



In hospital and in the community

proud to make a difference

Sheffield Teaching Hospitals



NHS Foundation Trust

Annual Report and Accounts

Incorporating the Annual Quality Report

2013/14



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Incorporating the
Annual Quality Report

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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.

Chairman's statement



During what has been another busy and demanding year, I am pleased to report that Sheffield Teaching Hospitals NHS Foundation Trust has continued to perform very well.

Our priorities in 2013/14 were to:

- Deliver the best clinical outcomes,
- Foster a positive patient experience,
- Employ caring and cared for staff
- Be a leader in healthcare research and innovation.
- Provide value for money
- Use our resources wisely

I consider that we have largely met those objectives and you will see some good examples in the other pages of this report. I would like to highlight just a few aspects.

On outcomes, we focus on a number of indicators and particularly mortality rates, which have remained low. We are never complacent about this and the Board monitors this aspect very regularly. I am also pleased to report that we have seen a reduction in the number of Never Events which occurred within the Trust. Unusually we saw a small rise in 2012/13 but after prompt action this has significantly improved in 2013/14 and we continue to give this a very high priority as we are quite clear that we aim to have no Never Events at STH.

We have also been giving particular attention to hospital acquired infection rates and in particular *C.difficile*. Creating a clean and welcoming environment for our patients, visitors and staff is a sign of a high level of attention to detail and pleasingly, during 2013/14 we reduced the number of cases by more than 23% to the lowest ever level.

During 2013/14 we invested more than £3million to expand and refurbish the Accident and Emergency Department at Northern General to accommodate increased demand and improve patient's experience and privacy. This undoubtedly contributed towards us being one of only 18 NHS Trusts in England that achieved the A&E 4 hour maximum waiting time standard. Over the year, despite very high levels of demand, we saw over 95% of patients who arrived at A&E within 4 hours or less.

Rapid diagnosis and treatment of patients is a key objective. And despite the high level of demand I have referred to, during 2013/14 we achieved all of the national waiting time targets.

Our waiting times remain among the lowest in the NHS. However with more and more patients choosing to have their treatment with us we have been looking at improving the processes we currently use so that we can treat patients as efficiently and timely as possible. More detail about this work and our focus on ensuring the rising emergency care demand does not impact on the cancellation of non-urgent procedures wherever possible can be found on page 8.

A considerable amount of our work is now done in the community and indeed we see a third of our patients outside the hospital environment. This underlines the importance of our role as a provider of community services in Sheffield. Working increasingly closely with GPs, Social Services and voluntary teams is the objective of the City's Right First Time (RFT) programme and we aim to continue to develop this with our colleagues to enhance the experience of those in the city who need to access health services.

Another initiative which we have developed in the year to improve services for patients, is the Working Together programme, which is a partnership of 7 Acute Trusts in South Yorkshire and North Derbyshire. The aim is to share best practice and improve patient care. We believe that working together on a number of common issues will allow all the Trusts to deliver benefits that they would not achieve by working on their own.

So overall on outcomes and experience for patients, there is a lot of good progress. We are keen to learn where there are opportunities to improve and hence we have given considerable attention to recent reports on issues within the NHS, including the Francis Report, and subsequent reports by Sir Bruce Keogh, Don Berwick and others. We see these as very helpful in giving us the opportunity to test what we are doing and explore what more we can do to improve even further.

It is always pleasing to receive external validation of what we are achieving and pleasingly, two separate unannounced inspections by the Care Quality Commission found we are meeting all of the essential quality and safety standards and many aspects of our care were praised by patients and commended by the inspectors.

It is also pleasing to have recognition through awards and this year we were delighted to be named Sexual Health Team of the Year and Midwifery Team of the Year and to be shortlisted in the Patient Safety Awards. We also won first place in both the Medipex Innovation and the Royal College of Speech and Language Therapists awards.

