
October 2011 to September 2012	**0.90** This is rated as 'Lower than expected' (Dr Foster) and 'As expected' (Information Centre)
October 2010 to September 2011	**0.90**

When looking specifically at weekend mortality there is variation in mortality rates depending on day of admission. This variation is anticipated and does not result in a mortality rate that can be described as 'higher than expected'. When reviewed against similar Trusts and comparing the range of variation possible the Trusts score is in the middle (i.e. average).

However the Trust will continue to review this area to ensure any variation between days of the week is minimal.

More widely the Trust is working with the Global Comparator groups of the Dr Foster GOAL project with one of the work streams looking at weekend mortality for Stroke patients. Analysis of the global mortality data for Stroke patients is being led by a team from North America and the Trust is working with the team as the UK link on this project.

Dr Marc Randall, Consultant Neurologist, is representing the Trust on the GOAL project and its ongoing work to compare and contrast organisational outcomes to learn from each other internationally.

At present the data comparing UK, Europe and North America is coded by country and the data is not identifiable by country or individual institution. The effect on Stroke mortality with weekend working is an area for review that appears global and not limited to individual countries. This ongoing work will eventually enable the Trust to analyse our performance in detail and understand how this compares with international partners.

This work will be continued into 2013/14.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.6 Promote a good experience for patients who have dementia

Target

Undertake environmental audits across all appropriate directorates and put in place improvement plans to address areas of concern (Link to the Kings Fund Dementia work and ward essential maintenance programme).

Outcome

In 2012, the Trust created a ward environment to meet the needs of patients who are cared for on our specialist Dementia Ward. This work was an extension of the work undertaken by the Trust on the Enhancing the Healing Environment Project supported by the Kings Fund.

Having undertaken an environmental audit and after talking to patients, visitors and staff, changes were planned to the ward in line with best practice guidance from both the Kings Fund and Stirling University. A significant refurbishment was then undertaken under the ward essential maintenance programme utilising additional Women's Royal Voluntary Service (WRVS) charitable monies.

Changes to the ward included the creation of a dining area and sitting room, clear demarcation of staff and patient areas, easily identifiable bed bays and the reduction of clutter.

Having successfully completed this work the Trust is currently in the planning stage for three further refurbishments involving the Assessment Units at the Northern General Campus.

As the objectives were not fully achieved, the Trust continued to monitor and address the following objectives which required further work in 2011/12:

2.1.7 Improving the care received by older people using our services - Nutritional assessment

Target

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

Outcome

46% of patients aged 65 or over received a MUST screen within 48 hours of admission (Audit data: November 2012).

Of those aged 65 or over and identified as being at risk i.e. a MUST score of 2 or more, 64% went on to receive an appropriate care plan.

This is an improvement on the historical achievements for screening (from 40% Audit data: February 2012). The Trust has undertaken detailed analysis work to address this issue. Nursing documentation has undergone a significant review resulting in the implementation of a new core screening booklet in September 2012 which contains the MUST score.

A continued focus on improvement around nutritional care will see the development and pilot of a nutrition and hydration accreditation programme for all clinical settings within Sheffield Teaching Hospitals. It is anticipated that the accreditation programme will include sections on food management, equipment, assessment and monitoring of care including documentation, artificial nutrition and hydration, education and training and patient information. Regular audits covering the range of sections will provide local and trust level data to ensure that nutritional and hydration care is continually monitored, providing more detail than the audits carried out in the past.

Progress on nutritional assessment and the nutrition and hydration accreditation programme will be reported in the 2013/14 Quality Report.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.8 Reduce hospital acquired infections

Target

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

Outcome

The Trust is very pleased to have achieved its target to reduce the number of cases of *Clostridium Difficile* in 2012/13. The final number of cases at 104 was 29% below the threshold of 134. However, the Trust is determined to continue to improve and is considering what further improvements can be made to achieve a further substantial reduction in 2013/14.

2.1.9 Reduce the number of operations cancelled for non-clinical reasons

Target

768 cancellations or fewer in 2011/12 and 2012/13

Outcome

Year	Cancelled Operations
2008/09	879
2009/10	690
2010/11	768
2011/12	1106
2012/13	1161

In previous years bed availability had been thought to be the biggest single cause of cancelled operations for non-clinical reasons and significant progress had been made to address this issue.

Despite this progress the overall reduction in the early months of the year was not as great as anticipated as other problems needed to be addressed.

Maintaining progress through the winter period remains a concern as this illustrates the impact that high numbers of emergency admissions and winter viruses can have on elective activity. The improvement work required to address this area of concern links to the priority regarding 'length of stay'.

This priority will be carried over to 2013/14, as one of the key improvement priorities.

2.1.10 Priorities for Improvement 2013/14

This section describes the Quality Improvement Priorities that have been adopted for 2013/14. These have been agreed by the Quality Report Steering Group after discussion with patients, clinicians, Governors, LINk and Commissioners. These were approved by the Trust Board of Directors on 17 April 2013. The Trust has compared hospital and community service priorities for the coming year choosing three areas to focus on which span the domains of patient safety, clinical effectiveness and patient experience.

Priorities for 2013/14 are:

1. To reduce the number of operations cancelled on the day of surgery.
2. To reduce the prevalence of all Grade 2,3 & 4 pressure ulcers city wide.
3. To improve the provision of discharge information for patients.

In addition to these priorities for improvement there are many quality improvement proposals in the Sheffield Teaching Hospitals Quality Strategy and the Commissioning for Quality and Improvement (CQUIN) Programme (see part 2).

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.11 Detailed objectives linked to Improvement Priorities

Priority 1

Patient Experience

Our Aim	**Cancelled Operations** To reduce the number of operations cancelled on the day of surgery.
Past Performance	<table><tr><th>Year</th><th>Cancelled Operations</th></tr><tr><td>2008/09</td><td>879</td></tr><tr><td>2009/10</td><td>690</td></tr><tr><td>2010/11</td><td>768</td></tr><tr><td>2011/12</td><td>1106</td></tr><tr><td>2012/13</td><td>1161</td></tr></table>
Key Objectives	To reduce the number of operations cancelled on the day. We have commenced a review of the inpatient waiting list management process within Orthopaedics with the aim of standardising this process. This will then be rolled-out across our surgical specialities. In 2012/13 6.5% of planned operations were cancelled on the day (clinical and non-clinical reasons). The target is to reduce this figure to 4% (within month) by April 2014 and to realise a full year effect in 2014/15. A continual improvement approach will then be used to reduce this further in future years.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation lead	**Rachel Cooper** Nurse Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 2

Patient Safety

Our Aim	To reduce the prevalence of all Grade 2,3 and 4 pressure ulcers city wide.
Past Performance	Monthly survey data for the period from October 2012 to March 2013: Proportion with pressure ulcers acquired whilst in STHFT care = 1.77% Proportion with pressure ulcers prior to receiving care from STHFT = 4.18% Overall proportion = 5.95%
Key Objectives	Reduction in the prevalence of Grade 2, 3 and 4 pressure ulcers reported within STHFT acute and community based services, including both ulcers acquired whilst receiving STHFT care and community-acquired pressure ulcers. The aim is to reduce the 'all Pressure Ulcer Rate' from 5.95% to 5%. The target for this objective has been calculated on the basis of achieving the equivalent of a 50% reduction in the proportion of patients with ulcers acquired whilst receiving STHFT care, but expressed as a reduction in the overall proportion (that is, both those acquired in STHFT services and those acquired in the community). On this basis, the target proportion for 2013/14 is 5.0%. A Project Board will be established to oversee the service improvement work on reducing pressure ulcers. The Board will oversee specific streams of work on: • Ensuring that all patients at risk of developing pressure ulcers have an effective care plan which is implemented. • Ensuring the risk of a patient developing a pressure ulcer is effectively communicated when patients transfer between wards. • Reducing pressure ulcers which develop in patients receiving care in Critical Care Units which are often associated with medical equipment. • Effective use of aids to preventing pressure ulcers including cushions, mattresses and boots.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Professor Hilary Chapman** Chief Nurse/Chief Operating Officer
Implementation lead	**Chris Morley** Deputy Chief Nurse

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Priority 3

Clinical Effectiveness (outcomes)

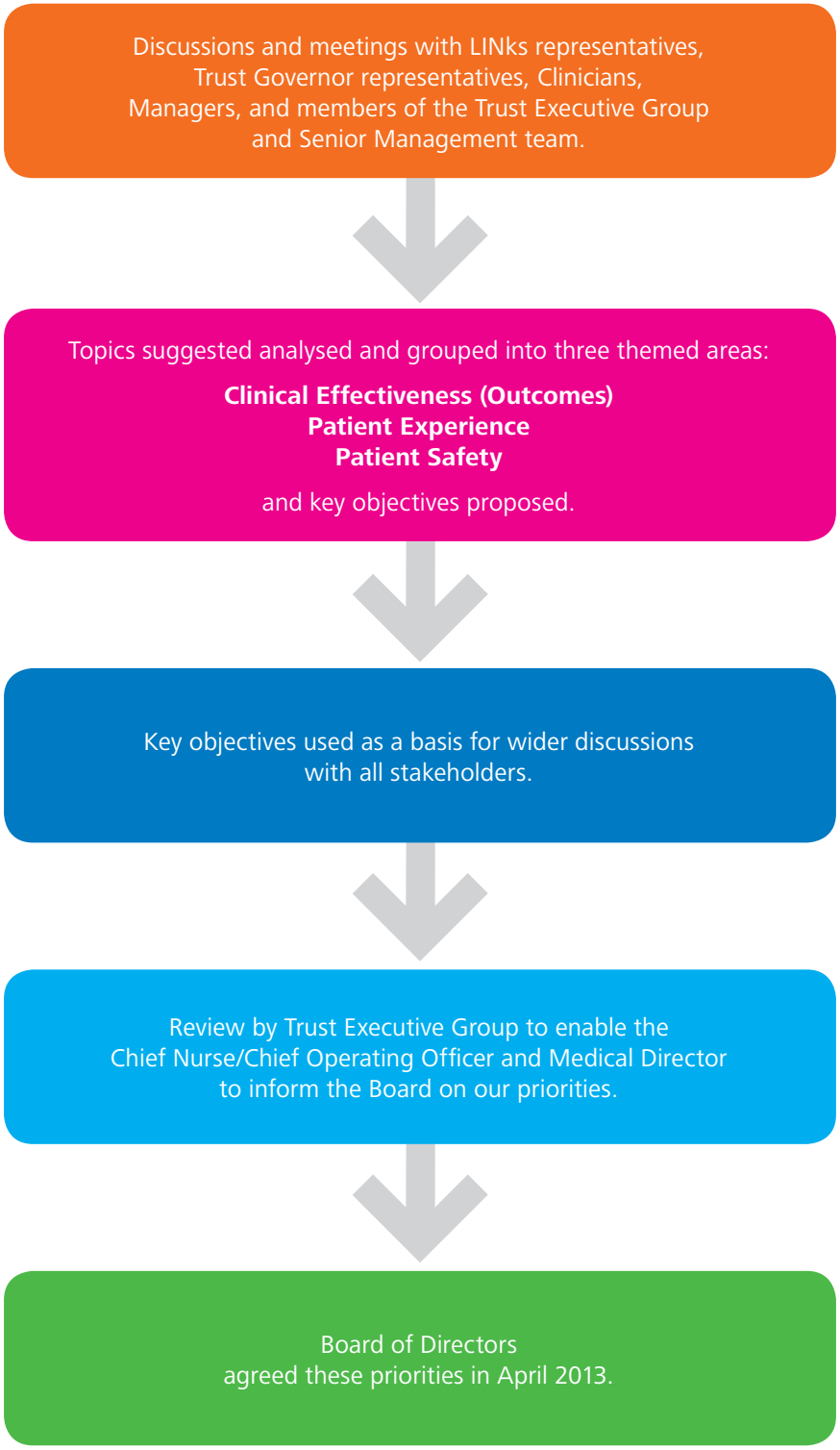
Our Aim	To improve the provision of discharge information for patients.
Past Performance	The quality of discharge information available for patients is variable, and has been a cause for complaint from some patients. Whilst local improvement work has taken place this audit work aims to ensure a Trust wide consistent standard for discharge information.
Key Objectives	To improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards. Deficiencies identified during this process will be addressed by improvement activities at Directorate and Trust level. The software package Interlagos Advanced Publishing System[2] will enable Directorates to produce bespoke discharge information in a standardised format for use across the Trust. Improvements in discharge documentation will enable patients, relatives and carers to understand what to look for once they have been discharged including who to contact if concerned.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2013/14.
Board Sponsor	**Dr David Throssell** Medical Director
Implementation lead	**Janet Brain** Senior Manager, Clinical Effectiveness Unit **Sue Butler** Head of Patient Partnership **Sandi Carman** Head of Patient and Healthcare Governance

2 www.interlagos.co.uk

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1.12 How did we choose these priorities?



Part 2

Priorities for Improvement and Statements of Assurance from the Board

Equality and Human Rights

The Trust considers that ensuring equality, diversity and human rights are an integral component of high quality services.

The Trust's progress on the Pubic Sector Equality Duty is published in the Trust annual Equality and Human Rights Report. Also included is data and information relating to people who use Trust services and people employed by the Trust. In April 2012 the Trust identified and published four Equality Objectives. These reports and information about the Trusts Equality Objectives are published on the Trust public website in the Equality and Diversity section.

The Trust adopts a number of approaches and practices to ensure that people have equal access to Trust services and a positive experience. Some of these approaches are well established whilst other areas are still in development. Services provided to people with Learning Disabilities are well embedded across the Trust, supported by the lead Nurse Director and each service area has a local lead. People are supported taking into account their individual needs and examples of action taken locally include communication books, longer appointments and a flexible approach to service delivery. There is a range of information available for staff and patients.

The Trust has also considered how it can best meet the needs of patients with Dementia and over the last few years a number of projects and partnerships with specialist services in the city have been taken forward.

Areas that are continuing to develop include improving access to large print or e-mail versions of correspondence which are available on request and ensuring that where people have specific needs these are identified at an early stage and communicated onwards when patients move to different areas of the Trust.

This work continues to be led and developed by the Equality and Humans Rights Manager.

2.2 Statements of Assurance from the Board

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

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

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

a) Services Provided

During 2012/13, Sheffield Teaching Hospitals NHS Foundation Trust provided 40* core and sub-contracted general hospital services locally, tertiary services regionally and specialist services nationally. Sheffield Teaching Hospitals has reviewed all the data available to them on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by Sheffield Teaching Hospitals for 2012/13.

The data reviewed in Part 3 covers the three dimensions of quality - patient safety, clinical effectiveness and patient experience.

* Taken from the Monitor schedule of services.

b) Clinical Audit

During 2012/13 38 national clinical audits and 3 national confidential enquiries covered NHS services that Sheffield Teaching Hospitals provides. During that period Sheffield Teaching Hospitals participated in 36 (95%) national clinical audits and 3 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The two national clinical audits and the Trusts reason for non-contribution this year are detailed later in this section.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals participated in during 2012/13 are shown in Table 1 as follows:

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Adult community acquired pneumonia (British Thoracic Society)	Yes	100% (51/51)**
Adult critical care units (ICNARC CMP)	Yes	100% (1506/1506)
Emergency use of oxygen (British Thoracic Society)	Yes	100% (29/29)**
Patient Outcome and Death (NCEPOD)	Yes	87% (68/78)
National Joint Registry (NJR)	Yes	100% (1365/1365)
Non-invasive ventilation (British Thoracic Society)	Yes	100% (24/24)**
Renal colic (CEM)	Yes	100% (50/50)
Trauma (TARN)	Yes	96%(514/534)
Blood and Transplant		
Cardiothoracic transplants (Blood & Transplant)	Yes	100% (89/89)
Potential donor audit (Blood & Transplant)	Yes	100% (349/349)
Comparative audit of blood transfusion (Blood & Transplant)	Yes	100% (63/63)
Renal Transplantation (NHSBT UK Transplant Registry)	Yes	100% (55/55)
Cancer		
Bowel cancer (NBOCAP)	Yes	91% (313/343)
Head and neck oncology (DAHNO)	Yes	89% (123/138)*
Lung cancer (NLCA)	Yes	93% (445/480)*
Oesophago-gastric cancer (NAOGC)	Yes	32% (58/182)*
Heart		
Acute Myocardial Infarction: MINAP (NICOR)	Yes	100% (1389/1389)
Adult Cardiac Surgery (NICOR)	Yes	100% (792/792)
Cardiac Arrhythmia (NICOR)	Yes	100% (752/752)
Congenital Heart Disease: adults (NICOR)	Yes	100% (30/30)
Coronary Angioplasty (NICOR)	Yes	100% (1648/1648)
Heart Failure Audit (NICOR)	Yes	100% (503/503)
Cardiac Arrest (ICNARC)	No	See statement 1 below
Vascular Surgery (VSGBI)	Yes	61% (267/441)
Pulmonary Hypertension Audit (NHSIC)	Yes	100% (1291/1291)

Table continues overleaf:

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Long Term Conditions		
Adult asthma (British Thoracic Society)	Yes	100% (71/20)**
Bronchiectasis (British Thoracic Society)	Yes	100% (42/42)**
Diabetes - Adult (NHSIC)	Yes	100% (5322/5325)*
Diabetes Inpatient Audit (NHSIC)	Yes	100% (236/236)
Diabetes: Paediatric (RCPCH)	N/A	
Inflammatory Bowel Disease (RCP)	Yes	See statement 2 below
Asthma Deaths (RCP)	Yes	0/0 See statement 3 below
Pain Database (Dr Foster Research Ltd)	Yes	33.3% (4/12) See statement 4 below
Renal Registry (UK Renal Registry)	Yes	100% (648/648)
Mental Health		
Psychological therapies (RCPsych)	N/A	
Prescribing Observatory for Mental Health (POMH UK)	N/A	
Suicide and homicide in mental health (NCISH)	N/A	
Older People		
Carotid Interventions Audit (RCP)	Yes	95% (97/102)
Fractured Neck of Femur (CEM)	Yes	100% (50/50)
Hip Fracture Database (BOA & RCS)	Yes	100% (624/620)
National Audit of Dementia (RCPsych)	Yes	100% (80/80)
Parkinson's Disease (Parkinson's UK)	No	See statement 5 below
Stroke National Audit Programme - combined Sentinel and SINAP (RCP)	Yes	96% (932/970)*
Other		
Elective Surgery - National PROMS Programme (NHSIC)	Yes	76.5%
Women's and Children's Health		
Epilepsy 12 - childhood epilepsy (RCPCH)	N/A	
Maternal, infant and perinatal (MBRRACE)	Yes	100% (83/83)
Neonatal intensive and special care (RCPCH)	Yes	100% (841/841)
Paediatric asthma (British Thoracic Society)	N/A	
Fever in children (CEM)	N/A	
Paediatric intensive care (PICANet)	N/A	
Paediatric pneumonia (British Thoracic Society)	N/A	

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Please note the following:

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

** British Thoracic Society (BTS): Sample sizes are not predetermined for BTS audits but are based on a time-limited data period. This means that sometimes the number of cases submitted is higher than the required minimum standard.

Supporting Statements:

1. ICNARC NCAA: Cardiac Arrest:

The Trust Resuscitation Committee acknowledges that whilst contributing to the National Cardiac Arrest Audit is desirable, it is not currently feasible due to the resource implications. The Trust is working towards improving compliance with completion of local Resuscitation Audit forms to enable participation in the audit in 2013/14.

2. Inflammatory Bowel Disease (RCP)

Data collection commenced for this audit but unfortunately the continuous follow up of patients proved unfeasible alongside clinical requirements and commitments. A plan is under discussion to enable participation in 2013/14.

3. Asthma Deaths (RCP)

The Trust has not yet had any eligible patients though are committed to participate fully in the Confidential Enquiry. Data collection period is 1 April 2012 - 31 January 2013 and submission deadline for data is 30 September 2013.

4. Pain Database (Dr Foster Research Ltd)

The follow up questionnaire is administered six months after the initial PROMS questionnaire, the patient response rate was 33% following distribution to 12 patients.

5. Parkinson's Disease (Parkinson's UK)

Implementation of the Action Plan was still in the active stage at the point of the re-audit commencing. The Trust position was to concentrate on completing the implementation of change and participate in the next round. This has been recognised nationally and future audits will be undertaken every second year rather than annually.

Clinical Audit (continued)

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals participated in, and for which data collection was completed during 2012/13, are listed above in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of a number of registered cases required by the terms of that audit or enquiry.

The reports of 25 national clinical audits were reviewed by the Trust in 2012/13, 14 of these reports were reviewed by Committees of the Board and 11 reviewed by Senior Teams in clinical areas. Sheffield Teaching Hospitals intends to take a number of actions to improve the quality of healthcare provided, some the examples of which are included over the page.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

British Thoracic Society (BTS) National Non Invasive Ventilation (NIV) Audit 2012

Aim:

The aim is to identify that the expected standards of care required for patients (adults) receiving NIV are met; namely patient management, knowledge and skills, equipment and documentation. The audit includes questions on cause of respiratory failure, prior lung function and performance status.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Continue to improve on the use of the Oxygen alert card.	100% of patients discharged from the Respiratory Support Unit following a known episode of hypercapnic respiratory failure should have an oxygen alert card issued.	Immediate September 12
Improve rehabilitation referral	Ensure all referral forms are available. Ensure all team know referral process. Ensure 'patient consent' or 'refusal to be referred' or 'referral inappropriate' is documented in casenotes.	Completed December 12
Review length of stay during the re-audit in February 13	Participate in BTS re-audit February 13.	February 13

Conclusion:

STH performs better than comparative units across UK based on BTS comparison data. Results locally demonstrate good compliance with audit standards and the action plan seeks to improve this position. The Trust is participating in the 2013 re-audit.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Audit of Insulin Self Administration

Aim:

To determine compliance with National Patient Safety Agency (NPSA) Patient Safety Alert (PSA) 003.