During the year we have continued to focus on research. We continued to be an active partner in driving forward the work of the Yorkshire and Humber Academic Health Science Network and the National Centre for Sports and Exercise Medicine which both promise to deliver a transformation in the health and wellbeing of our local population and workforce over coming years.

We have also pioneered new treatments for multiple sclerosis, cancer and many long term conditions through innovative translational research trials and we have continued to introduce new equipment such as a new £1.8mn Da Vinci robot to ensure we stay at the leading edge of medical practice.

To increase the efficiency of our services and maintain high quality, safe care for patients as well as ensure that we are able to continue to invest in improvements to our buildings and services, requires us to be financially sound. Despite the continuing difficult economic climate, and thanks to the efforts of our staff through their ongoing focus on delivering excellent care efficiently, the Trust has performed well again financially. Our total income last year was £932.9m and we declared a small surplus of £7.2m which will be used to fund service and facility developments which further enhance patient care.

Our key asset is our staff and they have continued to perform at a very high level despite considerable pressure from the high volume of work we have faced. Their dedication and commitment is a source of great strength for the Trust. On behalf of the Board, I thank them most sincerely for all they do.

We are also very fortunate to be supported by a strong group of hard-working Governors, some very committed volunteers and a number of very active charities. I thank them all for their huge contribution to the success of the Trust.

I know that 2014/15 will be an equally demanding year as we strive to improve further in delivering the highest level of care for our patients and the best possible experience for them and their families and carers. I am confident that we will meet that challenge if we stay focused on our vision which 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.



Tony Pedder OBE
Chairman



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.



Our aim: to provide patient centred services



Sir Andrew Cash OBE
Chief Executive

'Making a Difference'

At Sheffield Teaching Hospitals we remain committed to delivering good clinical outcomes and a high standard of patient experience to patients both in our hospitals and in the community. Thanks to the dedication and professionalism of our 16,000 staff we have a strong track record in this area but we are never complacent and continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

This drive for improvement is embodied within the Trust's Corporate Strategy 'Making a Difference'.

The strategy outlines five overarching aims:

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation.

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.

We are always seeking to improve what we do, whether through health research that aims to deliver better treatments, through training and education of our staff, or through investment in new facilities for our patients.

Patients, partners and our Governors/ members continue to make a valuable contribution to our improvement plans. Patients and stakeholders are involved in

decisions about changes and developments to services and were at the heart of the design for our Frailty Unit, 'All about me' booklet and new Discharge to Assess process.

We are now a year on from the release of the Francis Report into standards of care at Mid Staffordshire NHS Foundation Trust. The official Government response to the Mid Staffordshire Public Inquiry 'Hard Truths' has now been published outlining how the whole health and care system will prioritise and build upon the previous work already undertaken following the Robert Francis QC report.

As a Trust we have outlined our response to the Mid Staffordshire Public Inquiry in the Quality Report on page 65. After consultation with our patients, Governors and partners we have also selected one of our key quality objectives for 2014/15 directly from the Government's 'Hard Truths' report. The objective chosen is: to ensure that every hospital patient should have the name above their bed of the consultant and nurse responsible for their care. The remainder of our priorities have been set in consultation with our own patients and their representatives.

During 2013/14 we built on our strong foundations to achieve our goals and the next few pages highlight where we have improved even further the care and experience our patients receive. However we also shine a light on the areas where we have more to do or where patients have asked us to do things differently.

Delivering the best clinical outcomes

In September 2013 the Care Quality Commission (CQC) conducted a routine unannounced inspection of the Trust. Inspectors visited Jessop Wing, Royal Hallamshire Hospital, Northern General Hospital and Weston Park Hospital to observe care on wards and in theatres. The inspection reports were very positive and the Trust was found to be compliant with all the standards that had been inspected.





An important clinical quality indicator is the mortality rate after surgery and for many years I am pleased to report that we have had a consistently lower than expected mortality rate. This is testament to the skill and care of our teams.