To determine if all hospital inpatients are given the choice of self-monitoring and managing their own insulin.

To determine if all hospital inpatients who self-administer insulin have the necessary equipment.

Main objectives:

Identify the proportion of diabetic patients self-administering insulin.

Check compliance with the PSA 003 checklist and the current audit standards.

Recommend methods of promoting self-administration of insulin where feasible and safe.

Recommendations and Action Plan:

Recommendation and Actions	Timescale
Roll-out Dispensing for Discharge on all wards which meet criteria	December 13
Consider implementing a rota of Medicine Management Technicians (MMT) who may be contacted to attend to assess the suitability of insulin management on wards without MMT	Completed (May 12)
Train pharmacists and MMTs in changes to self-administration policy in relation to patients on insulin	Completed (March 12)
Implement e-learning module for self medication to include changes for self administration of insulin described in revised policy	Completed (December 12)
Consider amendment of the medicines reconciliation chart to include: 'Patient normally self-medicates at home - yes/no'.	Completed (September 12)
Consider inclusion of 'Does the patient normally self-monitor their blood glucose at home?' on the assessment form for self-administration	Completed (September 12)
Recommend a suitable lockable device for insulin to wards without Dispensing for Discharge	Completed (September 12)
Improve patient awareness of the significance of safe medicine storage whilst in hospital - make the patient information leaflet for self administration available to all patients self administering insulin	Completed (September 12)

Conclusion:

Almost 100% compliance with the standard relating to the secure storage of medication and indicates self-administration at STHFT only occurs, quite rightly, when bedside lockers are available. STHFT also demonstrates exceptionally good practice in sharps disposal.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Confidential Enquiries

The Trust Patient Safety Manager has an overview of National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD) and puts action plans together as reports are issued. The standing agenda item at the Clinical Effectiveness Committee provides a forum for updates, and if any action plan requires an audit this is included on the Trust Clinical Audit Programme. One example of an audit related to 'Are we there yet?' is an Audit of Consent for Children's Surgery undertaken in April/May 2012. The Report (May 2012) has been reviewed at the Children's and Young People's Services Group.

Data is continually collected and submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom - see table for participation rate).

Local Clinical Audits

The reports of 169 local clinical audits were reviewed by the Trust in 2012/13 and Sheffield Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided:

Care Home Support Team: Core Skills Training Outcomes

Aim and Objectives

The aim of the audit was to measure improvement in practice by Care Home staff as a result of training provided by the Care Homes Support Team (CHST). This was to ensure that patients/residents in Care Homes would benefit from receiving care from well trained and skilled staff. The audit would identify future training needs for Care Home staff and priorities for the Care Home Support Team.

Recommendations:

As a result of the audit the following recommendations were made:

- Where concerns are raised about a care home's performance this training model be utilised and/or adapted to support an objective appraisal of specific areas of practice.
- Where care practices in individual care homes are identified as not improving, worsening or non-compliant, as measured against agreed standards and indicators at post training observation, appropriate actions to address the issues are to be taken by the CHST. This could include reporting concerns into the Key Performance Indicator (KPI) process and/or developing a further action plan with the care home manager.
- Where care practices in relation to specific standards, such as infection control and activity/occupation are not showing significant improvement at post observation this data is used to inform future training development proposals.
- This training approach be considered and further developed to support a model of self-assessment in care homes to benchmark practice and identify specific training needs.

Conclusion

This audit has shown that by developing a pre and post-observation tool and applying it within the workplace, it may be possible to measure both improvement in specific areas of practice as a result of CHST training and identify emerging and collective trends to inform future training development. Given this is a resource intensive approach to identifying practice and training needs in care homes, consideration should be given to further developing this tool to support a model of self assessment in care homes.

Dates for future re-audit

This audit relates to a time limited training programme that concluded in 2011. The recommendations and outcomes of this audit will be taken forward to inform future workforce development proposals through Sheffield City Council's Training and Commissioning Strategic Group, Quality in Care Homes Executive Board and Care Homes Support Team Task and Finish Group.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Thalidomide Celgene Pharmacy Audit

Thalidomide Celgene is prescribed and dispensed according to the Thalidomide Celgene Pregnancy Prevention Programme. Celgene Ltd. is obliged to report to the Medicines and Healthcare Products Regulatory Agency (MHRA) and the European Medicines Agency (EMEA) on the effectiveness of this programme. To achieve this, registered pharmacies are required to undertake a standard audit and submit their anonymised data to Celgene.

Aim:

Evaluate compliance with the Thalidomide Pharmion Prescription Authorisation and Treatment Initiation Forms.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Improve filing of Prescription Authorisation Forms	File upgraded at the Northern General Hospital NGH	Completed
Raise awareness with pharmacists at NGH of risk and actions required	Notice alert placed in dispensing file	Completed
	Discuss at Monday morning meeting	Completed
Ensure a Prescription Authorisation Form is always sent to pharmacy with prescription	Ensure Prescription Authorisations Forms available to prescribers	Completed
Check on success of above actions.	Spot check of Prescription Authorisations Forms at NGH	Completed May 12 and July 12
Celgene re-audit	Re-audit in April 2013	April 13

Conclusion:

Although the compliance rate is very good and no patients were put at risk, it is vital that continuous full compliance is achieved for this audit as it is directly related to ensuring safety. Although we are only required to undertake the audit for Celgene annually, checks will be made more frequently to provide assurance of compliance.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Age Equality in Community Services

Aim:

The aim of the audit was to ensure compliance with Age Discrimination legislation. The objective was to provide an understanding of the Trust's current position. All services under the Primary and Community Services Care Group completed an on-line survey by 31 January 2013. A total of 24/28 services completed the survey. Therefore, the overall response rate was 85.7%.

Recommendations and Action Plan:

Recommendation	Action	Timescale
Service managers need to ensure they understand why Commissioners place age restrictions of service specifications and service level agreements.	Service Managers to seek clarity on the clinical reasons for any proposed age restrictions in contracts	Within 12 months or as contracts are reviewed (February 14)
The Care Group needs to review this audit periodically to ensure compliance	To re audit on a regular basis	Within 2 years (February 15)

Conclusion:

Community services have been shown in this audit to be open to all age groups except when age specific services are more appropriate, for example, under 16-18 years or where there is a restriction required through the contracting process.

Services had a lower age limit because there were other more appropriate services supporting children. There is guidance for transition of children into other services as they approach the age to move into our adult services at ages 16 or 18 years old. The exceptions to this are the Falls Service and Care Home Support Team whose lower limit is set by Commissioners. The Care Home Support Team focus is currently under review and they may be supporting age groups for individuals with Learning Difficulties within a Care Home setting. An upper age limit was only relevant to the specialist Weight Management service which is a commissioned service and the age parameters are set by NHS Sheffield.

The clinical reasons for age restriction require clarity within the service specification or service level agreement and this will be emphasised in the next contracting round.

c) Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Sheffield Teaching Hospitals in 2012/13 that were recruited during that period to participate in research approved by a Research Ethics Committee was 12,142 (2011/12 - 6646).

In line with the National Institute for Health Research publication 'We do clinical research: A guide for support material that help Trusts promote clinical research in the NHS' the Trust is taking steps to increase research awareness across the Trust. The Trust will be celebrating International Clinical Trials Day on the 20 May to commemorate the day that James Lind started his famous trial. James Lind is generally considered to be the originator of clinical trials because he was the first to introduce control groups into his experiments on patients with scurvy.

International Clinical Trials Day provides a focal point to raise awareness of the importance of research to health care and highlight how partnerships between patients and healthcare practitioners are vital to high-quality, relevant research. On the 20 May there will be promotional events across the Trust to raise research awareness.

d) CQUINs Framework

A proportion of Sheffield Teaching Hospitals income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available on line at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275.

In 2012/13, 2.5% of our contractual income (£16.4 million) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield.

For 2012/13 the Commissioning for Quality and Innovation payment framework has included:

- Improved identification and assessment of patients who may have Dementia with over 90% of patients over 75 now screened for dementia
- Improved responsiveness to the personal needs of patients, with over 90% of patients surveyed expressing complete satisfaction with the help they received with nutrition, pain control and going to the toilet
- The introduction of an enhanced recovery model of care for certain procedures in Urology and Gynaecology, so that patients appropriately spend less in time in hospital after their operation
- The introduction of a structured model of care for inpatients with Chronic Obstructive Pulmonary Disease (COPD), to improve their condition in hospital and reduce the chance that they are readmitted

e) Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals during the period 1 April 2012 - 31 March 2013. Sheffield Teaching Hospitals has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13.

i. Northern General Hospital routine inspection

The CQC carried out a routine inspection of 4 wards at Northern General Hospital on 14 December 2012 and interviewed governance staff on 20 December 2012. The CQC found the Trust to be meeting all three standards that were inspected and were satisfied overall with their findings regarding respectful interactions, the management of clinical risk, safeguarding practice, training, care records, and governance structures and systems. No action plan was required by CQC.

ii. Royal Hallamshire Hospital routine inspection

The CQC conducted a routine inspection at Royal Hallamshire Hospital on 17 January 2013. The CQC found the Trust to be meeting both standards that were inspected and were satisfied overall with their findings regarding treating people with dignity and respect, induction, training, appraisal and supervision. No action plan was required by CQC.

iii. Northern General Hospital Mental Health Act Commission visit

The Mental Health Act Commission carried out a scheduled monitoring visit to Northern General Hospital on 21 March 2013 on behalf of the CQC. The Trust is currently implementing a plan to ensure full compliance with the Mental Health Act Code of Practice. Actions include finalising the Trust Mental Health Act policy, ensuring appropriate training is in place and formalising the arrangements required to ensure patients are detained safely.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

f) Data Quality

Sheffield Teaching Hospitals submitted records during 2012/13 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which were included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.7% for admitted patient care

99.8% for outpatient care

98.7% for Accident and Emergency care

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

100% for admitted patient care

100% for outpatient care

100% Accident and Emergency care

These figures are at the same high level as previous years.

Sheffield Teaching Hospitals Information Governance Assessment Report overall score 2012/13 was 73% and was graded satisfactory and green.

All relevant Data Quality Controls in the 500 series of the Information Governance Toolkit are graded at green and level 2 or above. Work is continuing by the Trust Data Quality Manager to satisfy the requirements for level 3 where this has not so far been reached.

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

1. Continue to feedback errors in incorrectly recorded GPs to Directorates
2. Review the Trust's Access Policy
3. Convene the new Waiting List Management Group to oversee the recording and reporting of waiting times including 18 weeks referral to treatment
4. Continue with the audit programme for clinical coding
5. Aim to improve the accuracy of clinical coding to achieve level 3 for this element of the Information Governance Toolkit.

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

4.0% primary diagnosis incorrect

7.0% secondary diagnosis incorrect

7.0% primary procedures incorrect

8.0% secondary procedure incorrect

The figures above relate to the correct recording of patient diagnosis and procedures from case notes. The standard is 90% correct recording of the primary diagnosis and procedure, and 80% correct recording of the secondary diagnosis and procedure. This is an improvement from the last audit where up to 14% of the diagnosis was incorrectly recorded from the case notes.

The results should not be extrapolated further than the actual sample audited. Areas audited were taken from a cross section of specialities specified by our commissioners, which were:

60 sets of case notes with a code of pneumonia

60 sets of case notes with a code of inpatient fall

100 accident and emergency episodes of care.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

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

g) Patient Safety Alerts

The National Patient Safety Agency analyses reports on patient safety incidents received from NHS staff and uses this to produce resources (alerts or rapid response requests) aimed at improving patient safety. Table 1 below details the Alerts and Rapid Response Reports which have been received during the year 2012/13.

Table 1: Alerts completed and closed during 2012/13

NPSA Ref	National Patient Safety Authority - Alert Title
NPSA/2012/RRR001	Harm from flushing of nasogastric tubes before confirmation of placement
NPSA/2011/RRR003	Minimising risks of mismatching spinal, epidural and regional devices with incompatible connectors
NPSA/2011/PSA003	The adult patient's passport to safer use of insulin
NPSA/2011/PSA001	Safer spinal (intrathecal), epidural and regional devices

There are no outstanding alerts for 2012/13.

h) Annual Staff Surveys

Staff Engagement

The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care.

Staff Involvement

During 2012 the implementation of the Trust Staff Engagement Strategy has been ongoing. A number of 'Let's talk' events and timeouts have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements. The Chief Executive undertook a wide consultation exercise on the corporate strategy visiting a number of staff in their work areas. In addition regular meetings between the Chairman of the Trust and the Staff Governors have been introduced.

Appraisal

During 2012 a performance, values and behaviours based appraisal process was piloted with senior leaders in the Trust to confirm that our staff are not only competent but demonstrate the right values and behaviours. This is based on the PROUD values which were developed in conjunction with staff and patients i.e.

Patients first
Respectful
Ownership
Unity
Delivery

Evaluation of the pilot showed the importance of good quality appraisal training, so a significant investment in this area has been made to support the roll out of this appraisal process to all staff over the next few years.

Health and Wellbeing

Further Health and Wellbeing festivals have been held across the Trust in the last year which provide staff with a range of information on how to improve their health and wellbeing. Staff views have been sought to identify what support they would like to see and in response to this a number of initiatives have been held on site, including exercise classes and weight management classes run by dieticians.

Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we are looking to expand this service across the whole Trust and link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety and depression.

The intention is to develop a seamless service between Occupational Health, Physiotherapy and Mental Health practitioners to support staff who are absent and in time, be able to provide a preventative service which will reduce sickness absence rates within the Trust and improve staff engagement overall.

The outcome of research undertaken in conjunction with Sheffield Hallam University regarding the provision of staff health checks proved promising but consideration is being given to undertaking a larger scale pilot programme across the Trust to determine the efficacy of the service.

Leadership and Management Development

As part of the Trust's regular programme a leadership forum was held in November when Dr Joanna Watson, Clinical Director of the Point of Care programme at the Kings Fund spoke to delegates about the importance of the patient experience.

Our first Institute of Leadership and Management (ILM) level 5 programme is due to commence in September and steps have been taken to improve the mentoring and coaching capacity within the Trust with a number of managers currently being trained by an external organisation to act as performance coaches. In addition the Dartmouth Institute Microsystem coaching approach is being introduced to support service improvement.

A further 3 cohorts of staff have attended the Senior Leaders programme developed in conjunction with Sheffield Hallam University along with a further 2 cohorts of the level 3 ILM programme. The 'Effective Manager' rolling management programme and the leadership guest lecture series continue to be well supported with speakers from NHS Employers and the Dartmouth Institute[3] in America being welcomed to the Trust during the year.

3 www.sheffieldmca.org.uk/sheffields_approach

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Staff survey

Staff engagement is measured every year via the annual NHS staff survey which includes an overall score for staff engagement. It was pleasing to note that this progress was maintained during 2012 despite a period of change in the NHS.

Top five ranking scores:

Key Finding	STH 2012	NHS 2012	STH 2011	NHS 2011	Improvement/deterioration
Staff working unpaid extra hours (%)	**64**	70	**52**	65	Deterioration
Staff experiencing harassment/bullying/ abuse from staff (%)	**23%**	24%	**n/a**	n/a	
Staff recommending Trust to work/for treatment	**3.65***	3.57	**3.60**	3.50	Improvement
Handwashing materials available (%)	**61**	60	**69**	66	Deterioration
Work pressure felt by staff	**3.07***	3.08	**n/a**	n/a	

Bottom five ranking scores:

Key Finding	STH 2012	NHS 2012	STH 2011	NHS 2011	Improvement/deterioration
Staff motivation at work	**3.68***	3.84	**3.60**	3.82	Improvement
Staff having well structured appraisals in last 12 months (%)**	**26**	36	**27**	34	Deterioration
Effective team working	**3.61***	3.72	**3.62**	3.72	Deterioration
Received equality and diversity training in last 12 months (%)	**39**	55	**37**	48	Improvement
Support from immediate managers	**3.48***	3.61	**3.55**	3.62	Deterioration

Most improved

Key Finding	STH 2012	STH 2011
% of staff able to contribute to improvements at work	63	52
% staff appraised in last 12 months**	76	67

* Possible scores range from 1 (poor) to 5 (good)

** In common with a number of Trusts, the figure for staff indicating that they had received a well structured appraisal is lower than the % of staff appraised, the appraisal improvement work detailed above seeks to address this concern.

Priorities for Improvement and Statements of Assurance from the Board

It is pleasing to note that 78% of the staff who work at Sheffield Teaching Hospitals are satisfied with the quality of work and patient care they are able to deliver and 70% of our staff would recommend the Trust to family and friends which is well above the NHS average of 60%.

An action plan has been drawn up to address the areas for improvement highlighted in the survey, which is currently being implemented.

i) Annual Patient Surveys

The Trust undertakes a wide range of activities to find out what patients feel about the services they receive. Survey work during 2012/13 has included participation in the national survey programme for inpatients, accident and emergency departments and cancer services. In addition, an extensive programme of local surveys is undertaken using a range of methods including paper based surveys and the real time frequent feedback system in which views of patients about a wide range of services are gathered by volunteers.

In the National Accident and Emergency Department Survey 2012, our scores were similar to those of other trusts. Questions where our scores were high include doctors and nurses working well together and courtesy of reception staff. Areas identified where improvements can be made include informing patients of the waiting time to be examined and the provision of written/printed information about the patient's condition and treatment.

The National Inpatient Survey 2012 also showed our scores overall to be in line with those of other trusts nationally. High scoring questions include cleanliness of the patient's room, ward and toilets and doctors being knowledgeable about the patient's condition and treatment. Lower scoring questions where improvements can be made include provision of enough information about ward routines and delays in discharge.

The second National Cancer Survey was carried out in 2012. This Trust's scores were once again very good overall. High scoring questions include the patient's overall rating of care as 'excellent' or 'very good' and staff providing complete explanations regarding operations. Areas where scores were lower include the provision of information regarding financial help and staff asking the patient what name they prefer to be called by.

Following any patient feedback, action plans are agreed at local and Trust level to address areas where improvements can be made. There are ongoing programmes of work which aim to improve patient experience and Trust scores in both local and national surveys help us to monitor the impact of this work.

j) Complaints

Improving the experience and learning from complaints.

The Trust continues to value complaints as an important source of patient feedback. We provide a range of ways in which patients and families can raise concerns or make complaints. All staff receive training at induction on how to respond to concerns and how to advise patients on making a complaint.

All concerns whether they are presented in person, in writing, over the telephone or by email are assessed and acknowledged within two days and where possible, we aim to take a proactive approach to solving problems as they arise. We have been able to respond to 85% of complaints requiring more detailed and in depth investigation within our target of 25 working days (1444 complaints received during 2012/13).

Regular complaints and feedback reports are produced for the Board of Directors, Patient Experience Committee, Care Groups and Directorates showing the number of complaints received in each area and illustrating the issues raised by complainants. This reporting process ensures that at all levels, the Trust is continually reviewing information so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff.

We remain committed to learning from, and taking action as a result of complaint investigations where it is found that mistakes have been made or where services could be improved. During the past year we have introduced a formal process for monitoring and following up actions agreed to ensure any changes have been made and implemented as planned.

Work on auditing both the quality of our complaints service against the standards we have set and the experience of complainants has continued during the year. We will continue to use the findings of this audit and review work alongside national initiatives and recommendations following the Mid Staffordshire NHS Foundation Trust Public Inquiry[4] to continually improve and develop our complaints service.

4 The Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, HC 947, London: The Stationery Office.

k) Eliminating Mixed Sex Accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation except when it is in the patient's overall best interest or reflects their personal choice. As a result we have not identified any breaches of the Eliminating Mixed Sex Accommodation during 2012/13.

l) Coroners Rule 43 Letter

In September 2012 the Trust along with Doncaster and Bassetlaw Hospitals NHS Foundation Trust, received a Rule 43 letter from the Coroner following an inquest into the death of a patient who received care within Doncaster but was not transferred to Sheffield for emergency treatment. These letters are written when the Coroner feels further improvement action needs to be implemented following a death. In a joint response to the Coroner both hospitals detailed the changes made to the way we care for patients requiring urgent intervention in order to prevent a similar situation happening again.