During 2013/14 we also continued to review weekend mortality rates. Our Hospital Standardised Mortality Ratio for weekday and weekend emergency admissions is both 'within expected range'. However, given the importance of mortality rates and continual monitoring to ensure that any variance can be spotted quickly and acted upon, it has been agreed that this will again be a priority for improvement for 2014/15.

We consider rigorous infection control and clean facilities to be fundamental to our care standards and so I am pleased to report that this year we saw a further reduction in cases of *C.difficile* and now have our lowest levels ever recorded. Despite treating over 1.2 million patients last year we only had four cases of MRSA. Clearly our aim is to have zero cases and we will continue to strive for this goal. (See page 21 for more details about our performance on infection control). Patient safety is paramount and

during last year a number of areas were a particular focus for us. One such area was to reduce the number of patients who sustain a pressure ulcer while in our care.

During 2012/13 1.77% of patients receiving hospital care acquired a pressure ulcer. Last year this dropped to 1.4%. Further work within the hospitals is planned including the identification of patients at risk of developing a pressure ulcer, instigation of early intervention by the Pressure Ulcer Prevention Team, and targeted work with clinical areas with a high prevalence of pressure ulcers. We have also provided cameras to appropriate staff to enable wound imaging, which can be attached to the electronic record and viewed remotely by the Tissue Viability Team. Further work is planned including a project for a Tissue Viability Nurse to work alongside a community team to understand the prevalence of pressure ulcers within their patient group.

We have introduced two major initiatives to support diabetes patients. The 'Think Glucose' educational programme and the 'Think Foot' initiative have received accolade nationally. The 'Think Foot' initiative has included

the introduction of a daily foot assessment. This facilitates timely referrals of patients with foot problems to the multi-disciplinary team and the prevention of new foot problems developing in hospital inpatients. This has resulted in a significant reduction in the number of foot amputations.

Over 90% of patients over 75 are now screened for dementia and the Trust has developed a personal information booklet called 'All About Me' which is specifically tailored for use by patients with confusion/dementia and their carers. The booklet is based on the Alzheimer's Society 'This is Me' booklet. See page 9 for further details.)

An innovative test confirming diagnosis of a devastating rare blood disorder which kills approximately half of sufferers within one to two days of first signs appearing is being performed within a next day timescale. Sheffield's Coagulation and Haematology department is currently the only laboratory in the North of England capable of performing the highly complex ADAMTS-13 test in a rapid timescale.

New equipment such as our new £1.8m Da Vinci robot bring futuristic advancements into healthcare right here in the heart of the UK. The robot, which was acquired by the Trust in 2013, allows surgeons to perform pioneering surgery using a robotic console. The surgeon can control a camera ten times more accurate than the human eye and specially designed 'wristed' instruments attached to the robotic arms using joysticks and foot pedals. From here, the surgeon can perform complex surgery through small incisions with precision, as the machine adjusts itself to compensate for the natural tremor in the human hand.

The development of a new pioneering 3D imaging laboratory at the Royal Hallamshire Hospital uses some of the most advanced techniques in the world, giving clinicians access to high quality scans and easier-to-interpret data which can help better predict the outcome of heart disease, dementia and tumours. It is the only one in the UK to have integrated this type of technology into daily medical practice. The laboratory is one of six Sheffield Teaching Hospitals innovations nominated for the 2013 Medipex NHS Innovation Awards which highlight pioneering ways of improving patient care.

We have also developed new treatments for many other conditions through translational research trials.

The integration of community services with acute hospital services is proving to be a unique and exciting opportunity to develop new ways of delivering services for the patients we serve. We have made great progress in the joining up of services since adult community services became part of Sheffield Teaching Hospitals NHS Foundation Trust from 1st April 2011. The next step will see the Directorate of Geriatric and Stroke Medicine (GSM) and Primary and Community Services Cares Group brought together in October 2014 to enable the excellent transformation work which has started to flourish further.