Part 3

Review of Services in 2012/13

3.1 Quality Performance Information 2012/2013

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

As there are new indicators added this year all of the indicators have been grouped into three sections:

i) Mandated Indicators - Department of Health (Gateway reference 18690)

ii) Mandated Indicators - Monitor (Schedule 6 - Feb 13 v55)

iii) Local Indicators.

i) Mandated Indicators - Department of Health (Gateway reference 18690)

Prescribed Information	2010/11	2011/12	2012/13
1. Mortality			
(a) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period; **National average: 1** **Highest performing Trust score: 0.68** **Lowest performing Trust score: 1.21**	.86	.92*	**.90** **(Oct 11 - Sept 12)**
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. (The palliative care indicator is a contextual indicator). **National average: 18.9%** **Highest performing Trust score: 43.3%** **Lowest performing Trust score: 0.2%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are extracted from the Information Centre SHMI data set*. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate and so the quality of its services, by: • *Ensuring consistent Mortality and Morbidity reviews are undertaken across the Trust.* • *Monitoring the mortality data at a diagnosis level to ensure any areas for improvement are constantly reviewed and where appropriate ensure actions are taken to address.* * The 0.87 reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. July 10 - June 11. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2011 - March 2012 was released at the end of October 2012 and reported as 0.92. This can be validated via the NHS Choices website.	17.9%	17.5%	**18%** **(Oct 11 - Sept 12)**

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
2. Patient Report Outcome Measures (PROMs)			
The Trust's patient reported outcome measures scores for:			Apr - Jun 12
(i) Groin hernia surgery			
Sheffield Teaching Hospitals' score:	0.083	0.086	**0.104**
National average:	0.085	0.087	0.091
Highest score:	0.156	0.143	0.158
Lowest score:	-0.020	-0.002	0.017
(ii) Varicose vein surgery			
Sheffield Teaching Hospitals' score:	0.082	0.065	*
National average:	0.091	0.094	0.093
Highest score:	0.155	0.167	0.138
Lowest score:	-0.007	0.047	0.024
(iii) Hip replacement surgery			
Sheffield Teaching Hospitals' score:	0.359	0.365	*
National average:	0.405	0.416	0.437
Highest score:	0.503	0.532	0.502
Lowest score:	0.264	0.306	0.333
(iii) Hip replacement surgery			
Sheffield Teaching Hospitals' score:	0.327	0.313	**0.255**
National average:	0.299	0.302	0.312
Highest score:	0.407	0.385	0.387
Lowest score:	0.176	0.180	0.244

PROMs scores represent the average adjusted health gain for each procedure. Scores are based on the responses patients give to specific questions on mobility, usual activities, self care, pain and anxiety after their operation as compared to the scores they gave pre-operatively. A higher score suggests that the procedure has improved the patient's quality of life more than a lower score.

* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received.

The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are taken from national Information Centre PROMs data set*.

The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score and so the quality of its services, *by reviewing in detail a breakdown of EQ-5D and OHS data for hips and undertaking improvement work as necessary.*

Performance remains within acceptable ranges for other PROMs and scores will continue to be monitored. The focus is to understand the lower PROMs scores, which is a highly complex issue requiring expert input.

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
3. Readmissions			
The percentage of patients aged:			
(i) 0 to 14; and	0%	0%	**0%**
(ii) 15 or over,	10.7%*	10.7%*	**11.36%**
readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust. **Comparative data is not available** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are taken from the Trust's Patient Administration System*. * These figures are different from last year as the way the data is calculated has changed (Data definition). The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage *and so the quality of its services by reviewing the reasons for readmission and working with our partners in the wider Health and Social Care community to prevent avoidable readmissions. This will be delivered through the Right First Time initiative*.			
4. Responsiveness to personal needs of patients			
The trust's responsiveness to the personal needs of its patients during the reporting period. **National average: 68.1%** **Highest performing Trust score: 84.4%** **Lowest performing Trust score: 57.4%** The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as *the data are provided by national CQC survey contractor.* * The scores represent the five questions from the National Inpatient Survey which have been selected nationally to form part of the CQUIN scheme, as a measure of responsiveness to patient needs. The Sheffield Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, *as for the last two years the Trust and PCT have agreed that, whilst important, the areas highlighted in the national survey were not as important as some fundamental areas which include help to go to the toilet, controlling pain, help with nutrition, being treated with dignity and theses are the areas on which the Trust's Patient Experience is being measured through an ongoing programme of patient interviews (approximately 400 each month).*	71.9%	72%	**68.6%***

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
5. Staff who would recommend the Trust The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: 60% Highest performing Trust score: 94% Lowest performing Trust score: 35% The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described *as the data are provided by national CQC survey contractor.* The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage and so the quality of its services, by *continually involving staff and seeking their views in how to make improvements in the quality of patient services.*	73%	75%	**70%**
6. Patients risk assess for Venous Thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. Comparative data is not available The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as they are taken from the Trusts Patient Administration System and audit data. * These figures are different from last year as the way the data is calculated has changed (Data definition). The Sheffield Teaching Hospitals NHS Foundation Trust *continues to take the following actions to improve this percentage and so the quality of its services, by ensuring completion of VTE risk assessment form for every patient admitted to STH. Undertaking surveillance of returns and feedback to Directorates on performance and carrying out root cause analysis of cases of VTE which are thought to be hospital associated.*	73.97%*	91.1%*	**93.33%**

Part 3

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
7. Rate of *Clostridium Difficile*			
The rate per 100,000 bed days of cases of *Clostridium Difficile* infection reported within the trust amongst patients aged two or over during the reporting period. National average: 18.5 Highest performing Trust score: 0 Lowest performing Trust score: 39.5 The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as the data is provided by the Health Protection Agency. The Sheffield Teaching Hospitals NHS Foundation Trust *continues to take* the following actions to improve this rate and so the quality of its services, by having a dedicated plan as part of it's Infection Prevention and Control Programme to continue to reduce the rate of *Clostridium Difficile* experienced by patients admitted to the Trust.	31.0	30.0	**17.7**

Review of Services in 2012/13

Prescribed Information	2010/11	2011/12	2012/13
8. Rate of patient safety incidents			
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period.			
Number of Incidents reported	10,495	10,192	**9,684***
The Incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data below is for the first 6 months of 2012/13. Full information for the financial year 2012/13 is not available from the National Reporting and Learning System until mid 2013 **Cluster** average: 6.8** **Highest performing Trust score: 12.12** **Lowest performing Trust score: 2.77**	5.3	5.2	**4.8** **As per NRLS data Apr-Sep 2012**
and the number and percentage of such patient safety incidents that resulted in severe harm or death. **Cluster** reporting data: 850 (0.6%)** **Highest reporting Trust: 81 (0.8%)** **Lowest reporting Trust: 1 (0.02%)**	55 (0.5%)	46 (0.4%)	**47* (0.5%)**
* Information taken from the Trust incident reporting system on 24/4/2013 ** Comparative data is sourced from the National Reporting Learning System, data is split into cluster/peer groups with Sheffield Teaching Hospitals NHS Trust being part of the 'Acute Teaching Hospitals' cluster. The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described *the data are taken from the National Reporting and Learning System (NRLS).* *The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by introducing web based reporting throughout the Trust by autumn 2013. This will increase access to the reporting system, encourage increased incident reporting and speed up the Incident Management process.* **To note:** As this indicator is expressed as a ratio, the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is also clinical judgement required in grading incidents as 'severe harm' which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited.			

Review of Services in 2012/13

ii) Mandated Indicators - Monitor (Schedule 6 - Feb 13 v55)

Measures of quality performance	2010/11	2011/12	2012/13
9. Percentage of patients who wait less than 31 days from diagnosis to receiving their treatment for cancer			
Sheffield Teaching Hospitals achievement	97%	98%	**98%**
National Standard	96%	96%	96%
Data Source: Exeter National Cancer Waiting Times Database			
10. Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Sheffield Teaching Hospitals achievement	86%	91%	**89%**
National Standard	85%	85%	85%
Data Source: Exeter National Cancer Waiting Times Database			
11. Percentage of patients who have waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis			
Sheffield Teaching Hospitals achievement	93%	95%	**95%**
National Standard	93%	93%	93%
Data Source: Exeter National Cancer Waiting Times Database			
12. All cancers: 31-day wait for second or subsequent treatment, comprising:			
Surgery:			
Sheffield Teaching Hospitals achievement	96%	97%	**97%**
National Standard	94%	94%	94%
Anti-cancer drug treatments:			
Sheffield Teaching Hospitals achievement	99%	99%	**100%**
National Standard	98%	98%	98%
Radiotherapy:			
Sheffield Teaching Hospitals achievement	97%	98%	**99%**
National Standard	94%	94%	94%
Data Source: Exeter National Cancer Waiting Times Database			

Review of Services in 2012/13

Measures of quality performance	2010/11	2011/12	2012/13
13. Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge			
Sheffield Teaching Hospitals performance	97.6%	95.6%	**93.2%**
National Standard	95%	95%	95%
Data Source: Patient Administration System (PAS)			
14. MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals	9	2	**3**
Sheffield Teaching Hospitals threshold	13	10	1
Data Source: Health Protection Agency			
15. Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals achievement	93%	90%	**90.6%**
National Standard	90%	90%	90%
Data Source: Patient Administration System (PAS)			
16. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Sheffield Teaching Hospitals achievement	98%	97%	**96.6%**
National Standard	95%	95%	95%
Data Source: Patient Administration System (PAS)			
17. Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway			
Sheffield Teaching Hospitals achievement	91%	90.4%	**93.2%**
National Standard	92%	92%	92%
Data Source: Patient Administration System (PAS)			
18. Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Referral to treatment information:			
Sheffield Teaching Hospitals achievement			**60%**
National Standard			50%
Referral information:	New indicator	New indicator	
Sheffield Teaching Hospitals achievement			**100%**
National Standard			50%
Treatment activity information:			
Sheffield Teaching Hospitals achievement			**100%**
National Standard			50%

Review of Services in 2012/13

iii) Local Indicators

Measure of quality performance	2010/11	2011/12	2012/13
19. Never Events			
Sheffield Teaching Hospitals Performance	2	3	**7**
Data Source: National Patient Safety Agency			
The Trust has experienced 7 Never Events during the year; 3 retained objects, 3 medication incidents following the incorrect prescribing and administration of Methotrexate and a misplaced nasogastric tube. A full review of Never Events has taken place and the Trust has been in close liaison with commissioners. A 'Never Event' summit took place in February 2013 to highlight issues across the Trust and ensure systems were in existence for the management of each separate category.			
The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents can be investigated, trends analysed and lessons can be learnt across the Trust.			
20. Hospital Standardised Mortality Ratio (HSMR)			
Sheffield Teaching Hospitals performance	91%	98%	**98%**
National Benchmark	100%	100%	100% (April 12 - Jan 13)
Data Source: Dr Foster			
21. Percentage of hip replacements we do in the Trust that are revisions			
Sheffield Teaching Hospitals performance	21.1%	20.3%	**25.7%**
National Benchmark not available	22.1%	21.3%	N/A
Data Source: Patient Administration System			
22. Patients who receive Primary Percutaneous Coronary Intervention within 150 minutes of calling for help			
Sheffield Teaching Hospitals achievement	N/A	74%*	**75.3%****
National Standard	N/A	75%	75%
Data Source: Myocardial Ischaemia National Audit Project (MINAP)			
* The value provided each year is an estimate of the data at the time of publication (75% as at April 2012). The process of validation of this data continues during April and May to meet the MINAP submission deadline of 31 May. This is because MINAP recognise that the data from patients treated up to the end of March requires inclusion and subsequently needs to be validated. MINAP published their annual report in November 2012 which, included the fully validated figure of 74% for 2011/12.			
** Interim return, further validation required.			

Part 4

4.1 Response to Partner organisation comments 2011/12

LINk, NHS Sheffield, Trust Governors and the Sheffield Health and Community Care Scrutiny Committee commented in the 2011/12 Quality Report. The following table summarises the Trust's response to those comments.

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

NHS Sheffield (2011/12)

Abridged comments	Our response
We do, however, note that the Trust made mixed progress during 2011/12 on delivering its agreed improvement priorities, and there are therefore some important outstanding issues for 2012/13. These include:	
• **Improving the care of older people:** achieving real progress on nutritional assessment and treatment and continuing to deliver reductions in the number of Grade 2 pressure sores	Nutrition is reported in section 2.1.7. Pressure Ulcers continue to be an area for improvement by the Trust. Overall, the proportion of patients who acquire pressure sores whilst in STHFT beds is 1.77%, we aim to reduce this by 50% during 2013/14.
• **Improving infection control:** achieving a significant reduction in the number of Clostridium Difficile infections, in line with the target set by the Department of Health of 134 cases for 2012/13	Reported in section 2.1.8
• **Reducing cancelled operations:** reversing the increase seen in 2011/12 in the number of planned operations which had to be cancelled for non-clinical reasons	Objective for this years Quality Report Section 2.1.11
• **Improving the patient experience of outpatient care:** ensuring that the Trust Outpatient Transformation Programme delivers real improvements for patients, in terms of environment, waiting times and customer service standards and works with clinical commissioners to ensure the right clinical balance of services between hospital clinics and community settings closer to patients' homes	The Trust has adopted 'Clinical Microsystems' as an approach to transform how services are delivered. This is a multi-disciplinary team approach that engages the people who are actually involved in delivering the service on a day-to-day basis. The approach also puts the patient at the heart of the redesign. Progress has been made in Renal, Cystic-fibrosis, Hearing services, Urology and Diabetic Foot Outpatient services where waiting times have come down by up to 20%. Work has commenced in Ante-natal, Oncology, Immunology and Anti-Coagulation Outpatient clinics. Work in the Anti-Coagulation services has also resulted in joint work with Sheffield Clinical Commissioning Group reviewing how phlebotomy will be delivered across the city in the future. The Trust recognise that it is critical to ensure that blood is taken at a time and place that is convenient for the patient.

Sheffield Local Involvement Network (2011/12)

Abridged comments	Our response
We have been assured that an 'easy read' version will be produced this year to sit alongside the more formal STHFT Quality Account. Sheffield LINk looks forward to receiving the 'easy read' version.	A summary version was incorporated in the 'Making a difference - a summary of quality improvements and priorities', a similar exercise will be repeated this year.
Sheffield LINk requests that STHFT consider how LINk can be provided with a full and complete version to enable comment within the required timescale.	The Trust will provide LINks and subsequently Healthwatch with a publication that includes the best available data at the time of distribution. Unfortunately due to the tight timescales this may not always include final year end figures for some indicators. The Trust recognises this is frustrating to partners when requested to review the Trusts achievements.
Sheffield LINk recommends that information regarding 'the place receiving discharged patients' and 're-admission data' both in the context of older people, be collected and a report made in the next QA.	During engagement meetings with LINks we discussed the challenge of providing discharge destination data, given there was no robust way of ensuring if this was the most appropriate destination for that patient. However the Trust is fully committed to the cross city initiative of Right First Time which aims to ensure that patients are treated in the most appropriate location and which aims to prevent inappropriate admission to hospital. Readmission data is included in Part 3 of the Quality Report.
Sheffield LINk would particularly wish to highlight the 'Productive Ward' and 'Proactive Rounding' as omitted priorities from the STHFT process and emphasise an expectation that work will continue in these areas.	Productive Ward is a series of tools and techniques produced by the NHS Institute for Innovation and Improvement. They are service improvement tools which can be used to try to improve the efficiency of wards and clinical departments. They are one of the tools that the Trust uses to improve efficiency on wards alongside other initiatives such as the Clinical Assurance Toolkit and E-rostering. We have been working with the Productive Ward initiative now for a number of years. The tools and techniques continue to be used by wards and departments across the Trust, alongside other service improvement activity such as the Clinical Microsystems work highlighted above. Care (Proactive) Rounding is being used across all parts of the organisation in a number of ways. Predominantly rounding is delivered on a two hourly basis and paperwork has been developed in areas to act as a prompt and provide further record of cares delivered to patients. Each area has its own guidance on completion depending upon their patient group, their needs and preferred ways of working. The paperwork is based on the NHS Quest Skin bundle. The Trust Record Keeping Group is currently reviewing the paperwork that exists in order to establish a preferred form. A minority of areas have opted for a paperless system but posters advertise to patients and visitors, as well as ward staff, that care rounding is being undertaken.

Abridged comments	Our response
Sheffield LINk requests that regular reports on priorities for improvement be placed on the STHFT website.	The Trust has made some progress towards achieving this objective as Board of Directors meetings are now held in public and monthly papers are published on the Trust website. These include a general update on improvement activity across the Trust. However the Trust recognises there is more work to be undertaken in this area.
Sheffield LINk will look forward to a proportionate but detailed report on Adult Community Services in next year's QA.	Community Services data is included within the performance data provided. This year the Pressure Ulcer improvement objective covers improvement work within the Community alongside Hospital services.
Sheffield LINk is pleased to note that staff received training especially in Dignity and Dementia, but it would give more reassurance if the proportion of staff compared to the total relevant workforce was always used rather than a single number.	This is noted for future reporting of training activity (when required). Training in dignity and dementia continues across the organisation.

Sheffield Health and Community Care Scrutiny Committee (2011/12)

Abridged comments	Our response
The Committee recognises that the Quality Priorities represent only a small part of the work that the Trust undertakes and looks forward to engaging with Trust over the coming year both in monitoring progress on the quality priorities, and on wider issues.	The Trust recognises the significant impact of the Mid-Staffordshire Inquiry Report and looks forward to working collaboratively with Committee members to ensure positive but robust arrangements are in place to enable appropriate scrutiny and oversight.
In particular, the Committee welcomes the work ongoing to understand the reasons for patients being readmitted to hospital. We look forward to seeing improvement on this performance indicator.	The Trust has undertaken work to look at the reasons for readmission, these are varied and a number do not relate to the previous reason for admission. Collaboration with partners across the City is essential to reduce the number of avoidable admissions and therefore the Right First Time initiative continues in collaboration with key partners across the City.
The Committee also recognises the increasingly important role the Trust has as a provider of Community Services and is keen to see greater emphasis on this area of work in future.	Community Services are an integral part of the Trust and bring a rich emphasis on both primary, community and intermediate care services, which has been increasingly valuable to provide a seamless service to our patients and their carers.

Trust Governor Involvement (2011/12)

Abridged comments	Our response
We noted that not all the priorities for 2011-2012 were achieved and confirmed that processes should be in place to follow these up and make sure that work continued on them to effect their achievement.	Priorities not achieved in the 2011/12 report are reported in this 2012/13 Quality Report. Where performance has required further improvement this work will continue.

4.2 Statement from our partners on the Quality Report 2012/13

Statement from NHS Sheffield Clinical Commissioning Group

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.

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.

Our view is that Sheffield Teaching Hospitals NHS Foundation Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust continues to achieve good results in hospital standardised mortality ratios, remaining low relative to national averages, and it has achieved significant reduction in Clostridium Difficile cases this year. Other areas of achievement this year include dementia care and improving feedback from patients and carers via frequent feedback surveys and the introduction of the Friends and Family test in March 2013.

The national surveys of patient experience results remain similar year on year, however the number of questions that were rated as significantly better, compared with other trusts has reduced from previous years.

The trust has unfortunately experienced a number of never events during 12/13, and we are working closely with them to reduce the risk of recurrence.

Nonetheless, we are satisfied that the specific priorities for 2013/14 which the Trust has highlighted in this report - understanding why operations are cancelled, reducing the prevalence of all Grade 2, 3 and 4 pressure ulcers city wide and improving the provision of discharge information for patients - are all appropriate areas to target for continued improvement.

Three of these priorities are worthy of specific comment.

- Cancelling operations at short notice has a significant impact on patients. Understanding the causes of cancellations and more importantly, taking action to address these causes will improve individual patient's experience and will more broadly, contribute to the maintenance of Eighteen Week Waiting times.
- There has been a reduction this year in the overall numbers of patients with pressure sores in the community and an objective to reduce the numbers both in primary and secondary care next year will be welcome. It will be supported by the prevalence data submitted via the NHS Safety Thermometer and enable specific wards or services to be targeted.
- The standardised provision of discharge information will be welcome to clinical commissioners and patients. It will support a more seamless transfer of care between primary and secondary care and it will provide patients and their carers with information on what to expect post discharge.

We do, however, note that the Trust has indicated that it will carry over and/or report on indicators from 2012/13 and 2011/12 in 2013/14. These include:

- Optimising length of stay - achievement of clinically appropriate length of stays in line with national and local benchmarks in key areas
- Improving the care of older people - nutritional assessment - achieve further improvements in the number of patients aged 65 or over screened using MUST and the percentage of patients at risk that receive an appropriate care plan

Submitted by Jane Harriman on behalf of:

Kevin Clifford, Chief Nurse

and

Kate Gleave, Contract Lead STHFT

Sheffield Clinical Commissioning Group

April 29th 2013

Part 4

Commentary from Healthwatch Sheffield on the Sheffield Teaching Hospitals NHS Foundation Trust Quality Accounts 2012-13

These comments are based on the Trust's draft Quality Report 2012/13 version 1.0 dated 29th April 2013 and on meetings with the Trust to discuss the Report throughout the year.

We appreciated the opportunity to work with STHFT throughout the year preparing and debating the Quality Account, but also in the process, to feed our concerns and compliments into the Trust's working practices. From our perspective the process has been invaluable, particularly in understanding the constraints and difficulties in delivering the planned-for outcomes.

Part 1

Page 33. Regarding the reference in the Foreword to the production of a second more accessible version of the Quality Report for patients and the public. Whilst this is welcome it is our understanding that agreement was reached at meetings during the year that this will be more than a summary version incorporated in the 'Making a difference - a summary of quality improvements and priorities' document which has a limited circulation. We would like to see a clearer commitment in the Quality Report to the production and wide circulation of an easier to read summary version.