Our strategic mission is to help our local population achieve the highest physical and mental health status possible. 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 (www.rightfirsttimesheffield.co.uk).



The City's partners in health and social care have 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 NHS Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust and Sheffield Clinical Commissioning Group.

The partnership is one of 13 initiatives from across England to be recognised by Professor Sir Bruce Keogh, NHS Medical Director for England, for work to deliver NHS services, seven days a week. Right First Time was one of over 70 programmes to apply to be considered for Sir Keogh's 'Early adopter' scheme and along with only 12 other successful projects, will lead the way in delivering seven day services by building communities of practice and learning networks across the country.

Throughout the year we continued to invest in the very latest medical treatments and 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 Advanced Obstetric Care Unit (AOCU) on the Labour Ward at the Jessop Wing. The Unit cares for women who suffer complications or who have complex medical conditions. The unit, was designed following a consultation with local women on how they wanted the area to look and feel.

We have also completed the rollout of e-discharge summaries during the year which enables clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs.

And finally, we have approved a £35m investment in technology which will provide the opportunity to transform the way we deliver care both within the hospital and also in people's own homes and communities. This five year programme will also enable the organisation to become paper light and support the work underway to develop integrated care teams and new models of care.

The programme will oversee the implementation of three major systems; an electronic patient record, an electronic document management system, and a clinical portal. This will provide clinicians with the information they need, at all times and in all locations. It will improve patient safety and our communication with patients, increase operational effectiveness (releasing time to care) as well as supporting clinical practice and research.





Provide patient centred services

During the past 12 months we have focused as much on patient experience as clinical outcomes.

We know our patients want timely care and when it's urgent it is even more important that a diagnosis and treatment is provided as quickly as possible. I am therefore pleased to report that during 2013/14 we once again met or exceeded all of the waiting time standards for patients requiring cancer care.

We have continued to work hard so that the majority of our other patients are also seen in less than 18 weeks from the date their GP refers them for a hospital consultation.

Indeed the majority of our patients are seen and treated in under 5 weeks. However for the last few years we have seen an increase in the number of patients choosing to have their treatment with us and this extra demand means we have had to look at improving the processes we currently use so that we can treat patients as efficiently and timely as possible.

In 2013/14 we achieved the 90% of admitted patients receiving treatment within 18 weeks of GP referral but we narrowly missed the 95% non-admitted patients standard with 94.8% of patients seen within 18 weeks. Actions are already being taken to ensure we continue to treat people as quickly as possible.

We believe the experience our patients and their visitors have with us should be as positive as possible. A number of national surveys undertaken in 2013/14 suggest we are broadly meeting our patients needs but we are never complacent.

Over 98% of the 407 inpatients surveyed as part of the National Inpatient Survey by the Care Quality Commission in 2013 said our wards were clean and over 85% said they were treated with respect and dignity. Over 90% of patients surveyed expressed complete satisfaction with the help they received with nutrition, pain control and going to the toilet

73% of the patients treated at the Royal Hallamshire Hospital, Weston Park Hospital, Jessop Wing and Northern General Hospital rated their experience as 8 out of 10 or better (up from 67% in 2012) and 32% rated their experience as 10 out of 10.

The care and treatment received in the A&E Department at the Northern General Hospital, was highlighted as better than the national average, as was patient information and the amount of emotional support patients received from staff.

Yet again the Trust was praised in the national Maternity Services Survey by the Care Quality Commission. This was echoed by Jessop Wing winning numerous national awards in the last year including Midwifery Team of the Year in the British Journal of Midwifery Awards.

Whilst these results are very encouraging and testament to the care and compassion shown by our staff, we remain open to scrutiny from our patients, commissioners and partners. It is this challenge and feedback which enables continuous improvement of our services.



their identity whilst in hospital and help staff to provide care tailored to an individual person. The patient's family or carer can fill out the booklet to create a picture of all the patient's likes and dislikes. The booklet captures personal details such as what makes the person anxious and what comforts them. It provides a guide to ensure all the patients' needs are met. This is very important when it comes to nutrition as some patients are unable to express their preferences including what foods they enjoy or how they have their tea. This can lead to them avoiding food or drink and them becoming malnourished. The booklet has been successfully piloted across a number of wards at the Trust, receiving excellent feedback, and was launched across all the five hospitals in March 2014.

At the Northern General Hospital, Vickers 4 is undergoing an improvement scheme which includes adding a bathroom to the building, as all other facilities are wet rooms with showers. Bedside televisions have been removed from certain areas to avoid causing some patients confusion and distress, though this is reviewed on an individual basis.

A specific session on dementia awareness is to be added to the Trust induction for all members of staff, both clinical and non-clinical from April 2014. More comprehensive training is available for those who regularly care for people with dementia to ensure they are equipped to care for this patient group.

Going forward we will step up even further our efforts to listen to both patients and staff, particularly those working at the frontline, as these are the people who are best placed to provide an honest view of how we are doing and what we might do better.

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. From October 2013, FFT was 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 publish the results for each ward and department to enable those people who need our care to see how we perform.

Hearing directly from patients about the things that matter to them is already helping us to make small changes that will improve their experience of care.

One example of the work undertaken last year focuses on one of our most vulnerable groups of patients. Working with Sheffield Health and Social Care Trust we have focused on supporting the needs of this growing number of people who live with dementia. A discrete symbol has been developed to enable staff to easily recognise a patient suffering with dementia. This symbol will then prompt staff to refer to a new booklet which has been developed.

The 'All About Me' booklet has been designed to help patients keep



Employ caring and cared for staff

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 PROUD values and behaviours will continue to underpin the way we lead and deliver through change in the next five years. If we are to flourish as an organisation we will need to rely on these values and ensure they guide how we work and deliver services.

The Trust has just over 16,000 employees whose skills, hard work and dedication play a significant part in the success of the Trust. We recognise the importance of positive staff engagement and good leadership to ensure good quality patient care.

During 2013/14, our Staff Engagement Strategy had a particular focus on improving both staff involvement and the appraisal rates for all staff across the Trust. During the year I am delighted to

report that we increased the number of staff who had an appraisal to just over 97% and we began to introduce values and strengths based recruitment.

Our staff engagement score in the National Staff survey rose again and we were particularly pleased to note that the majority of our staff would recommend the Trust as a place to work or receive care. We conducted a full census NHS Staff Survey in Autumn 2013 to give all staff the opportunity to contribute their views and suggestions.

We have also worked with NHS England on the introduction of staff 'friends and family' testing, which will be introduced into the Trust on a quarterly basis in 2014/15. This will give more staff the opportunity to give more frequent feedback.



listening... sharing... improving

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.

In response to staff feedback through the Let's Talk programme a number of initiatives have been taken up throughout the year including the introduction of uniforms for Nurse Directors, and senior nursing staff to ensure patients and staff can easily recognise senior nursing staff. All Nurse Directors and the Chief Nurse, already carry out clinical shifts on wards every month to ensure they continue to experience first-hand the care being delivered and also to understand the challenges and opportunities nursing teams face. Throughout 2014 this initiative will be expanded to involve other senior managers who will also work alongside members of staff from a variety of clinical and non-clinical departments in order to further their understanding of the patient and staff experience.

A number of 'Let's talk' engagement events have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements. In addition some directorates are now using the Microsystems Coaching Academy approach to improving services (see page 15). Many areas have introduced staff suggestion boxes after these were successfully piloted in the Hotel Services Directorate during 2012/13.



Our aim: to employ caring and cared for staff.

The health and wellbeing of our staff is incredibly important and a number of initiatives have been put in place during the year in response to staff suggestions.

An innovative workplace health scheme was piloted at the Trust with 60 employees. The programme which is run in partnership with Sheffield Hallam University significantly improved fitness and wellbeing in 71% of those staff taking part.