Page 34. We are pleased to see the statement from the Chief Executive on the importance of the Mid-Staffordshire Public Inquiry Report and the commitment to respond positively to its recommendations.

Part 2

2.1.1 Priorities for Improvement 2012/13

1. Optimise length of stay - Behind Schedule

We acknowledge the difficulty of optimising patients' length of stay in the Trust's hospitals, but we can find no overt commitment to continuing this priority into next year or any mention of how progress on this will be measured. We hope this will continue to be a priority for the Trust in succeeding years until the situation has improved.

2. Discharge letters for GPs - Almost Achieved

We note that the audits show mixed success and wonder whether the reasons for this were explored. We look forward to seeing the results following the introduction of the system of e-discharge summaries and that further local action plans will then be implemented.

3. Giving Patients a Voice - Achieved

We welcome the increased feedback through forms and comments cards. This year's statistics are interesting but it would be helpful to see a comparison with the last two years and with the total number of patients being treated in the Trust's hospitals.

5. Holistic Care to promote a good experience for patients who have dementia, Improve Dementia Awareness - Achieved.

All the reported work in relation to this priority has focused on the built environment, and to a lesser degree on nutritional screening. Whilst this is important we would like to see some work on how the Trust can meet individual patients' needs and to know what measures and processes have been put in place to improve Dementia Awareness in the Trust's hospitals and how this will be kept ongoing, especially in the light of the Francis Report. We shall be interested to read about the progress of the three further up-grades - we consider Vickers 4 ought to also have priority as this ward is specifically focused on the after care of older people following orthopaedic operations.

Page 41, 2.1.8 Reduce hospital acquired infections.

We commend the Trust on a reduction in the number of cases of *C. Difficile* in 2012-13 and hope this will be continued. We would be interested to know what further improvements are under consideration.

2.1.10 Priorities for Improvement in 2013/14

As a general statement we would find it most helpful to see priorities from the earlier years which have not been achieved or only partially achieved, included as on-going priorities in the following year, as well as the measures used to indicate success. For example, it is acknowledged in the Quality Account that Nutritional Assessment will be reported in 2013/14, but it is not in the summative list of priorities.

We are surprised that Accident and Emergency waiting times are not a priority as the Trust has failed to meet the 95% target in 2012-13.

Last year we were clear in our comment that Community Services, part of the Trust's responsibilities, ought to be included in the Quality Account. We appreciate information may not be immediately available in a suitable statistical form, but the Report is not clear on this important and expanding part of its responsibilities. We will look for more evidenced descriptions in next year's QA.

Part 4

Clinical Audit

Page 51. Audit of Insulin Self Administration. We note that 100% compliance can be achieved if bedside lockers are available and we would be interested to know whether there are enough lockers for all patients who are capable of managing the self administration of their insulin?

Page 52. Care Home Support Team: Core Skills training Outcomes. We welcome the training of care home staff through this initiative. It is not clear from the document if the Trust is going to continue to provide a comprehensive Care Home Support Team but we hope the Trust will continue to provide comprehensive Core Skills Training for care home staff, particularly in view of its increasing Community Services provision and responsibilities.

Page 55. (c) Northern General Hospital Mental Health Act Commission visit. By implication there was not full compliance and more detail on this visit report would be helpful.

Page 56. Data Quality. We are surprised that patients' unique NHS numbers are not used in every case / document; this presents a potential for serious confusion.

Page 57. Patient Safety Alerts. Sheffield LINk always asked Trusts to include information on Patient Safety Alerts (PSAs) in Quality Accounts. Therefore we are pleased to see that that all PSAs were completed during 2011-12 and that there are no outstanding alerts for 2012-13.

We would also like to see reported in Quality Accounts information on any Coroners Rule 43 Requests that were received by the Trust in 2012-13 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.

Page 59. Staff Survey. It is of some concern to us that there are 5 areas of deterioration in the survey results, and in particular that staff having well structured appraisals continues to be low scoring as it was last year. We would like to see reference to plans to address these findings.

Page 60. Patient Surveys and Complaints. We note that one of the identified areas for improvement in the national A&E Survey is the provision of written/printed information. This is an area that HWS would be keen to work with the Trust on to improve these communications.

Page 60. Complaints. We are surprised that numbers of complaints, their nature and actions taken as a result are not reported, which we feel are essential to the Quality Account.

Part 3

Page 62. Mandated Indicators. It would be helpful if the relevant years were repeated at the top of each page as an aide memoire.

Part 4

We commend the Trust for giving detailed responses to comments received from external partner organisations on the 2011-12 Quality Report, which is most helpful.

Notwithstanding all of the above, we felt the on-going relationship during the year to be most positive, productive and helpful, and we wish to commend the Trust and its officers for willingly joining with us in this debate and dialogue.

Mike Smith
Chair, Sheffield LINk (to March 2013)

Pam Enderby
Chair, Healthwatch Sheffield

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee comments:

The Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Sheffield Teaching Hospitals NHS Foundation Trust's Quality Account.

We'd like to thank the Trust for taking account of the views, comments and issues raised by the Committee during the Quality Accounts process, and is pleased to see that the Trust has engaged widely with stakeholders, such as the Local Involvement Network, in the development of the final report.

The Committee commends the Trust for the format and presentation of the report - which makes a complicated subject matter clear and easy to understand.

The Committee recognises that the Quality Account is not intended to reflect all of the improvement work which is taking place across the Trust, however suggests that a greater emphasis is placed on reporting progress on previous year's quality objectives. This would help us to build up a picture of how the Trust is progressing over time.

The Committee looks forward to working with the Trust over the coming year, and seeing progress on this year's quality priorities.

Cllr Mick Rooney
Chair

Governor involvement in the Quality Report Steering Group

Five Governors attended the Quality Report Steering Group during the year. We enjoyed our participation in the group and felt heard.

We contributed to deciding the content and the wording of the Quality Report.

Choosing the priorities for the Quality Report was challenging as many were proposed both from within the Trust and by LINk. Those chosen had to be both relevant and meaningful, and also measurable. Outcomes of softer more feeling-centred priorities are more difficult to measure and this may have also limited the choice even though such priorities have as much value.

We felt that the final choices for 2013/14 were a good and representative sample that could give meaningful results and result in real improvements in quality.

We noted that not all the priorities for 2012/13 were achieved and are very clear that processes should be in place to follow these up and to make sure that work continues on them to effect their achievement.

We appreciate the enormous amount of work that goes into the writing of this report and also that the largely prescribed text makes the report more difficult for non-hospital related readers to understand. We look forward to a readable summary version.

Andrew Manasse

17 April 2013

4.3 Statement of Directors' responsibility

Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to May 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to May 2013
  - Feedback from the commissioners dated 29 April 2013
  - Feedback from Governors dated 17 April 2013
  - Feedback from Local Healthwatch dated 14 May 2013
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 May 2013
  - The latest national inpatient survey March 2012 and the Accident and Emergency Survey December 2012
  - The latest national staff survey March 2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2013
  - CQC quality and risk profiles dated March 2012 - March 2013
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

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

By order of the Board

Chairman

23 May 2013

Chief Executive

23 May 2013

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

We have been engaged by the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.
- Emergency readmissions within 28 days of discharge from hospital

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

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

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

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

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

- Board minutes for the period April 2012 to April 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to April 2013;
- Feedback from the Commissioners dated 29 April 2013;
- Feedback from local Healthwatch organisations dated 14 May 2013;
- The Trust's 2012/13 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012 national inpatient survey dated Feb 2013
- The 2012 accident and emergency department patient survey;
- The 2011/12 cancer patient experience survey dated Aug 2012;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles dated April 21012 to April 2013;
- The draft Head of Internal Audit's annual opinion over the Trust's control environment dated 25 April 2013 and
- Quality Report Steering Group minutes for the period April 2012 to April 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Teaching Hospitals NHS Foundation Trust's quality agenda,

performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sheffield Teaching Hospitals NHS Foundation Trust

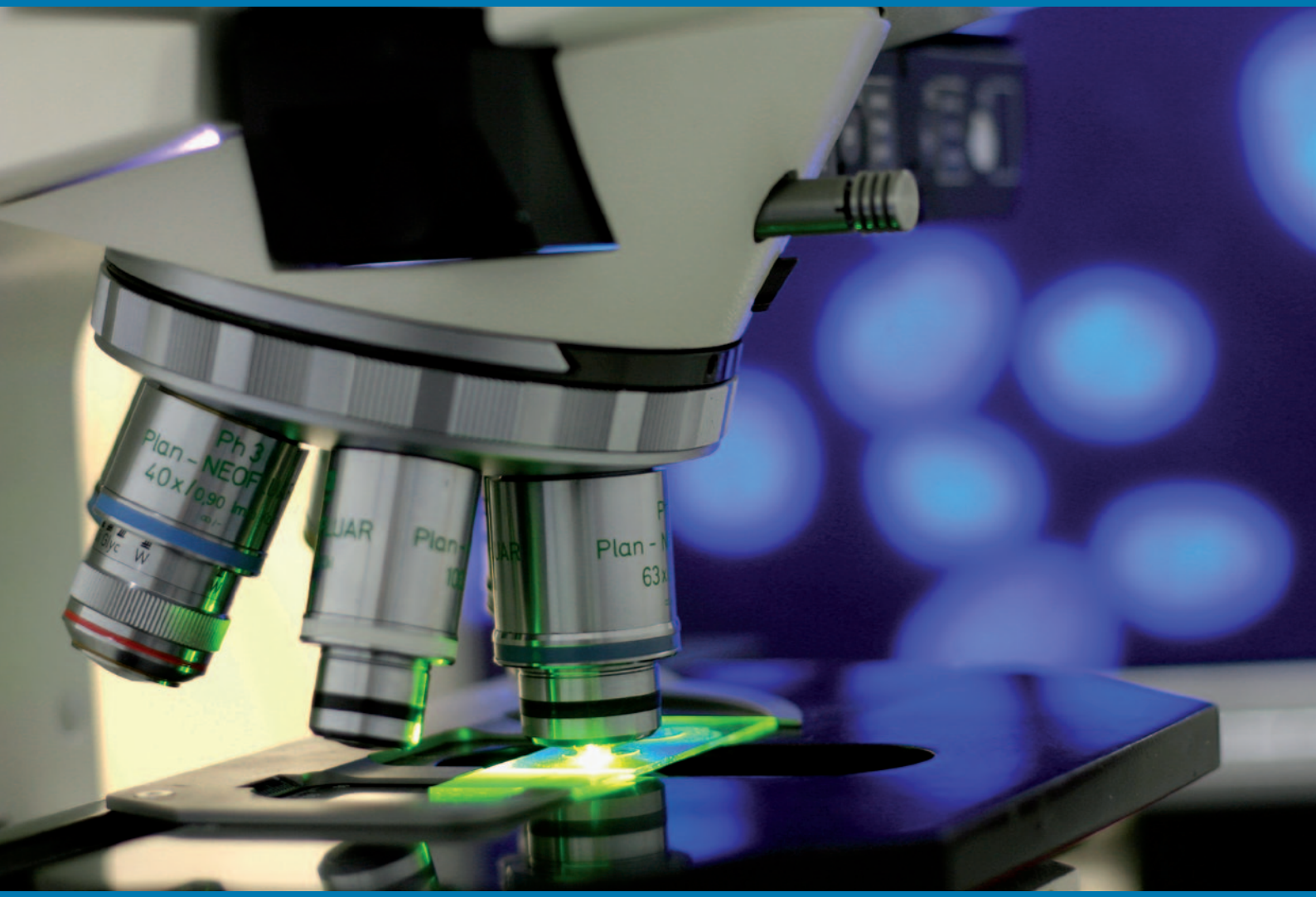
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

KPMG LLP,
Statutory Auditor
1 Neville Street,
Leeds,
LS1 4DW

23 May 2013



Our aim: to deliver excellent research, education and innovation

7 Research and innovation

We are committed to undertaking a large volume of excellent research for the benefit of our patients exemplified by embedding this work into clinical care.

Research and Innovation

The Trust leads on a significant portfolio of health research underpinned by our relationships with the University of Sheffield and partners in Industry.

We have created a group of Academic Directorates who integrate research into their clinical work. These Directorates are centred on our strongest research areas, Neuroscience, Cardiovascular Medicine, Specialised Cancer, Diabetes & Endocrinology, Clinical Dentistry, Communicable Diseases, Specialised Medicine and Respiratory Medicine.

All our researchers are supported by a Clinical Research Office (CRO) jointly managed by the Trust and the University of Sheffield and conduct their work in dedicated world-class facilities. The CRO aims to provide a 'one-stop shop', so researchers can easily obtain the necessary support and advice.

Our clinical research portfolio ranges from Experimental Medicine studies through to Applied Health Services Research. The involvement of patients and the public is central to all our activities. During the year, 228 non-commercial and commercial studies involving patients and healthy volunteers were approved, of which approximately 150 were National Institute for Health (NIHR) portfolio studies.

The Trust currently supports 725 active non-commercial and commercial research studies, of which 433 were supported by the NIHR. We have recruited more than 12,100 patients and healthy volunteers and of these, almost 6,000 were recruited to portfolio studies.

The Trust is aiming to increase the number of industry sponsored trials, in partnership with the South Yorkshire Clinical Local Research Network (SYCLRN). Commercial studies have increased by 30%, from 73 in 2011/12 to 95 in 2012/13.

Leading edge Clinical Research Facility (CRF)

Our **Clinical Research Facility**, a joint enterprise with the University of Sheffield, has sites on both the Royal Hallamshire Hospital and Northern General Hospital providing an excellent research infrastructure to all researchers. It provides dedicated core facilities and expert staff to facilitate research of all types including industry and grant funded studies.

In 2012 the joint enterprise was awarded £3.1 million of NIHR funding to support experimental medicine studies, particularly in Neurosciences, Diabetes & Endocrinology, Respiratory/Communicable Diseases, Musculoskeletal, and Cardiovascular disease.

We currently support around 350 studies and are developing outreach support across the Trust. We are implementing new initiatives to further enhance participants' experience. We are modifying working practices to shorten set up and deliver recruitment to time and target. Since its inception, the CRF has supported around 30,000 participant visits and is recognised amongst industry partners for being the fastest and highest recruiter to a number of studies.

Cancer Clinical Trials Centre (CCTC)

The North Trent Cancer Research Network and Sheffield Experimental Medicine Centre are based in the purpose-built Cancer Clinical Trials Centre at Weston Park Hospital. The multi-disciplinary team supports a large and diverse portfolio of trials ~ 90 open and recruiting during the year, ranging from complex phase I, II and III trials to the non-interventional observational and quality of life trials. The research covers most cancer types, from the more common cancers to rare and under researched tumours.

Recruitment into the more complex interventional trials was at its highest in 2012/13. One in five patients with a diagnosis of cancer across the North Trent Network is now included in some form of cancer clinical trial and over the last 10 years more than 10,000 participants have been recruited.

Patient and Public Involvement

We strive to put patients at the heart of our research; as such a number of directorates have ongoing and effective Patient and public involvement groups. Two additional patient panels have been set up in 2012/2013 in Communicable Diseases and Diabetes & Endocrinology. Three other Directorates have begun work in creating patient panels which will be set up in the coming year. We work closely with our South Yorkshire PPI colleagues in SYCLRN and Research and Design Services (RDS).

Key Ongoing Projects

NIHR CLAHRC for South Yorkshire

The Collaboration for Leadership in Applied Health Research and Care for South Yorkshire (CLAHRC SY) is a five year programme with a specific focus on the self-management of long-term conditions. At the beginning of 2013 CLAHRC SY, had 52 research projects, and 31 evidence implementation and service development projects, attracting over £22 million into our health economy.

Key projects have included:

- A focus on Patient and Public Involvement (PPI), including a new patient-facing website, developed with patients, http://beinvolved-sy.org.uk
- A pilot trial of WICKED (working with carbs, ketones, and exercise to manage diabetes), an educational intervention for adolescents with type 1 diabetes
- Dysphagia (difficulty swallowing) can be caused by stroke, dementia, and many other long-term conditions. We have developed, trialled and evaluated a training package for nurses, which led to changes in clinical practice that were sustained six months after the training
- Work on Improving Stroke Unit Quality which has led to recommendations for service improvements that go beyond the national guidelines
- Placements for MSc Clinical Research and MSc Science Communication students

Devices for Dignity (D4D) - Healthcare Technology Cooperative

The NIHR D4D develops technology solutions to support people with long term conditions, preserving their dignity and independence. D4D is hosted by STHFT, and operates as a consortium of seven NHS trusts and three universities. The three areas of specialism are Assistive and Rehabilitation Technologies, Urinary Continence Management and Renal Technologies. D4D has managed an active portfolio of 20 projects while constantly evaluating new areas of unmet needs and new project ideas. Innovative solutions in these areas make a difference to the lives of large numbers of people whilst also delivering real cost improvements to the delivery of health and social care provision. In April 2012, D4D received the Allied Health Professionals and Healthcare Scientists: Leading Together On Health Award at the 2012 Advancing Healthcare Awards.

In November 2012 D4D was awarded £800,000 further funding.

INSIGNEO Institute for in silico Medicine

This is a collaborative initiative between the University of Sheffield and STHFT involving technology experts, bioengineers and biophysicists, biomedical researchers, and clinical scientists. This multi-disciplinary institute has over 80 academics and clinicians who collaborate to develop computer simulations of the human body and its disease processes that can be used directly in clinical practice to improve diagnosis and treatment. This is probably the most sophisticated application of computing technology in healthcare, and Sheffield has become the UK's main centre for this work.

INSIGNEO is a significant part of the wider international research agenda on in silico medicine and has attracted over £11m of funding, and has grant applications under evaluation for another £20m. The current research focus is towards three major goals: Personal Health, The Digital Patient and in silico clinical trials forecasting and include independent, active and healthy aging and Personalised treatment. In Europe, our Trusts plays a key role in the Virtual Physiological Human initiative.

Sheffield Institute for Translational Neuroscience (SITraN)

SITraN is the realisation of a 10 year vision and research strategy, to bring a world-class research institute for Motor Neurone Disease (MND) research to Sheffield. The dedicated research accommodation encompasses tissue culture suites, facilities for image analysis, live cellular imaging,

confocal microscopy, laser capture microdissection, gene expression profiling by RNA microarray techniques, genetics, proteomics, histology, gene therapy, and small molecule drug screening. SITraN researchers have attracted over £7.3million of new research grant funding for Motor Neurone Disease and Spinal Muscular Atrophy in 2011-12.

Academic Health Science Network

Promoting excellence in research and innovation is one of the main aims of our Making a Difference strategy and although the Trust performs well against national research targets, there is room for improvement particularly in the type and number of studies and the breadth of research portfolio.

A more coordinated approach to deliver integrated innovation, research, adoption and spread will be developed over the next five years. New Academic Health Science Networks are targeted at closing the so-called second Translational Research and Development gap. During 2012/13 we have therefore been working closely with local partners and the Department of Health to ensure that Yorkshire and the Humber is well placed to be part of this important national policy development. The Yorkshire and Humber Academic Health Science Network Partners have submitted an application for official designation as an Academic Health Science Network.

The Academic Health Science Network (AHSN) for Yorkshire and the Humber will create and harness a strong, purposeful partnership between patients, health services, industry, and academia to achieve a significant measurable improvement in the health and wealth of the population.

The AHSN will generate significant added value for partner organisations by reducing service variability and improving patient experience.

The AHSN will also enable partners to improve efficiency and effectiveness and collectively create an environment that supports inward business investment leading to economic growth. The AHSN will become a partner of choice for local, national and international businesses wishing to innovate in the health sector.

Yorkshire & Humber Academic Health Science Network partners

INSIGNEO

D4D

SITraN

NHS National Institute for Health Research

CLAHRC for South Yorkshire

Our values are what make us different - **PROUD**

Patient-first - ensure that the people we serve are at the heart of all that we do

Respectful - be kind, respectful, fair and value diversity

Ownership - celebrate our successes, learn continuously and ensure we improve

Unity - work in partnership with others

Deliver - be efficient, effective and accountable for our actions

8 Our organisational structure

Our Governors continue to play a vital part in the work of the Trust. We are also fortunate to benefit from a strong Board of Directors, whose extensive experience underpins our continuing success.

Council of Governors

The Council of Governors advises us on how best to meet the needs of patients and the wider community we serve.

It has a number of statutory duties, including appointing the Chairman and other Non-Executive Directors, deciding on their remuneration and ratifying the appointment of the Chief Executive. The Council of Governors also receives the Trust's Annual Report and Accounts and the Auditor's Report. It also has input into the annual business planning process.

The patient, public and staff Governors on the Council are elected from and by the Foundation Trust membership to serve for three years. With the integration of community services in April 2011 the Council of Governors agreed to change the Trust's constitution to create an additional Governor to represent community staff.

Elections for the new Governors in the public, patient and staff constituencies took place in Spring 2012 with the greatest number of places on the Council available since we became a Foundation Trust.

Formal meetings of the Council of Governors are held four times a year. The Trust's Executive Directors also attend Council meetings facilitating the sharing of information and specialist knowledge with Governors. Non-Executive Directors are invited to attend the Council of Governors meetings and participated in a joint working group which reviewed the Trust's Constitution. Governors also contribute to a number of Trust committees and workstreams and specific projects.

Our membership

We have 26,608 members, of whom 4,006 are patient members, 7,357 are public members and 15,245 are staff members. We strive for a membership that represents the diverse communities we serve.

Members receive regular mailings and are invited to events including our Annual Members' meeting, Board of Directors Meetings and Council of Governors' meetings and events such as our regular health lectures and talks.

The Trust's membership is an essential and valuable asset. It helps guide our work, decision making and adherence to NHS values. It also provides one of the ways in which the Trust communicates with patients, the public and staff. There are three membership categories:

Patients: anyone who is 12 years of age or older and has been a patient of the Trust within the five years preceding their application.

Public: residents of Sheffield aged 12 years or over.

Staff: employees whose contract means they can work for the Trust for at least a year.

We are keen to hear members' views. Members wishing to get in touch with Governors or executive directors, or anyone wanting to know more about membership, should contact:

Foundation Trust Office
Sheffield Teaching Hospitals NHS FT
Northern General Hospital
Herries Road, Sheffield S5 7AU

Telephone: 0114 271 4322

Email: jane.pellegrina@sth.nhs.uk

	Elected from	Attendance (actual / possible)
Patient Governors		
Richard Barrass	1 July 2011	3/4
Roz Davies	1 July 2011	0/4
Caroline Irving	1 July 2010	2/4
John Holden	1 July 2009	1/1
Shirley Lindley	1 July 2009	0/1
David Owens	1 July 2012	3/4
Kath Parker	1 July 2012	3/4
Graham Thompson	1 July 2011	4/4
Michael Warner	1 July 2012	3/4
Public Governors		
Jo Bishop	1 July 2011	3/4
Yvonne Challans	1 July 2009	1/1
George Clark	1 July 2011	4/4
Anne Eckford	1 July 2010	4/4
Joyce Justice	1 July 2012	3/3
John Laxton	1 July 2011	3/4
Andrew Manasse	1 July 2012	4/4
Kaye Meegan	1 July 2010	4/4
Hetta Phipps	1 July 2010	4/4
Danny Roberts	1 July 2009	1/1
Shirley Smith	1 July 2012	2/3
Paul Wainwright	1 July 2012	3/3
John Warner	1 July 2011	4/4
Susan Wilson	1 July 2010	4/4
Staff Governors		
Frank Edenborough (Medical and Dental)	1 July 2012	3/4
Mark Hattersley (Management, Administration and Clerical)	1 July 2009	0/1
Christina Herbert (Nursing and Midwifery)	1 July 2012	1/3
Chris Monk (Allied Health Professionals, Scientists and Technicians)	1 July 2012	3/3
Vivien Stevens (Allied Health Professionals, Scientists and Technicians)	1 July 2009	0/1
Craig Stevenson (Ancillary, Works and Maintenance)	1 July 2012	3/3
Claudia Westby (Management, Administration and Clerical)	1 July 2012	3/3
Appointed Governors		
Mary Lea (Sheffield City Council)		0/4
Heather MacDonald (Sheffield College)		2/4
Michael Rooney (Sheffield Health & Social Care NHS Foundation Trust)		0/4
Maggie Rowlands (Voluntary Action Sheffield)		1/1
Nicola Smith (Voluntary Action Sheffield)		3/3
Ilyes Tabani (NHS Sheffield)		1/2
Jeremy Wight (NHS Sheffield)		2/4
Simon Torr (South Yorkshire Police)		0/4
Richard Webb (Sheffield City Council)		0/4

Annual Public Meeting

On 25 September 2012, around 100 people attended our Annual Public Meeting where members, the public including patients and relatives, staff and other stakeholders had an opportunity to meet and ask questions of the Board of Directors.

The event was held at the Trust's new £3m Clinical Skills Centre and included presentations on progress over the last year and plans for the future - new developments, challenges and future opportunities.

Board of Directors

The Board of Directors is made up of the Chairman, six Non-Executive Directors and six Executive Directors.

The Board's role is to:

- set the overall strategic direction within the context of NHS priorities;
- monitor performance against objectives;
- provide effective financial stewardship;
- ensure that the Trust provides high quality, effective and patient-focused services;
- ensure high standards of corporate governance and personal conduct;
- promote effective dialogue between the Trust and the local communities we serve.

The Trust is satisfied that the Board's knowledge, skills and experience is balanced, complete and appropriate.

The Trust is confident that all the Non-Executive Directors are independent in character and in judgement. The Vice Chairman of the Board of Directors, Vic Powell was appointed as Senior Independent Director in April 2007 and remains in this role.

The Board meets every month apart from August. Since May 2012, it has met in public although part of the meeting is held in private to deal with matters of a confidential nature. Board papers for the public meetings are published on the Trust's website.

The Board of Directors, including the Non-Executive Directors, use a number of ways to understand the views of our governors and members, including

- The Annual General Meeting
- Attendance by Executive Directors and Non-Executive Directors at Council of Governors meetings
- Regular feedback sessions by the Chairman and Chief Executive to Governors following Board of Directors meetings
- Non-Executive Directors attendance at Governor Forum meetings to describe their roles
- Joint meetings between the Board of Directors and Council of Governors on significant issues e.g. the Francis Report
- Active involvement of Governors in key decision making groups e.g. Quality Report Steering Group, Trust Constitution Review Steering Group.

Board of Directors membership and attendance

Name	Position	Attendance (actual/possible)
Tony Pedder	Chairman	11/11
Andrew Cash	Chief Executive	11/11
Mike Richmond[1]	Medical Director	3/4
David Throssell[2]	Medical Director	7/7
Hilary Chapman	Chief Nurse / Chief Operating Officer	11/11
Neil Priestley	Director of Finance	11/11
Mark Gwilliam	Director of Human Resources	10/11
Kirsten Major	Director of Strategy and Planning	11/11
Vic Powell	Non-Executive Director	9/11
Tony Weetman	Non-Executive Director	11/11
Vickie Ferres	Non-Executive Director	11/11
Shirley Harrison	Non-Executive Director	9/11
Rhiannon Billingsley[3]	Non-Executive Director	6/8
John Donnelly	Non-Executive Director	11/11
Iain Thompson[4]	Non-Executive Director	1/1

The Trust Secretary, the Director of Communications and the Director of Corporate Development also attend all Board meetings.

1 Mike Richmond with effect until 31.08.2012

2 David Throssell with effect from 1.09.12

3 Rhiannon Billingsley with effect until 31.12.2012

4 Iain Thompson with effect until 30.04.2012

Registers of Interests

The Trust holds two Registers of Interest, one for the Board of Directors and one for Council of Governors. Directors and Governors are required to declare any interests that are relevant and material on appointment or after appointment or election, or should a conflict arise during the course of their tenure.

The registers which are updated and published annually, are maintained by the Trust Secretary. Members of the public can access to the registers by making a request in writing to the Trust Secretary, Sheffield Teaching Hospitals NHS Foundation Trust, 8 Beech Hill Road, Sheffield S10 2SB.

The Chairman has the following other significant commitments: He holds directorships in Sheffield Forgemasters International Ltd, Yorkshire and Humber IDB Ltd, Metalysis Ltd, EEF Ltd, JSW Ltd (India) and HCF International Advisors Ltd. He is a Member of Council, University of Sheffield and a trustee of Sheffield Theatres and Whirlow Hall Farm Trust.

Audit Committee

The Audit Committee is appointed by the Board of Directors and consists of four Non-Executive Directors. The Chair of the Healthcare Governance Committee is an ex-officio member.

The committee provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides an assurance of independent external and internal audit, ensures standards are set and monitors compliance in the non-financial, non-clinical areas of the Trust.

It is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff. Last year, the Committee approved the internal and external audit work plans and received regular reports.

Other Committees

Other Committees of the Board include the Finance and performance Committee, the Healthcare Governance Committee and the Pay and Remuneration Committee.

Audit Committee membership and attendance

Name	Position	Attendance (actual / possible)
John Donnelly (Chairman)	Non-Executive Director	5/5
Vic Powell (Vice Chairman)	Non-Executive Director	4/5
Shirley Harrison	Non-Executive Director	3/5
Tony Weetman	Non-Executive Director	3/5

The Director of Finance, the Trust Secretary, the Head of Internal Audit and a representative of the Trust's External Auditors KPMG normally attend the meetings.

Pay and Remuneration Committee membership and attendance

Members	Meeting date	
	18 July 2012	21 November 2012
Tony Pedder (Chair)	✓	✓
Vic Powell	✓	✓
John Donnelly	✓	✓
Vickie Ferres	✓	✓
Shirley Harrison	✓	✓
Rhiannon Billingsley	✓	✗
Tony Weetman	✗	✓

Other committees

Committee	Membership (Board Of Directors members)
Healthcare Governance Committee	Vickie Ferres (Chair), Tony Pedder, Tony Weetman, Shirley Harrison, Andrew Cash, Hillary Chapman, Mike Richmond[1], David Throssell[2], Mark Gwilliam, Kirsten Major.
Finance and Performance Committee	Vic Powell (Chair), Tony Pedder, John Donnelly, Andrew Cash, Neil Priestley, Hillary Chapman, Kirsten Major, Mark Gwilliam.

1 Mike Richmond with effect until 31.08.2012

2 David Throssell with effect from 01.09.2012

Nominations Committee

The Nominations Committee makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and other Non-Executive Directors and considers and contributes to the appraisal of the Chairman and Non-Executive Directors.

This year the Council of Governors approved the Committee's recommendations to re-appoint the following Non-Executive Directors: Shirley Harrison and Tony Weetman for four years and Vickie Ferres for one year.

Sir Andrew Cash OBE
Chief Executive
23 May 2013

Nominations Committee membership and attendance

Name	Actual/possible
George Clark	3/3
Christina Herbert	1/2
John Holden	1/1
John Laxton	3/3
Heather MacDonald	2/3
Andrew Manasse	1/3
Chris Monk	1/2
Tony Pedder	3/3
Vivien Stevens	1/1
John Warner	2/2
Jeremy Wight	1/3

Board of Directors 2012/13

Chairman
Tony Pedder

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

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

Executive Directors

Chief Executive
Sir Andrew Cash OBE

Andrew joined the NHS as a fast track graduate management trainee and has been a chief executive for more than 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 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.

Chief Nurse/Chief Operating Officer
Professor Hilary Chapman CBE

Hilary is the Chief Nurse / Chief Operating Officer at Sheffield Teaching Hospitals NHS Foundation Trust and has spent her entire career in the NHS and the vast majority of it in nursing. Hilary is a member of the National Quality Board, the National Institute of Health Research (NIHR) Advisory Board, the Independent Commission on Whole Person Care and is a visiting Professor within the Faculty of Health and Well Being at Sheffield Hallam University. Hilary was awarded a CBE for services to nursing in the 2012 New Years Honours.

Director of Finance
Neil Priestley

Neil 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. Neil is a Fellow of the Chartered Association of Certified Accountants.

Medical Director (from 1.09.12)
Dr David Throssell

David has previously held the posts of Deputy Medical Director, Clinical Director and he has also been a Consultant Renal Physician for many years at Sheffield Teaching Hospitals NHS Foundation Trust. He trained in Medicine and Nephrology in Leicester and Cardiff before moving to Sheffield in 1996.

Medical Director (until 31.08.12)
Mike Richmond

Mike 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. Mike 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.

Director of Strategy and Planning
Kirsten Major

Kirsten joined the Trust in February 2011. Before her current post she was the Executive Director of Health System Reform at NHS North West Strategic Health Authority. Kirsten is a health economist by background beginning her career at the Greater Glasgow Health Board and has worked at Ayrshire and Arran Health Board before moving to the North West in 2007.

Director of Human Resources
Mark Gwilliam

Mark took up his post as Director of HR 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 three years. Prior to this he worked as head of HR at Central Manchester and Manchester Children's University Hospital. Prior to joining the NHS in 2004 on the Gateway to Leadership Programme, he held a number of senior posts in the food industry.

Non Executive Directors

Vic Powell

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

He was involved in the management of the North-East Region in general and the Sheffield office in particular where he was Business unit Managing Partner for nine years until retiring in December 1999.

Vickie Ferres

Vickie Ferres is Director of Age Concern in Doncaster - a position held since 1983. During this time the organisation has grown from having an annual turnover of £20,000 to over £1.25 million.

A Sheffield resident, Vickie has extensive experience in working with elderly people and understanding the health and social care issues that affect them. Mrs Ferres 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 as an academic.

She was formerly the director of public relations at Sheffield city council and has written a number of books and papers on the subject of communication. Her community activities include the criminal justice field, where she serves as a JP, and health.

Following cancer treatment in 2000 she has represented patients on a number of local, regional and national bodies, largely concerned with cancer education and research.

She has been appointed to a number of public sector boards ranging from broadcasting to consumer affairs and was until March 2007 chair of the South Yorkshire Probation Board. She is a former chair of the Human Fertilisation and Embryology Authority and current chair of the Human Tissue Authority.

Professor Tony Weetman

Professor Tony Weetman is Pro Vice Chancellor of the Faculty of Medicine, Dentistry and Health at the University of Sheffield and is the appointed academic representative on the Trust Board.

Professor Weetman is Professor of Medicine and an Honorary Consultant at the Trust with a special interest in thyroid disease and autoimmune endocrine disorders. He was formerly a non-executive director with both Sheffield Health Authority and the Northern General Hospital NHS Trust.

John Donnelly

John Donnelly retired as a Chief Superintendent with South Yorkshire Police in 2005. In addition to his role with the Trust he is a trustee of the Sheffield Hospitals Charitable Trust and a Chair of the General Medical Council Fitness to Practice Panel.

Professor Rhiannon Billingsley
(until 31.12.12)

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

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

Iain Thompson
(until April 2012)

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

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

Other Directors who attend the Board

Trust Secretary
Neil Riley

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

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

Director of Communications
Julie Phelan

Julie 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.

Director of Corporate Development
Andrew Riley

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

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

Every year we help bring over 7,500 new lives into the world and provide specialist care for those babies who need a little extra support in their first few months.

9 Remuneration report

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is determined by the Nominations Committee of the Council of Governors.

The committee comprises seven Governors and the Trust Chairman. The Chairman does not attend or participate in any meetings of the committee when matters relating to the Chairman's remuneration are under discussion.

The decisions of the Nominations Committee are reported to the Council of Governors. In determining the remuneration of the Chairman and Non-Executive Directors account is taken of guidance provided by the Foundation Trust Network.

Remuneration of Executive Directors and Senior Managers

The remuneration of Executive Directors and Senior Managers (Spot salaried) is determined by the Pay and Remuneration Committee which 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 is comprised of the Non-Executive Directors of the Board, including the Chairman. The Chief Executive (except where matters relating to the Chief Executive are under discussion), the Director of Finance and the Director of Human Resources and Organisational Development are in attendance at all meetings to advise the committee (except where matters relating to their posts are under discussion). The committee is supported by the Trust Secretary to ensure that an appropriate record of proceedings is kept.

In determining the pay and conditions of employment for Executive Directors and senior managers, the committee takes account of national pay awards given to the Medical & Non-Medical staff groups, together with Executive Directors' remuneration data from comparative Teaching Hospitals. Affordability, determined by corporate performance and individual performance, is also taken into account. Where appropriate, terms and conditions are consistent with NHS pay arrangements such as Agenda for Change.

Assessment of performance

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

During the year regular reviews take place to discuss progress and there is an end of year review to assess achievements and performance. The Executive Directors are assessed by the Chief Executive.

The Chairman undertakes the performance review of the Chief Executive and Non-Executive Directors.

Duration of Contracts

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

The Chairman and Non-Executive Director appointments are due for renewal as shown:

Name	Term of Office commenced	Term of Office ends
Tony Pedder (Chairman)	01.01.2012	31.12.2016
Rhiannon Billingsley	01.07.2011	Resigned 31.12.2012
John Donnelly	01.07.2010	30.06.2014
Vickie Ferres	01.07.2009	30.06.2013
Shirley Harrison	01.11.2011	31.10.2015
Vic Powell	01.07.2011	30.06.2015
Tony Weetman	01.07.2009	30.06.2013
Iain Thompson	01.05.2008	30.04.2012

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).

Expenses

Expenses for Directors, Non-executive Directors and Governors are reimbursed on a receipted basis, evidencing the business mileage or actual travel/subsistence costs incurred. Reimbursement rates for mileage are those applied to all Trust employees and do not exceed national guidelines. Total expenses for 2012/13 were less than £10k.

Hutton Report Disclosure

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

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

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

The banded remuneration of the highest-paid Director in the Trust in the financial year 2012/13 was £217.5k (2011/12, £217.5k). This was 8.39 times (2011/12, 8.46) the median remuneration of the workforce, which was £25,721 (2011/12, £25,506). The figures are shown in tabular format [above].

Pay Multiple Statement

	2012/13	2011/12
Highest-paid Director Total Remuneration (mid point banded remuneration in multiples of £5k)	£217.5k	£217.5k
Median Total Remuneration	£25,721	£25,506
Ratio	8.39	8.46

Pay Multiple Statement

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

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

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

Pay Multiples 2012/13 and 2011/12

The remuneration of the highest-paid Director has remained at the same level for the past three years.

The total median remuneration of the organisation has increased in 2012/13 owing to pay rises for members of staff on certain Agenda for Change pay grades. The increase in total median pay in 2012/13 and the 'freeze' in the pay of the highest-paid Director serves to explain the decrease in the multiple from 2011/12 in the above table.

Disclosure of Off-Payroll Engagements

The Trust has one off-payroll arrangement which exceeded a cost of £58,200 and which has been in existence for more than six months during the financial year.

When originally entered into, it was anticipated that the engagement would be for too short a period to require contractual assurances regarding tax obligation.

It was, however, subsequently deemed necessary to progressively extend the arrangements as retaining the skill set and experience of the individual concerned was considered of critical importance to this Foundation Trust.

Although the engagement continues to be viewed as short term and temporary, re-negotiation with the appointee is to be undertaken on the assurances.

Other Information

Please refer to the notes in the 2012/13 Accounts contained on pages 125 and 126 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Changes in Pension at age 60 during 2012/13
- Value of the cash equivalent transfer value at the beginning of the year
- Changes in the cash equivalent transfer value during 2012/13.

Sir Andrew Cash OBE
Chief Executive
23 May 2013

Our aim: to spend public money wisely.

The new Laboratory Medicine Centre at the Northern General Hospital enables us to handle 10 million tests every year more efficiently and provide faster diagnosis for patients.

10 Annual Governance Statement 2012/13

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 2013 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 and its license with Monitor.

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

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

- Audit Committee
- Healthcare Governance Committee
- Finance and Performance Committee
- Remuneration Committee

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

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

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

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

The *Risk Management Policy* indicates the level of training for all grades of staff commensurate with their responsibility for risk management. For individual members of staff, risk management training is identified and delivered via the annual appraisal process. 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. At the corporate level, a risk management training needs analysis has been undertaken and Risk Management/Health and Safety is included as a core topic in the Trust's mandatory training programme. All directorates are required to produce a risk-based induction and update plan for mandatory and job-specific training.

The department of Patient and Healthcare Governance provides additional support and expert advice/guidance to staff on risk management.

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

Serious incidents are escalated to the Serious Untoward Incident (SUI) Group which meets weekly. Facilitated by the department of Patient and Healthcare Governance, membership of the group includes the Medical Director, Chief Nurse/Chief Operating Officer, Trust Secretary and Head of Patient and Healthcare Governance. The SUI Group review and classify serious incidents to determine which must be reported to the appropriate Clinical Commissioning Group as a SUI and which may not meet the commissioners' SUI criteria but are deemed serious enough to be similarly investigated and managed. The SUI Group request the relevant directorate(s) to undertake an investigation using root cause analysis techniques and to make recommendations to mitigate the risk of recurrence.

Once the group is satisfied with the investigation report and action plan it is signed off. Implementation of the action plan is monitored by the department of Patient and Healthcare Governance with external oversight by the Clinical Commissioning Group (where appropriate). Lessons learned are shared via appropriate forums at directorate and Trust-wide level. The Healthcare Governance Committee and the Safety and Risk Management Board receive a monthly verbal update on SUIs and a quarterly written report. Work is underway developing a Trust policy which will formalise the systems and processes for managing a SUI and strengthening reporting mechanisms.

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

Underpinned by a comprehensive policy, the Trust has a well established process for the management of planned and unannounced external agency visits, inspections and accreditations. The process is supported by a dedicated database, maintained by the Chief Executive's Office, which also acts as an electronic repository for agency reports and the Trust's action plans, if required. The department of Patient and Healthcare Governance monitors the implementation of the action plans and provides assurance via a monthly progress report of outstanding action plans to the Healthcare Governance Committee

National survey results are routinely reported to the Trust Executive Group, the Healthcare Governance Committee and the Board of Directors. The survey findings are analysed to compare the results against previous surveys; to benchmark against other comparable trusts; and to triangulate with other internal data or intelligence to identify problem areas or areas of best practice. Action plans are developed to ensure targeted improvement and progress is closely monitored by regular reports to Trust Executive Group, the Healthcare Governance Committee and the Board of Directors

The risk and control framework

The past year has seen a number of developments building upon the Trust's successful review of Quality Governance arrangements, using Monitor's Quality Governance Framework, undertaken in 2011/12.

A 5-year Quality Strategy, supporting the corporate strategy Making a Difference, was launched which sets out the Trust's goals to strengthen quality improvement and quality governance. A Quality Board, reporting to the Healthcare Governance Committee has been established to oversee implementation of the Quality Strategy.

The Healthcare Governance Committee's agenda has been restructured to more closely align with the Darzi definition of quality incorporated into the Quality Strategy, namely patient safety, patient experience and clinical effectiveness (outcomes).

A far reaching programme of quality improvement work to address priority areas identified in the Quality Strategy is underway. With support from The Health Foundation, the Trust has set up an academy to train staff to work as coaches to front line teams, using Clinical Microsystems methodology to introduce quality improvements, placing patients at the centre of redesign.

The Trust has undertaken a 'True for Us' review of its governance arrangements against the best practice principles set out by the National Quality Board's report *Quality in the new health system* published in 2012. A number of areas for improvement were identified and are being actioned, including the introduction of a local Quality Healthcheck, based upon the outcomes and corresponding indicators used in the NHS Outcomes Framework, and the approval and launch of Healthcare Governance Policy and supporting systems, processes and procedures which formalise the Trust's governance arrangements.

Following the publication of the Francis Report on the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust and the government's interim response to the Francis Report recommendations, the Trust has established a Working Group to consider the Trust's response.

The *Risk Management Policy* is approved by the Board. It is maintained by the department of Patient and Healthcare Governance and is regularly reviewed. It is widely promoted across the organisation and is available to all staff on the Trust intranet.

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

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

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

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

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

The major risks facing the Trust are:

In-year Risks:

- **Failure to maintain financial balance 2012/13.** This risk has been successfully managed and mitigated by detailed annual planning; an efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- **Meeting the A&E 4-hour Waiting Time target.** In the face of increases in A&E attendance and admissions (particularly in the over-85s), delayed transfers of care, adverse weather and winter viruses, the Trust breached this challenging target for Q3 and Q4. In response, the Trust developed a comprehensive action plan to deliver sustainable improvements in performance. Implementation of the action plan is led by myself, as Chief Executive, and supported by strengthened oversight by the Trust Executive Group and the Board of Directors.
- **Ensuring patients are cared for in an appropriate setting.** The Trust is a partner in a city-wide initiative, the Right First Time project, to re-design the way patients receive their care based on a guiding principle of 'right care, at the right time, in the right place and by the right person'. The partnership involves primary and social care colleagues, including NHS Sheffield Clinical Commissioning Group. Key elements for the Trust include the development of new models of care improving patient flow by avoiding unnecessary admissions and ensuring more efficient and timely discharge from hospital.

Future Risks:

- **Failure to maintain financial balance in future years (2013/14 onwards)** which will be managed and mitigated by detailed annual planning; an efficiency programme; ongoing performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- **Failure to meet the A&E 4-hour Waiting Time target.** Meeting the target in 2013/14 will continue to be extremely challenging to the Trust and actions currently underway will be rolled over to next year and further actions to manage and mitigate the risk developed, as necessary. Performance will be closely monitored by the Trust Executive Group and the Board of Directors.
- **Care of patients in an inappropriate setting.** The Trust will continue work with its partners through the Right First Time project to manage and mitigate the risk.
- **Infection Prevention and Control** will be managed and mitigated by continued investment and a detailed annual work programme supported by the specialist Infection Prevention and Control Team led by the Director of Infection Prevention and Control under the executive lead of the Chief Nurse / Chief Operating Officer. The Trust faces a considerable challenge in meeting reduced target cases for C. Difficile for 2013-14.
- **Managing the implementation of the Health and Social Care Act 2012** as it affects the Foundation Trust and the wider health economy. The Trust will work closely with its partners, particularly the NHS Sheffield Clinical Commissioning Group and NHS England, to understand and mitigate the risks associated with implementation of the Act.

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

The Assurance Framework identifies the Trust's principal objectives and the high level risks that threaten their achievement along with key controls and sources of assurance. Underpinning the Assurance Framework is the Trust's Risk Register which includes those strategic risks identified by TEG and reported via the Top Risk Report and operational risks identified by clinical and corporate directorates. Both reports inform and update the Board of Directors and TEG on key strategic risks and allow progress against Executive Director-led action plans to be effectively monitored. The integration of the Assurance Framework and the Risk Register into the business planning process ensures that risk-based decisions can be made in relation to service developments and capital allocation. The Trust intends to rebuild its Assurance Framework using the objectives included in our corporate strategy Making a Difference and the supporting strategies, launched in 2012.

The Board of Directors receive a monthly Performance Report which includes performance against national targets, CQUIN standards, the Trust's KPIs and inpatient and outpatient activity. The Board is assured of the quality of information included in the performance report via a number of sources including routine internal quality assurance systems that support the Performance Management Framework; relevant internal audit reports (e.g. Data Quality audit which this year tested the quality of 18-week wait data, relevant Financial Systems audits, Pharmacy audit etc); external audit reports (notably KPMG's Limited Assurance report on the Quality Report); and the Clinical Coding audit undertaken by independent auditors.

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 Board appointed Senior Information Risk Owner (SIRO), is the Informatics Director. The SIRO was actively engaged in the review of this statement and has written to me endorsing the content.

The Information Governance Management Framework brings together all the statutory requirements, standards and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Framework Programme.

Supported by relevant policies and procedures, notably the Procedures for the Transfer of Person Identifiable Data (PID) and other Sensitive and Confidential Information and the Confidentiality - Staff Code of Conduct, the Trust has an ongoing programme of work to ensure that PID is safe and secure when it is transferred within and outside the organisation. The Internet - Acceptable Use Policy and the Confidentiality - Staff Code of Conduct have been reviewed and updated to ensure robust information governance in response to the changing use of social network sites.

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

In accordance with the Information Asset Policy, a centralised major information asset register is in place which supports the role of the Trust's Information Asset Owners who report to the SIRO. Any concerns identified through the registration and management of the Information Assets will be pursued through the recognised and accepted managerial line. Failure to deal with a concern through that route will be taken up by the SIRO with the appropriate Information Asset Owner within the Trust.

The Trust had one serious data security incident during 2012/13. The incident was reported to the Department of Health and the Information Commissioner's Office (ICO). The ICO undertook an investigation as there was a potential breach of the Data protection Act 1998. In its report to the Trust in March 2013, the ICO concluded that no further action was necessary.

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

- NHS Sheffield Clinical Commissioning Group
- NHS England
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- Neighbouring Trusts in South Yorkshire and North Derbyshire
- Sheffield City Council
- Sheffield Health and Wellbeing Board
- Sheffield Health and Community Scrutiny Committees
- Healthwatch (formerly LINk)
- Sheffield Executive Board
- University of Sheffield and Sheffield Hallam University

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 the Foundation Trust Network, NHS Confederation and Association of UK University Hospitals and is able to help influence national policies.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). It is required to maintain ongoing compliance with the CQC essential standards of quality and safety for all its regulated activities across all its locations.

In July 2012, the Trust's CQC Compliance Review Group was dissolved after successfully completing a baseline evaluation of compliance with each of the essential standards supported by an archived library of evidence, subject to periodic review as necessary. Since then, the department of Patient and Healthcare Governance has established a risk-based programme of Quality Governance Inspections which simulate CQC inspection methodology using direct observation, structured interviews with patients and staff and a review of relevant documentation. The inspections also review internal performance monitoring data such as patient and staff survey results, incidents, complaints, eCAT, external visits and inspections, CQC Quality Risk Profile etc. The areas visited receive a report and are expected to develop an appropriate action plan to address the main findings and shall be re-inspected to monitor improvement.

The Healthcare Governance Committee receives a monthly update report on Quality Governance Inspections. The report also includes trend analysis on the CQC Quality Risk Profile, a summary of CQC issues that the Trust is formally notified of and development news from the CQC. The committee also receive all CQC inspection reports in full for discussion and action, if necessary.

During the year, the CQC made two unannounced routine inspections of the Trust. One visit to the Northern General Hospital in December 2012 and one visit to the Royal Hallamshire Hospital in January 2013. The CQC found the Trust to be compliant with all the standards covered by the inspection and no concerns were raised.

In March 2013, the CQC made a routine visit to the Northern General Hospital to monitor systems in place for detaining people under the Mental Health Act 1983, as part of a national programme of announced visits. The visit was conducted by a Mental Health Act Commissioner on behalf of the CQC. The CQC identified a number of areas for improvement in its report to the Trust.

Working with Sheffield Health and Social Care NHS Foundation Trust, the Trust has drawn up an action plan, incorporating work that was already underway, to address the findings from the CQC report. The action plan has been approved by the Healthcare Governance Committee.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

It has an established Equality and Human Rights Steering Group (reporting to TEG and the Healthcare Governance Committee and chaired by the Trust Secretary) and an Operational Leads Group (reporting to the steering group and including representatives from each care group) which ensures good practice in equality and diversity is identified and shared across the organisation. In addition, it has a policy, procedures and lead posts (for example in safeguarding) in place to ensure that the Trust considers and maintains Human Rights for its staff and across the services it delivers.

The Trust has identified four Equality Objectives. These are published on the Trust's website which also includes the Trust's Equality and Human Rights Annual Report showing progress on the Public Sector Equality Duty as well as data on people who use the Trust's services and Trust staff.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has made considerable progress against the Sustainable Development Action Plan approved by the Board of Directors in 2011. The action plan was delivered as part of a successful Trust-wide campaign called Be Green and only one objective is outstanding, due for completion by December 2013. Be Green is now firmly embedded within the organisation with its own intranet site (including news and guidance for staff and updated energy and emissions data), supported by a network of trained Be Green representatives who promote sustainability and undertake sustainability audits within their own areas.

The Trust has achieved significant reductions in its energy use and carbon emissions over the past year through a number of initiatives, for example the replacement of power transformers with high efficiency units, conversion of steam infrastructure to low temperature water for space and water heating and an ongoing programme of conversion to high efficiency low energy lighting. Notable sustainability achievements over the past year include an award for sustainable building design, construction and operation for the new Laboratory Building; the introduction of an electric bus funded by the League of Friends and operating around the Northern General Hospital site; a joint initiative with the University of Sheffield's School of Health and Related Research to investigate ways to reduce NHS carbon emissions.

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

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

The in-year use of resources is monitored by the Board and its committees via a series of detailed monthly reports, covering finance, activity, capacity, performance, quality, human resource management and risk. These documents are a consolidation of detailed reports that are provided at Directorate and Department level to allow active management of resources at an operational level. Quarterly monitoring returns are submitted to Monitor from which a risk rating is again attributed to the finance, and governance elements. The Trust's performance management processes are crucial in early identification of any variances from operational or financial plans and in ensuring effective corrective action.

Particular attention is given to financially challenged Directorates and support is provided internally through the Performance Management Framework with external input where required. The use of capital resources is planned and monitored by the Trust's Capital Investment Team which reports quarterly to the Board.

The Trust continues to drive enhanced efficiency through targeting areas for improvement; through setting Directorate targets and performance managing delivery; and through developing capability and capacity to deliver the required change. A key principle of the programme is to seek improvements to patient care alongside efficiency gains. The development of information and performance management systems remains a key element of the programme.

The Trust employs a number of approaches to ensure best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service re-design leading to improvements in the quality of services and patient experience as well as financial performance. External consultants are commissioned where appropriate to assist in identifying areas where economy, efficiency and effectiveness can be improved and in delivering the required changes. The Trust utilises its Service Line Reporting (SLR) and Patient Level Costing System to enable better understanding of income and expenditure at various levels and, therefore, to facilitate improved financial and operational performance. The SLR information informs performance management and budget-setting and action plans are being developed/ implemented by those areas which make significant losses. As mentioned elsewhere, the Board receives assurance on the use of resources from a number of external agencies, for example Monitor's Financial and Governance risk ratings and the Care Quality Commission's Quality and Risk Profile and inspection reports. Such reviews are reported to the Board of Directors and its relevant committees.

All of the above is underpinned by the Trust Scheme of Reservation and Delegation of Powers, Standing Orders and Standing Financial Instructions, which allow the Board to ensure that resources are controlled only by those appropriately authorised. These documents are reviewed annually.

The Trust also makes use of both Internal and External Audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits the Internal Audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed thereby assisting prioritised action plans which are agreed with management for implementation.

All action plans agreed are monitored and implementation is reviewed regularly and reported to the Audit Committee as appropriate.

Annual Quality Report

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

The Trust has an established process for preparing the Quality Report. Overall responsibility for the report rests with the Medical Director but the Head of Patient and Healthcare Governance is operationally responsible. The Quality Report Steering Group oversees the design, production, publication and review of the report. The group is accountable to TEG and membership includes managers, clinicians and Governors.

The Steering Group has reviewed progress made against the five quality priorities that were agreed for 20012/13 and has identified three new priorities for 2013/14 with an explicit commitment to consider areas where there was a recognised need to improve the quality of care as well as areas of known good practice. The priorities were agreed by the Sheffield Health and Community Scrutiny Committee, Healthwatch (formerly LINk), NHS Sheffield Clinical Commissioning Group and the Council of Governors and approved by the Board of Directors.

The group has responded to the recommendations in the External Assurance Report on last years Quality Report, in particular by undertaking an audit of the 18-week pathway.

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 Sheffield Health and Community Scrutiny Committee, Healthwatch and NHS Sheffield Clinical Commissioning Group and comments sought. Overall the stakeholder comments were positive and included constructive feedback on specific issues of concern. Our external auditors have reviewed the Quality Report and have provided independent assurance to the Board of Directors and the Council of Governors that the content of the report is in accordance with Monitor's Annual Reporting Manual.

Review of effectiveness

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

The Assurance Framework and the Top Risk report provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed.

The Audit Committee continues to receive and monitor the Assurance Framework and relevant internal audit reports. It plays a central role in performance managing the action plans to address the recommendations from audits which have identified the presence of medium to high risks or weaknesses in internal control. It also reviews the Annual Report and Accounts including the Trust-wide governance arrangements as described. The Vice-chair has recent and relevant financial experience which supports expert and rigorous challenge on financial reports received by the committee, an understanding of Monitor's Financial Risk Rating and sound accounting policies and practices.

The preparation of the Quality Report has been informed by an in-depth review of last year's process and by scrutiny of further guidance. All data incorporated into the Quality Report is from established sources which are subject to routine and regular audit of data quality. The comments from the Sheffield Health and Community Scrutiny Committee, Healthwatch and NHS Sheffield Clinical Commissioning Group provide external assurance of the effectiveness of internal controls. The external assurance audit undertaken by our external auditors which will report to the Board and to the Council of Governors 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 (Assure) who work to a risk-based annual plan approved by TEG and the Audit Committee with topics that cover Governance and Risk Management, Service Delivery and Performance, Financial Management and Control, Human Resources, Operational and Other Reviews.
- Opinion and reports by our external auditors (KPMG) and specifically their Annual Governance Report.
- Quarterly Financial and Governance Risk Ratings by Monitor.
- DH reports such as Performance Indicators.
- Ongoing compliance with CQC's Essential Standards of Quality and Safety for all regulated activities across all locations, as part of the registration process, CQC reports on its visits and inspections and its Quality Risk Profile.
- NHSLA assessments against Risk Management Standards and CNST for Maternity.
- Information Governance Assurance Framework and the Information Governance Toolkit
- Results of national Patient Surveys and the National Staff Survey.
- Investigation reports and action plans following Sudden Unexpected Incidents.
- User feedback such as Picker real-time monitoring of patient experience, complaints and claims.
- Other external Visits, Inspections and Accreditations
- Council of Governors reports.
- Clinical Audit reports.

Conclusion

No significant internal control issues have been identified.

Sir Andrew Cash OBE
Chief Executive
23 May 2013

11 Statement of the Chief Executive's responsibilities as the accounting officer of Sheffield Teaching Hospitals NHS Foundation Trust

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

Under the NHS Act 2006, Monitor has directed Sheffield Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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

Sir Andrew Cash OBE
Chief Executive
23 May 2013

12 Independent Auditor's report to the Council of Governors of Sheffield Teaching Hospitals

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2013 on pages 110 to 146. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

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

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 108 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Sheffield Teaching Hospitals NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

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

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

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.[1]

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

Certificate

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

Trevor Rees for and on behalf of KPMG LLP
Statutory Auditor
Chartered Accountants
1 The Embankment
Neville Street
Leeds LS1 4DW

23 May 2013

1 Where the AGS does not meet the disclosure requirements of the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with other information forthcoming from the audit, the auditors must refer to this in the audit opinion, although this does not result in a qualification of the accounts (para 5.8 of the March 2011 FT Audit Code).

13 Financial statements

Foreword to the accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2013 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

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

Sir Andrew Cash OBE
Chief Executive
23 May 2013

Statement of Comprehensive Income for the year ending 31 March 2013

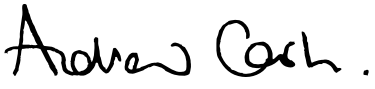
	NOTE	**2012/13 £000**	2011/12 £000
Operating Income from continuing operations	3.1	**909,487**	861,716
Operating Expenses from continuing operations	4.1	**(893,810)**	(840,900)
OPERATING SURPLUS		**15,677**	20,816
FINANCE COSTS			
Finance income	7.1	**178**	380
Finance expense- financial liabilities	7.2	**(3,449)**	(3,430)
Finance expense-unwinding of discount on provisions		**(64)**	(71)
Public Dividend Capital Dividends payable		**(9,926)**	(9,716)
Net Finance Costs		**(13,261)**	(12,837)
SURPLUS FROM CONTINUING OPERATIONS		**2,416**	7,979
Other comprehensive income			
Impairment		**0**	(14)
Revaluation		**7,371**	2,058
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**9,787**	10,023

The notes on pages 114 to 146 form part of these accounts
All income and expenditure is derived from continuing operations

Statement of Financial Position 31 March 2013

	NOTE	31 March 2013 **£000**	31 March 2012 £000	1 April 2011 £000
Non-current assets				
Intangible assets	8.1	1,199	947	1,139
Property, plant and equipment	9.1	419,402	410,702	389,628
Investments	11.0	0	0	0
Trade and other receivables	13.1	6,242	5,489	5,243
Total non-current assets		**426,843**	**417,138**	**396,010**
Current assets				
Inventories	12.1	12,991	13,674	12,179
Trade and other receivables	13.1	27,204	27,465	29,939
Current asset investments	14	0	0	0
Cash	22	71,089	65,133	64,895
Total current assets		**111,284**	**106,272**	**107,013**
Current liabilities				
Trade and other payables	15.1	(81,355)	(73,032)	(63,366)
Borrowings	17	(2,445)	(2,415)	(2,033)
Provisions due within one year	20	(3,289)	(2,531)	(4,489)
Other liabilities	16	(9,995)	(12,238)	(11,499)
Total current liabilities		**(97,084)**	**(90,216)**	**(81,387)**
Total assets less current liabilities		**441,043**	**433,194**	**421,636**
Non current liabilities				
Borrowings	17	(51,598)	(54,055)	(52,465)
Provisions due after one year	20	(2,165)	(2,035)	(2,308)
Other liabilities	16	(1,340)	(951)	(733)
Total non-current liabilities		**(55,103)**	**(57,041)**	**(55,506)**
Total assets employed		**385,940**	**376,153**	**366,130**
FINANCED BY:				
Taxpayers' equity				
Public Dividend Capital		324,657	324,657	324,657
Revaluation reserve	21	31,765	27,733	27,182
Income and expenditure reserve		29,518	23,763	14,291
Total Taxpayers' equity		**385,940**	**376,153**	**366,130**

The financial statements on pages 110 to 146 were approved by the Board on 23 May 2013 and were signed on behalf of the Board by



Sir Andrew Cash OBE
Chief Executive
23 May 2013

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012	376,153	324,657	27,733	-	23,763
Surplus for the year	2,416				2,416
Other recognised gains and losses	-		-3,339		3,339
Revaluation gains on property, plant and equipment	7,371		7,371		
Taxpayers' Equity at 31 March 2013	**385,940**	**324,657**	**31,765**	**-**	**29,518**
Taxpayers' Equity at 1 April 2011	366,130	324,657	27,182		14,291
Surplus for the year	7,979				7,979
Revaluation gains on property, plant and equipment	2,058		2,058		
Impairments	(14)		(14)		
Other recognised gains and losses	0		(1,493)		1,493
Taxpayers' Equity at 31 March 2012	**376,153**	**324,657**	**27,733**	**-**	**23,763**

Statement of Cash Flows 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Cash flows from operating activities			
Operating surplus from continuing operations		15,677	20,816
Non-cash income and expenditure			
Depreciation and amortisation		31,743	27,288
Impairments		18,803	692
Reversals of impairments		(15,387)	(1,593)
(Gain) on disposal		(29)	(26)
(Increase) / Decrease in Trade and Other Receivables		(189)	2,133
Decrease (Increase) in Inventories		683	(1,495)
Increase in Trade and other Payables		9,304	7,039
(Decrease) / Increase in Other Liabilities		(1,854)	958
Increase/(Decrease) in Provisions		824	(2,302)
Other operating cashflows		(2,724)	(300)
Net Cash Generated from Operations		**56,851**	**53,210**
Cash flows from investing activities			
Interest received		190	373
Purchase of intangible assets		(257)	(66)
Purchase of Property, Plant and Equipment		(37,265)	(40,073)
Sales of Property, Plant and Equipment		64	326
Net cash used in investing activities		**(37,268)**	**(39,440)**
Cash flows from financing activities			
Loans repaid		(1,445)	(1,445)
Capital element of finance lease rental payments		(380)	(366)
Capital element of Private Finance Initiative Obligations		(601)	(588)
Interest paid		(1,397)	(1,463)
Interest element of finance lease		(155)	(113)
Interest element of Private Finance Initiative obligations		(1,895)	(1,849)
PDC Dividend paid		(10,179)	(9,084)
Cash flows from other financing activities		2,425	1,376
Net cash used in financing activities		**(13,627)**	**(13,532)**
Increase in cash and cash equivalents		**5,956**	**238**
Cash and Cash equivalents at 1 April	22	65,133	64,895
Cash and Cash equivalents at 31 March		**71,089**	**65,133**

14 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 (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2012/13 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention

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

1.1 Income

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

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

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

1.2 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013 is based on data as at 31 March 2012 updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The scheme regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

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

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

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

1.3 Expenditure on other goods and services

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

1.4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

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

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

Measurement

Valuation

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

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

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

Revaluations are performed with sufficient regularity to ensure that the carrying amounts are not materially different from those that would be determined at the end of the reporting period. The current revaluation policy of the Trust is to perform a full valuation every five years, with an interim valuation in the third year. The interim revaluation in 2012/13 was carried out on 2 April 2012. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors' 'Red Book' (RICS) Appraisals and Valuation Manual.

Subsequent expenditure

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

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

Depreciation

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

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

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

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

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

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

Donated assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

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

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

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

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

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

Subsequently intangible assets are measured at fair value.

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

Amortisation

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

1.6 Revenue, government and other grants

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

1.7 Inventories

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

1.8 Financial instruments and financial liabilities

Recognition

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

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

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

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

De-recognition

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

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

Classification and Measurement

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

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

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

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

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

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

Loans and receivables

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

The Trust's loans and receivables comprise cash and cash equivalents, trade receivables and NHS 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 Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest 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 through the use of a bad debt provision.

1.9 Leases

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1.10 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using discount rates published and mandated by HM Treasury.

Clinical negligence costs

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

Non-clinical risk pooling

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

1.11 Contingencies

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

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as: possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or present obligations arising from past events for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

1.12 Public Dividend Capital

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

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

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

1.13 Value Added Tax

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

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

1.14 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their activities.

1.15 Foreign Exchange

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Balance Sheet date:

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

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

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

1.16 Third party assets

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

1.17 Losses and special payments

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

way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included in normal revenue expenditure).

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

1.18 Critical Accounting Estimate and Judgements

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

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

Plant, Property and Equipment Valuations - see paragraph 1.4 & note 9

Income Estimates - see paragraph 1.1. Included in the income figure is an estimate for partially completed spells, i.e. treatment for admitted patients which is ongoing at the close of 31 March each year. This income is estimated based on the average specialty tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.

Provision for Impairment of Receivables - see paragraph 1.1 & note 13.2

Expenditure Accruals - see paragraph 1.3 & note 15.1

Provisions - see paragraph 1.10 & note 20

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

The Treasury Financial Reporting Manual does not require the following Standards to be applied in 2012/13:

IAS 1	Presentation of financial statements (Other Comprehensive Income) - effective 2013/14 but not yet adopted by the EU
IAS 12	Income Taxes (amendment) - effective 2012/13, but not yet adopted by the EU.
IAS 19	Employee Benefits (revised 2011) - effective 2013/14
IAS 27	Separate Financial Statements - effective 2013/14 but not yet adopted by the EU
IAS 28	Investments in Associates and Joint Ventures - effective 2013/14 but not yet adopted by the EU
IAS 32	Financial Instruments Presentation (amendment) - effective 2014/15 but not yet adopted by the EU
IFRS 7	Financial Instruments: Disclosures (annual improvements) - effective 2013/14 but not yet adopted by the EU.
IFRS 9	Financial Instruments - effective date uncertain: not likely to be adopted by the EU until the IASB has finished its Financial Instruments project
IFRS 10	Consolidated Financial Statements - effective 2013/14 but not yet adopted by the EU
IFRS 11	Joint Arrangements - effective 2013/14 but not yet adopted by the EU
IFRS 12	Disclosure of Interests in Other Entities - effective 2013/14 but not yet adopted by the EU
IFRS 13	Fair Value Measurement - effective 2013/14 but not yet adopted by the EU

The application of the Standards as revised would not have a material impact on the accounts of the Trust for 2012/13, were they applied in that year.

2 Segmental analysis

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

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

3. Income

3.1 Income from Activities

Income from Activities	2012/13	2011/12
	£'000	£'000
Elective income	158,775	153,888
Non Elective income	177,204	170,984
Outpatient income	113,776	113,969
A&E Income	14,423	12,869
Other NHS Clinical income	226,109	207,993
Income re Community Services	55,786	53,081
Private Patient Income	3,762	4,194
Total income from activities	**749,835**	**716,978**

Other operating income	2012/13	2011/12
	£'000	£'000
Research and development	11,666	14,253
Education and training	65,608	66,150
Received from NHS Charities: Receipt of grants / donations for capital acquisitions	100	0
Received from other bodies: Receipt of grants / donations for capital acquisitions	2,624	0
Charitable and other contributions to expenditure	0	682
Non-patient care services to other bodies	49,870	47,641
Other	14,084	14,117
Gain on disposal	29	26
Operating lease income	284	276
Reversal of impairments of property, plant & equipment	15,387	1,593
Total other operating income	**159,652**	**144,738**
TOTAL OPERATING INCOME	**909,487**	**861,716**

3.2 Private patient income

The requirement to demonstrate that the percentage of patient related income represented by private patient income does not exceed that earned in the base year (2002/03) has been removed following the repeal of section 44 of the 2006 act by the Health and Social Care Act 2012, with effect from 1st October 2012.

3.3 Operating lease income

	2012/13 £'000	2011/12 £'000
Rents recognised as income in the period	284	266
Contingent rents recognised as income in the period	0	10
	284	**276**
Future minimum lease payments due		
Re Land		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	647	691
TOTAL	**647**	**691**
Re Buildings		
- not later than one year;	3	12
- later than one year and not later than five years;	334	648
- later than five years.	1470	1010
TOTAL	**1,807**	**1,670**
Total -All categories		
- not later than one year;	3	12
- later than one year and not later than five years;	334	648
- later than five years.	2117	1701
TOTAL	**2,454**	**2,361**

3.4 Operating Income (by type)

Income from Activities	2012/13 £'000	2011/12 £'000
Strategic Health Authorities	3,358	3,480
Primary Care Trusts	737,481	704,081
Local Authorities	344	333
NHS Other	1,511	1,295
Non NHS: Private patients	2,936	3,161
Non NHS: Overseas patients (non-reciprocal)	403	1,033
NHS injury scheme (formerley the Road Traffic Act Scheme)	3,656	3,450
Non NHS: Other*	146	145
Total Income from activities	**749,835**	**716,978**

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

Other Operating Income	2012/13 £'000	2011/12 £'000
Research and Development	11,666	14,253
Education and Training	65,608	66,150
Received from NHS Charities: Receipt of grants / donations for capital acquisitions	100	0
Received from other bodies: Receipt of grants / donations for capital acquisitions	2,624	0
Charitable and other contributions to expenditure	0	682
Non patient care services to other bodies	49,870	47,641
Reversal of impairments of property, plant & equipment	15,387	1,593
Operating lease income	284	276
Other **	14,084	14,117
Gain on disposal	29	26
Total Other income	**159,652**	**144,738**

**Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites.

The largest individual components relate to the provision of car-parking, catering, and nursery facilities.

All the above income, with the exception of Research and Development activities, relates to the provision of mandatory services under the Trust's terms of authorisation.

4. Operating Expenses

4.1 Operating expenses comprise:

	2012/13 Total £'000	2011/12 Total £'000
Services from other NHS Foundation Trusts	8,848	8,823
Services from other NHS Trusts	25	23
Services from Primary Care Trusts	463	448
Services from other NHS bodies	6,364	6,240
Purchase of healthcare from non NHS bodies	14,855	12,750
Executive Directors' costs	1,235	1,217
Non-Executive Directors' costs	165	185
Staff costs	548,304	541,738
Drugs costs	91,237	84,528
Supplies and services - clinical	86,990	79,425
Supplies and services - general	8,109	7,991
Establishment	8,966	8,855
Research and Development	3,424	4,555
Transport	735	634
Premises	35,881	32,291
(Decrease) / increase in bad debt provision	(840)	744
Depreciation on property, plant and equipment	31,355	26,863
Amortisation of intangible assets	388	425
Impairments of property, plant and equipment	18,785	691
Impairments of intangible assets	18	1
Operating lease costs	1,842	1,865
Audit services - statutory audit	56	54
Further audit assurance services	11	13
Clinical negligence	12,946	12,031
Legal fees	2,106	1,378
Consultancy costs	3,175	1,508
Training, courses and conferences	2,312	1,896
Redundancy	1,757	(93)
Insurance	993	719
Losses, ex gratia & special payments	442	231
Other	2,863	2,871
Total	**893,810**	**840,900**

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

4.2 Arrangements containing an operating lease

	2012/13	2011/12
	£'000	£'000
Minimum lease payments	1,842	1,865
Contingent rents	0	0
Less sublease payments received	0	0
Total	**1,842**	1,865

4.3 Arrangements containing an operating lease

	2012/13 £'000	2011/12 £'000
Future minimum lease payments due:		
Within 1 year	328	412
Between 1 and 5 years	2,794	2,888
After 5 years	791	1,254
Total	**3,913**	4,554

4.4 Salary and Pension entitlements of senior managers

a) Remuneration

	To 31 March 2013		To 31 March 2012	
Name and Title	Salary (bands of £5,000) £'000	Employee Short term benefits - Employer's National Insurance Rounded to the nearest £100	Salary (bands of £5,000) £'000	Employee Short term benefits - Employer's National Insurance Rounded to the nearest £100
Sir A J Cash, OBE, Chief Executive	215-220	28,600	215-220	27,500
Mr N Priestley, Director of Finance	170-175	21,900	150-155	18,400
Professor M Richmond, Medical Director (1 April 2012 to 31st August 2012)	75-80	14,000	165-170	23,900
Dr David Throssell, Medical Director (from 1st September 2012)	85-90	10,800	n/a	n/a
Professor H Chapman CBE, Chief Nurse / Chief Operating Officer	170-175	22,000	170-175	21,900
Ms K Major, Director of Service Development	135-140	16,400	125-130	15,100
Mr M Gwilliam, Director of Human Resources	135-140	16,400	125-130	15,000
Mr I Thompson, Non-Executive Director (term of office expired 30 April 2012)	0-5	100	15-20	1,200
Mr J P Donnelly, Non-Executive Director	15-20	1,100	15-20	1,200
Ms V R Ferres, Non-Executive Director	15-20	1,100	15-20	1,200
Mr V G W Powell, Non-Executive Director	15-20	1,500	15-20	1,500
Mrs J Norbron, Non-Executive Director (term of office expired 30 June 2011)	n/a	n/a	0-5	300
Professor R Billingsley (resigned 31 December 2012)	10-15	800	10-15	1,000
Ms S Harrison, Non-Executive Director	15-20	1,100	15-20	1,200
Professor A P Weetman, Non-Executive Director	15-20	1,100	15-20	1,200
Mr D Stone, Chairman (retired 31 December 2011)	n/a	n/a	40-45	5,300
Mr A Pedder, Chairman (from 1 January 2012)	55-60	7,000	10-15	1,800

4.5 Salary and Pension entitlements of senior managers

b) Pension Benefits

Name and title	Real change 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 March 2013 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Sir A J Cash, OBE, Chief Executive	n/a	n/a	n/a	1,984	n/a	n/a
Mr N Priestley, Director of Finance	32.5-35	255-257.5	1,188	957	181	24,500
Professor M Richmond, Medical Director (until 31 August 2012)	(2.5-5)	232.5-235	1,243	1,191	(10)	15,600
Professor H Chapman, CBE, Chief Nurse / Chief Operating Officer	(5-7.5)	292.5-295	1,273	1,198	13	24,500
Mr M Gwilliam, Director of Human Resources	7.5-10	60-62.5	271	217	43	18,900
Ms K Major, Director of Service Development	10-12.5	120-122.5	424	361	44	18,900
Dr D Throssell, Medical Director (from 1 September 2012)	10-12.5	185-187.5	867	730	99	12,200

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. Similarly, no disclosure is made under this note for any Senior Manager who is non-pensionable during the reporting period.

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

5.1 Employee expenses

	2012/13 Total £'000	Permanent £'000	Other £'000	2011/12 Total £'000	Permanent £'000	Other £'000
Salaries and wages	453,816	441,468	12,348	450,910	440,460	10,450
Social Security Costs	32,009	32,009	0	31,631	31,631	0
Employer contributions to NHSPA	49,734	49,734	0	49,846	49,846	0
Other pension costs	41	41	0	34	34	0
Agency / contract staff	13,939	0	13,939	10,534	0	10,534
Total	**549,539**	**523,252**	**26,287**	**542,955**	**521,971**	**20,984**

The above figure of £549,539k is net of the amount of £1,696k (2011/12 £1,680k) in respect of capitalised salary costs included in fixed asset additions (note 9.1).

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

	2012/13 Total Number	Permanent Number	Other Number	2011/12 Total Number	Permanent Number	Other Number
Medical and dental	1,729	1,616	113	1,714	1,595	119
Administration and estates	2,723	2,542	181	2,704	2,593	111
Healthcare assistants and other support staff	1,442	1,361	81	1,468	1,400	68
Nursing, midwifery and health visiting staff	5,432	5,140	292	5,528	5,285	243
Scientific, therapeutic and technical staff	2,358	2,302	56	2,306	2,280	26
Total	**13,684**	**12,961**	**723**	**13,720**	**13,153**	**567**

5.3 Employee benefits

	2012/13 £000	2011/12 £000
Benefits	0	0
	0	0

5.4 Staff Exit Packages

Exit package cost band	2012/13 Number of Compulsory redundancies	Number of other departures agreed	Total Number of Exit packages by cost band
<£10,000	0	13	13
£10,000 - £25,000	0	17	17
£25,001 - £50,000	0	19	19
£50,001 - £100,000	1	9	10
Total Number of Exit Packages by type	**1**	**64**	**65**
Total Cost	**£65k**	**£2,520k**	**£2,585k**

5.4 Staff Exit Packages

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

5.5 Early Retirements Due to Ill Health

	2012/13 £'000	2012/13 Number	2011/12 £'000	2011/12 Number
Number of early retirements agreed on the grounds of ill health		18		14
Cost of early retirements agreed on grounds of ill health	1,368		1,219	

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:

	2012/13	2011/12
Number of non NHS invoices paid	174,065	161,347
Number of non NHS invoices paid within 30 days	167,620	155,183
Percentage of invoices paid within 30 days	96.30%	96.18%
	£'000	£'000
Value of non NHS invoices paid	311,509	294,594
Value of non NHS invoices paid within 30days	296,413	278,885
Percentage of invoices paid within 30 days	95.15%	94.67%
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

	2012/13 £000	2011/12 £000
Bank account interest	178	380
Total	**178**	**380**

7.2. Finance costs - interest expense

	2012/13 £000	2011/12 £000
Loans from the Foundation Trust Financing Facility	1,399	1,469
Finance Lease interest	155	113
Finance Costs in PFI Obligations		
Main Finance Costs	1,353	1,390
Contingent Finance Costs	542	458
Total	**3,449**	**3,430**

7.3 Impairment of assets

	2012/13 £,000	2011/12 £,000
Loss or damage from normal operations	537	328
Abandonment of assets in course of construction	75	217
Changes in market price	18,191	161
Impairments charged to expenses	**18,803**	**706**
Reversal of impairments credited to income	(15,387)	(1,593)
TOTAL	**3,416**	**(887)**

8.1 Intangible fixed assets 2012/13

	Total £'000	Software licences £'000
Gross Cost at 1 April 2012	2,906	2,906
Reclassifications	533	533
Additions - purchased	82	82
Additions -donated	43	43
Disposals	(305)	(305)
Gross cost at 31 March 2013	**3,259**	**3,259**
Amortisation at 1 April 2012	1,959	1,959
Provided during the year	388	388
Impairments	18	18
Disposals	(305)	(305)
Amortisation at 31 March 2013	**2,060**	**2,060**
Net book value		
- Purchased at 31 March 2012	913	913
- Donated at 31 March 2012	34	34
Total at 31 March 2012	**947**	**947**
Net book value		
- Purchased at 31 March 2013	1,132	1,132
- Donated at 31 March 2013	67	67
Total at 31 March 2013	**1,199**	**1,199**

8.2 Intangible fixed assets 2011/12

	£'000	£'000
Gross cost at 1 April 2011	2,703	2,703
Reclassifications	130	130
Additions - purchased	68	68
Additions - donated	36	36
Disposals	(31)	(31)
Gross cost at 31 March 2012	**2,906**	**2,906**
Amortisation at 1 April 2011	1,564	1,564
Provided during the year	425	425
Impairments	1	1
Disposals	(31)	(31)
Amortisation at 31 March 2012	**1,959**	**1,959**

Note 8.3 Intangible assets acquired by government grants

	2012/13
	£,000
Initial fair value	0
Carrying amount at 31 March 2012	0
Carrying amount at 31 March 2013	0

Note 8.4 Economic life of intangible assets

	Min Life Years	Max Life Years
Intangible assets - purchased		
Software licenses	5	8

9. Property, Plant and Equipment

9.1 Property, Plant and Equipment 2012/13

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2012	546,140	16,693	326,026	2,226	29,049	122,560	982	24,071	24,533
Additions - purchased	33,969	0	3,177	34	27,094	2,820	151	606	87
Additions - donated	2,681	0	2,087	46	171	304	73	0	0
Reclassifications	(533)	0	33,924	0	(42,950)	5,382	0	2,153	958
Other Revaluations	(20,351)	(2,806)	(16,805)	(724)	(75)	59	0	0	0
Disposals	(11,648)	0	0	0	0	(9,778)	(49)	(1,730)	(91)
Cost or valuation at 31 March 2013	**550,258**	**13,887**	**348,409**	**1,582**	**13,289**	**121,347**	**1,157**	**25,100**	**25,487**
Accumulated Depreciation at 1 April 2012	135,438	0	21,737	223	0	74,156	606	19,580	19,136
Provided during the year	31,355	0	18,448	83	0	9,038	101	2,570	1,115
Impairments recognised in operating expenses	18,785	287	17,653	250	75	499	0	2	19
Reversal of impairments	(15,387)	0	(15,323)	(5)	0	(59)	0	0	0
Reclassifications	0	0	24	0	0	(39)	0	0	15
Other Revaluations	(27,722)	(287)	(26,951)	(468)	(75)	59	0	0	0
Disposals	(11,613)	0	0	0	0	(9,743)	(49)	(1,730)	(91)
Depreciation at 31 March 2013	**130,856**	**0**	**15,588**	**83**	**0**	**73,911**	**658**	**20,422**	**20,194**
Net book value									
- Purchased at 31 March 2013	367,009	13,266	288,218	1,343	13,116	41,148	426	4,628	4,864
- Finance Leases at 31 March 2013	3,689	0	0	0	0	3,689	0	0	0
- PFI at 31 March 2013	14,573	0	14,573	0	0	0	0	0	0
- Government granted assets at 31 March 2013	3,771	0	3,155	0	0	562	0	14	40
- Donated at 31 March 2013	30,360	621	26,875	156	173	2,037	73	36	389
Total at 31 March 2013	**419,402**	**13,887**	**332,821**	**1,499**	**13,289**	**47,436**	**499**	**4,678**	**5,293**

9.2 Analysis of Property, Plant and Equipment

Net book value									
- Protected assets at 31 March 2013	348,207	13,887	332,821	1,499					
- Unprotected assets at 31 March 2013	71,195				13,289	47,436	499	4,678	5,293
Total at 31 March 2013	**419,402**	**13,887**	**332,821**	**1,499**	**13,289**	**47,436**	**499**	**4,678**	**5,293**

9.3 Property, Plant and Equipment 2011/12

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2011	508,539	16,743	312,703	2,226	14,835	113,869	946	22,970	24,247
Additions - purchased	43,704	0	2,557	0	29,677	11,019	143	226	82
Additions - donated	646	0	287	0	223	121	0	0	15
Additions - government granted	1,071	0	0	0	1,071	0	0	0	0
Impairments	(14)	0	(1)	0	0	(13)	0	0	0
Reclassifications	(130)	0	10,652	0	(16,541)	4,526	0	1,034	199
Other Revaluations	(44)	50	30	0	(216)	92	0	0	0
Disposals	(7,632)	(100)	(202)	0	0	(7,054)	(107)	(159)	(10)
Cost or valuation at 31 March 2012	**546,140**	**16,693**	**326,026**	**2,226**	**29,049**	**122,560**	**982**	**24,071**	**24,533**
Accumulated depreciation at 1 April 2011	118,911	0	11,090	112	0	71,976	628	17,076	18,029
Provided during the year	26,863	0	14,089	111	0	8,800	85	2,663	1,115
Impairments	691	0	128	0	217	342	0	0	4
Reversal of impairments	(1,593)	0	(1,593)	0	0	0	0	0	0
Reclassifications	0	0	2	0	0	0	0	0	(2)
Other Revaluations	(2,102)	0	(1,977)	0	(217)	92	0	0	0
Disposals	(7,332)	0	(2)	0	0	(7,054)	(107)	(159)	(10)
Depreciation at 31 March 2012	**135,438**	**0**	**21,737**	**223**	**0**	**74,156**	**606**	**19,580**	**19,136**
Net book value									
- Purchased at 31 March 2012	360,039	15,808	262,503	1,844	28,982	41,220	366	4,411	4,905
-Finance leases at 31 March 2012	4,123	0	0	0	0	4,123	0	0	0
- PFI at 31 March 2012	14,817	0	14,817	0	0	0	0	0	0
- Government grant assets at 31 March 2012	3,914	0	3,117	0	0	729	0	24	44
- Donated at 31 March 2012	27,809	885	23,852	159	67	2,332	10	56	448
Total at 31 March 2012	**410,702**	**16,693**	**304,289**	**2,003**	**29,049**	**48,404**	**376**	**4,491**	**5,397**

9.4 Analysis of Property, Plant and Equipment

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

9.5 Economic life of Property, Plant and Equipment

	Minimum Life (years)	Maximum Life (years)
Land	0	0
Buildings excluding dwellings	3	50
Dwellings	12	23
Assets under Construction & payments on account	0	0
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	10	10

Non-Property Valuations

Net Book Value covered by each method for determining fair value

Method For Determining Fair Value	Plant & Machinery £,000	Transport Equipment £,000	Information Technology £,000	Furniture & Fittings £,000
Depreciated historic cost basis (as a proxy for fair value for short life assets)	47,436	499	4,678	5,293
	47,436	**499**	**4,678**	**5,293**

Property Valuations

Net book value of assets covered by valuation method	Land £,000	Buildings excluding dwellings £,000	Dwellings £,000
Modern Equivalent Asset (no Alternative Site)	13,887	332,821	1,499
Modern Equivalent Asset (Alternative Site)	0	0	0
Other Professional Valuations	0	0	0
Total	**13,887**	**332,821**	**1,499**

10 Non-current assets for sale and assets in disposal groups 2012/13

There were no non-current assets for sale and assets in disposal groups in 2012/13 and 2011/12

11. Fixed Asset Investments

The Trust has holdings in Zilico (formerly Aperio) Diagnostics and Epaq , companies commercially developing intellectual property. The Trust holding in these companies carry a minimal value at the Balance Sheet date (31 March 2013 and 31 March 2012).

The Trust owns 45.95% (45.95% 31 March 2012) of the share capital of Epaq, and 21.89% (21.89%, 31 March 2012) of the share capital of Zilico.

12.1. Inventories

	31 March 2013 £'000	31 March 2012 £'000
Drugs	5,158	5,907
Energy	414	368
Other	7,419	7,399
TOTAL	**12,991**	**13,674**

12.2 Inventories recognised in expenses

	2012/13 £'000	2011/12 £'000
Inventories recognised in expenses	95,332	94,606
Write down of inventories recognised as an expense	123	50
Total Inventories recognised in expenses	**95,455**	**94,656**

13.1. Trade receivables and other receivables

	31 March 2013 Total £'000	31 March 2012 Total £'000
Amounts falling due within one year:		
NHS receivables	10,685	11,952
Other receivables with related parties	3,758	4,309
Provision for impaired receivables	(2,757)	(5,135)
Prepayments	1,835	1,896
Accrued income	5,258	4,492
Interest receivable	19	31
Public Dividend Capital dividend receivable	358	105
VAT receivable	789	1,479
Other receivables	7,259	8,336
Total due within one year	27,204	27,465
Amounts falling due after more than one year:		
Accrued receivables	0	207
Other receivables	6,242	5,282
Total due after more than one year	6,242	5,489
TOTAL	**33,446**	**32,954**

13.2 Provision for impairment of receivables

	2012/13	2011/12
	£'000	£'000
At 1 April	5,135	4,690
Increase in provision	1,166	2,818
Utilised	(1,538)	(299)
Unused amounts reversed	(2,006)	(2,074)
At 31 March	**2,757**	**5,135**

13.3 Analysis of impaired receivables

Ageing of impaired receivables	£'000	£'000
0-30 days	43	27
30-60 days	30	29
60-90 Days	43	32
90-180 days	217	237
over 180 days	2,424	4,810
Total	**2,757**	**5,135**
Ageing of non-impaired receivables past their due date		
0-30 days	3,563	1,435
30-60 days	629	362
60-90 Days	696	733
90-180 days	255	(243)
over 180 days	214	388
Total	**5,357**	**2,675**

14. Current asset investments

	2012/13 Total £'000	2011/12 Total £'000
Additions	0	0
Disposals	0	0
Cost or valuation at 31 March	**0**	**0**

The Trust had no current asset investments in either financial year.

15. Payables

15.1 Trade and other payables

	31 March 2013 Total £'000	31 March 2012 Total £'000
Amounts falling due within one year:		
NHS payables	8,964	6,992
Amounts due to other related parties	8,191	4,712
Trade payables - capital	9,188	10,416
Other trade payables	16,538	16,220
Other payables	6,716	6,768
Accruals	21,129	17,063
Social Security and other taxes	10,629	10,861
Total current trade and other payables	**81,355**	**73,032**

	31 March 2013 Total £'000	31 March 2012 Total £'000
Amounts falling due after one year:	0	0
Total non-current trade and other payables	**0**	**0**

15.2 Early retirements detail included in payables above

	31 March 2013 Total £'000	31 March 2012 Total £'000
- outstanding pension contributions at 31 March	6,564	6,138

16 Other liabilities

Current	31 March 2013 £'000	31 March 2012 £'000
Deferred Income	9,995	12,238
Total Other Current liabilities	**9,995**	**12,238**
Non-current		
Deferred Income	1,340	951
Total Other Non-Current Liabilities	**1,340**	**951**

17 Borrowings

	31 March 2013 £'000	31 March 2012 £'000
Current		
Loans from Foundation Trust Financing Facility	1,445	1,445
Obligations under finance leases	395	368
Obligations under Private Finance Initiative contracts	605	602
Total Current Borrowings	**2,445**	**2,415**
Non- current		
Loans from Foundation Trust Financing Facility	27,626	29,071
Obligations under finance leases	3,230	3,637
Obligations under Private Finance Initiative contracts	20,742	21,347
Total Non Current Borrowings	**51,598**	**54,055**

18 Prudential Borrowing Limit

	2012/13 £'000	2011/12 £'000
Total long term borrowing limit set by Monitor	183,400	175,700
Working capital facility agreed by Monitor	60,000	60,000
Contracted working capital facility	60,000	60,000
Total Prudential Borrowing Limit	**243,400**	**235,700**
Long term borrowing at 1 April 2012	56,470	54,498
Net actual long term borrowing/repayment in year	(2,427)	1,972
Long term borrowing at 31 March 2013	**54,043**	**56,470**
Working capital facility at 1 April 2012	0	0
Net actual borrowing / repayment in year	0	0
Net Working capital facility at 31 March 2013	**0**	**0**

	2012/13 Limit	actual	2011/12 Limit	actual
Minimum Dividend Cover	>1	5.1	>1	4.81
Minimum Interest Cover	>3	14.74	>3	13.76
Minimum Debt Service Cover	>2	8.65	>2	8.10
Maximum Debt Service to Revenue	<3%	0.65%	<3%	0.68%

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code . The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The financial ratios for 2012/13 (2011/12) as published in the Prudential Borrowing Code are shown above with the actual level of achievement for the period.

19.1 Finance Lease Obligations

	31 March 2013 £000	31 March 2012 £000
Gross lease liabilities	4,291	4,826
of which liabilities are due		
- not later than one year;	535	535
- later than one year and not later than five years;	2,143	2,142
- later than five years.	1,613	2,149
Finance charges allocated to future periods	-666	-821
Net lease liabilities	**3,625**	**4,005**
- not later than one year;	395	379
- later than one year and not later than five years;	1,740	1,675
- later than five years.	1,490	1,951

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

	31 March 2013 £'000	31 March 2012 £'000
Gross PFI liabilities	40,803	42,757
of which liabilities are due		
- not later than one year;	1,920	1,954
- later than one year and not later than five years;	7,334	7,445
- later than five years.	31,549	33,358
Finance charges allocated to future periods	(19,456)	(20,808)
Net PFI liabilities	**21,347**	**21,949**
- not later than one year;	604	602
- later than one year and not later than five years;	2,449	2,410
- later than five years.	18,294	18,937

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

	2012/13 £000	2011/12 £000
Building Maintenance	305	294
Insurance	141	136
Other management services	98	95
Depreciation	399	346
	943	**871**

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

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

19.5 PFI Scheme details

Estimated capital value of PFI scheme	£14,573k
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	23.6
Contract end date	December 2036

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

	31 March 2013 Hadfield Block £000	31 March 2012 Hadfield Block £000
Within one year	3,276	3,197
2nd to 5th years (inclusive)	13,946	13,606
Later than 5 years	87,180	90,796

The PFI scheme is a scheme to design, build, finance and maintain a new medical ward block on the Northern General Hospital site (Sir Robert Hadfield Block). The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement.

20. Provisions for liabilities and charges

	Current		Non Current	
	31 March 2013 £'000	31 March 2012 £'000	31 March 2013 £'000	31 March 2012 £'000
Pensions relating to other staff	178	168	2,165	2,035
Legal claims	1,331	681	0	0
Agenda For Change	31	69	0	0
Equal pay claims	31	0	0	0
Redundancy	1,582	780	0	0
Other	136	833	0	0
Total	**3,289**	**2,531**	**2,165**	**2,035**

	Pensions relating to other staff	Legal claims	Agenda For Change	Equal Pay Claims	Redundancy	Other	**31 March 2013 Total**	31 March 2012 Total
	£'000	£'000	£'000	£'000	£'000	£'000	**£'000**	£'000
At start of period	2,203	681	69	0	780	833	**4,566**	6,797
Change in discount rate	90	0	0	0	0	0	**90**	0
Arising during the year	150	1,202	31	31	1,582	1,016	**4,012**	2,313
Utilised during the year	(123)	(438)	(4)	0	(651)	(1,610)	**(2,826)**	(3,003)
Reversed unused	(41)	(114)	(65)	0	(129)	(103)	**(452)**	(1,612)
Unwinding of discount	64	0	0	0	0	0	**64**	71
At 31 March 2013	**2,343**	**1,331**	**31**	**31**	**1,582**	**136**	**5,454**	**4,566**

	Pensions relating to other staff	Legal claims	Agenda For Change	Equal Pay Claims	Redundancy	Other	**31 March 2013 Total**	31 March 2012 Total
	£'000	£'000	£'000	£'000	£'000	£'000	**£'000**	£'000
Expected timing of cashflows								
Within one year	178	1,331	31	31	1,582	136	**3,289**	2,531
Between one and five years	671	0	0	0	0	0	**671**	626
After five years	1,494	0	0	0	0	0	**1,494**	1,409

Pensions relating to other staff represents the liability relating to staff retiring before April 1995 (£594k) and Injury benefit Liabilities (£1,749k).

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

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

Legal claims relate to -

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

Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA and not included above. The provision for such cases totals £530k

- A number of other legal cases, not being handled by the NHSLA, are also recorded under this heading. These total £170k.
- Provisions for certain other contractual issues in total amount to £631k.

The Agenda for Change provision relates to amounts that may become due to members of staff if they accept the new rates of pay under Agenda For Change. Consultation with individual members of staff on this issue is proceeding.

Other provisions relate to:-

- Costs likely to be incurred under the Trust's Mutually Agreed Resignation Scheme (£102k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (£34k)

The 'Back to Back' debtors sums owed by PCTs in respect of elements of these provisions have been paid off in full by the PCT during the year. At 31.03.12 £244k was owed by PCTs in respect of 'Back to Back' debts.

£80,457,476 is included in the provisions of the NHS Litigation Authority at 31/03/2013 in respect of clinical negligence liabilities of the Trust (31/3/2012 £62,269,833)

21. Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve - intangibles	Revaluation Reserve - property, plant and equipment
	£000	£000	£000
Revaluation reserve at 1 April 2012	27,733	0	27,733
Revaluations	7,371	0	7,371
Other recognised gains and losses	(3,339)	0	(3,339)
Revaluation reserve at 31 March 2013	**31,765**	**0**	**31,765**
Revaluation reserve at 1 April 2011	27,182	0	27,182
Impairments	(14)	0	(14)
Revaluations	2,058	0	2,058
Other recognised gains and losses	(1,493)	0	(1,493)
Revaluation reserve at 31 March 2012	**27,733**	**0**	**27,733**

22 Cash and cash equivalents

	31 March 2013 £000	31 March 2012 £000
At 1 April	65,133	64,895
Net change in year	5,956	238
At 31 March	**71,089**	**65,133**
Analysed as		
Cash at commercial banks and in hand	216	243
Cash at Government Banking Service	70,873	64,890
Bank overdraft	0	0
Cash and Cash Equivalents at 31 March	**71,089**	**65,133**

Third party assets held by the NHS Foundation Trust	31 March 2013	31 March 2012
At 1 April	4	30
Gross inflows	132	106
Gross outflows	(128)	(132)
At 31 March	8	4

23. Capital Commitments

Commitments under capital expenditure contracts at the Balance Sheet Date were £8.01m (31 March 2012, £9.1m). The major components of these commitments are as follows:

Scheme	Property, Plant and Equipment 31 March 2013 Amount £'000
Accident & Emergency Expansion	893
Car Parking Facilities, NGH Campus	702
Nurses Home Heating System	33
Low Temperature Water Heating Expansion to the Spinal Injuries Unit, NGH	15
Fluoroscopy Room - Spinal Injuries Unit, NGH	6
RHH Ward Refurbishment Programme	547
Catering Infrastructure - Ward Kitchens, RHH	111
RHH Endoscopy / Decontamination works	33
Lift Refurbishment - Service Block, RHH	293
Laboratory Medicine Reconfiguration, RHH	28
Angio Room 2 (formerly Room 8)	74
Biorepository Facility	33
Air Lock, Out Patient Department, RHH	45
Medical Equipment	5,196
Total	**8,009**

24. Events after the reporting period

On 1 April 2013 the Trust accepted the transfer from the demised Sheffield PCT of plant, property and equipment associated with the community services provided by the Trust. The value of assets transferred was £8.3m.

25. Contingencies

	2012/13 £000	2011/12 £000
Gross value	(260)	(270)
Amounts recoverable	0	0
Net contingent liability	(260)	(270)

Contingencies represent the consequences of losing all current third party legal claim cases (see note 20).

26.1 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 Declaration of Directors' interests is to be found on Page 90 of the Annual Report.

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

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

	2012/13 Income £'000	 Expenditure £'000	2011/12 Income £'000	 Expenditure £'000
Sheffield PCT	399,090	3,984	388,308	4,055
Bassetlaw PCT	7,572		7,554	
Derby County PCT	27,588		27,752	
Barnsley PCT	200,583		182,441	
Rotherham PCT	24,005		23,794	
Doncaster PCT	15,331		15,208	
Leicestershire County and Rutland PCT	38,381		35,968	
Yorkshire and The Humber Strategic Health Authority	65,927		65,546	
NHS Litigation Authority		13,433		12,571
National Blood Authority		6,339		5,975
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	6,969	7,551	6,614	6,761
Sheffield Health and Social Care NHS Foundation trust	1,548	3,303	1,470	3,254
Sheffield Children's NHS Foundation Trust	7,548	4,202	7,367	4,074
Barnsley Hospital NHS Foundation Trust	5,210	2,001	5,016	2,255
Chesterfield Royal NHS Foundation Trust	3,323	2,368	3,430	2,051
The Rotherham NHS Foundation Trust	4,530	1,952	4,308	1,879

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

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

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

Of the Trust's total receivables of £33,446k at 31 March 2013, (£32,954k at 31 March 2012, note 13.1) £15,943k (£16,651k at 31 March 2012) was receivable from NHS bodies. This sum comprises, in the main, monies due from Commissioners in respect of health care services invoiced, but not paid for, at the Balance Sheet Date.

The remainder of the balance comprises monies owed from NHS Trusts in respect of clinical support services provided.

£2,915k was receivable from the University of Sheffield at 31 March 2013, (31 March 2012, £3,587k) in respect of clinical and estates support services provided.

During the year the Trust purchased healthcare from Thornbury Hospital in the sum of £2,886k (2011/2012 £1,910k.)

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at Thornbury and Claremont private hospitals. This amounted to £8,848k (2011/2012 £7,972k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Payables falling due within one year of £81,355k (31 March 2012, £73,032k, note 15.1) include £8,964k owing to NHS bodies (31 March 2012, £6,992k). This sum includes monies owing to other NHS Trusts and Foundation Trusts for clinical support services received.

Certain members of the Trust's Council of Governors 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 Council of Governors 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 £1.1m (2011/12, £1.0m). The Trust has also received revenue and capital payments from a number of other charitable funds.

Certain of the trustees of the charitable trusts from whom the Trust has received grants are members of the NHS Foundation Trust Board.

27 Financial Instruments

27.1 Financial assets

	Loans and receivables	Assets at fair value through the SoCI*	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
NHS Trade and other receivables excluding non financial assets	10,658	-	-	-	10,658
Non-NHS Trade and other receivables excluding non financial assets	5,485				5,485
Cash and cash equivalents at bank and in hand (at 31 March 2013)	71,089				71,089
Total at 31 March 2013	**87,232**	**-**	**-**	**-**	**87,232**
NHS Trade and other receivables excluding non financial assets	16,651	-	-	-	16,651
Non NHS Trade and other receivables excluding non financial assets	5,281				5,281
Cash and cash equivalents at bank and in hand	65,133				65,133
Total at 31 March 2012	**87,065**	**-**	**-**	**-**	**87,065**

* SoCI - Statement of Comprehensive Income page 110

27.2 Financial liabilities by category

Liabilities as per Statement of Financial Position	Other financial liabilities £000	Liabilities at fair value through the SoCI* £000	Total £000
Borrowings excluding Finance lease and PFI liabilities	29,071		29,071
Finance lease obligations	3,625		3,625
Obligations under Private Finance Initiative contracts	21,347		21,347
NHS Trade and other payables excluding non financial assets	8,964		8,964
Non-NHS Trade and other payables excluding non financial assets	55,046		55,046
Provisions under contract	2,926		2,926
Total at 31 March 2013	**120,979**	**0**	**120,979**
Borrowings excluding Finance lease and PFI liabilities	30,515		30,515
Finance lease obligations	4,005		4,005
Obligations under Private Finance Initiative contracts	21,949		21,949
NHS Trade and other payables excluding non financial assets	6,992		6,992
Non-NHS Trade and other payables excluding non financial assets	48,411		48,411
Provisions under contract	4,566		4,566
Total at 31 March 2012	**116,438**	**0**	**116,438**

* SoCI - Statement of Comprehensive Income page 110

27.3 Fair values of financial assets at 31 March 2013

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

27.4 Fair values of financial liabilities at 31 March 2013

	Book Value £000	Fair value £000
Provisions under contract	2,926	2,926
Loans	29,071	29,071
Total	**31,997**	**31,997**

Fair value is considered to be equal to book value in all cases.

Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating and changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has borrowings for capital expenditure, but is subject to affordability as confirmed by the FT Financing Facility. The borrowings are for a maximum remaining period of 22 years, in line with the associated assets, and interest is charged at 4.80% and 4.59%, fixed for the life of the respective loans. The Trust therefore has low exposure to interest rate fluctuations.

The Trust also has borrowings in respect of leasing and its PFI contract which incur fixed interest rates of 3.83% and 6.32% respectively. Exposure to interest rate risk is therefore low as these borrowings are at fixed rates.

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 2013 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with Primary Care Trusts, or the Department of Health, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

28. Third Party Assets

The Trust held £7,645 (31 March 2012, £3,521) at bank and in hand at 31 March 2013, which related to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

29. Losses and Special Payments

There were 1,409 (1,300 in the year to 31 March 2012) cases of losses and special payments totalling £1,510k (12 months to 31 March 2012, £321k) approved during the financial year.

There were no cases of an individual loss exceeding £100,000 (2011/12 one case).

30. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £9,726k (2011/12 £9,716k) bear to the average net relevant assets during the twelve month period of £283,790k (2011/12 £275,631k), that is 3.5% (2011/12 - 3.5%).

This is calculated as follows:

	31 March 2013 £'000	31 March 2012 £'000
Total Capital and Reserves	385,940	376,153
Less		
Donated Assets / Lottery grant assets	(30,612)	(28,138)
Less - Cash held at Government Banking Service	(70,873)	(64,890)
Net Relevant Assets	**284,455**	**283,125**
Average Net Relevant Assets during the year	283,790	275,631
Dividend paid per Cash Flow statement	10,179	9,084
Dividend Debtor movement	(253)	632
Total Dividend paid and payable per Statement of Comprehensive Income	9,926	9,716
Percentage	**3.5%**	**3.5%**

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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Sheffield Teaching Hospitals NHS Foundation Trust
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