The same number of staff improved diet by following healthy eating and good nutrition guidance. 37% also began weight management programmes, 32% adopted mental wellbeing strategies, 11% reduced alcohol consumption, 7% improved posture and back care and 3% quit smoking. Researchers estimate that the £13,000 scheme has saved the Trust £36,000 in sickness absence alone. If these benefits were reproduced across the country, the NHS could save £3 for every £1 spent on employee health and wellbeing. Following the successful pilot of a fast track musculoskeletal service for staff in the Jessop Wing by PhysioPlus we have expanded this service across the whole Trust effective from April 2014. The Trust is looking to link this to the development of a fast track mental health pathway for staff absent due to stress, anxiety or 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. It is anticipated that this will reduce sickness absence rates within the Trust and improve staff health and wellbeing overall. We have seen some evidence of this during 2013/14 with a reduction in sickness absence levels from 4.61%

to 4.23% and we hope to make further improvements in 2014/15.

The Trust takes its responsibilities for education and training very seriously and works towards ensuring that all our staff have access to high quality education that gives them the skills and knowledge to carry out their role to the highest standards.. 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 meet essential requirements before taking up post. Our partnerships with Sheffield Hallam University and the University of Sheffield ensures our students are well supported in their clinical placement settings and staff can meet their Continuing Professional Development requirements. There is also an extensive portfolio of further learning opportunities for all staff.

The year 13/14 has seen a number of new developments in education for our staff. As part of our widening participation agenda we have worked with three schools as part of the Cutlers 'Company programme supporting 60 14-16 year old students prepare for the world of work and provide them with work placements in procurement and supplies, hotel services and business administration. This has had a positive impact in the staff who work in these areas and the young people who have all expressed an interest in working with us in the future.

In response to the recommendations from the Francis enquiry we also now recruit our newly qualified nurses and support workers differently through assessment stations to ensure we recruit staff with the right values and behaviours to care for our patients. This theme also underpins the preparations

programmes we provide for these staff. In 2013 we invested in a new web based learning management system which is locally called PALMS (personal achievement learning management system) which goes live later in 2014 giving all staff access to their own training record and to on line learning from mobile devices as well as fixed computer terminals. This will be a major step forward for the recording of mandatory training and make it easier for staff to access training too.

Leadership is at the heart of high quality patient care. The Trust has invested in leadership development in 2013/14 and continues to do so. Most staff in leadership roles undertake some form of leadership development and we are pleased to be working with the NHS leadership academy and Sheffield Hallam University in providing many of those opportunities.

The creation of Health Education England has made Trusts more accountable for the education and training of their workforce.





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



Our aim: to deliver excellent research, education and innovation



Three examples of the service improvement work undertaken during 2013/14 include a re-design of the renal outpatients and Falls assessment clinics and the introduction of the Discharge to Assess process.

In June 2011 the Trust's Service Improvement Team developed a Trust Wide service improvement strategy for Outpatients (OP) services. The document set out to deliver outpatient services that are more patient centred, efficient and engage staff in the redesign of their service for the benefit of patients. The renal outpatient clinic re-design has delivered a 63% reduction in the waiting time for renal outpatients and Did Not Attend rates reduced from 11% to 6% in the same clinics.

A re-design of the Falls clinic resulted in the time patients spent in clinic reduced from 380 minutes to 155 minutes and the whole day assessment service now only takes half a day. Savings of £48,000 were delivered giving a Return on Investment of 5:1. However the most important outcomes were that a new home hazard assessment visit reduced the number of patients seen in the hospital's clinic to less than 5% and patient feedback was overwhelmingly positive. Previously frail older patients coming to the clinic complained of being exhausted by the whole day of multidisciplinary assessment.

The use of a 'big room' approach to transform the way older people are assessed for discharge from hospital has also had impressive initial results. Traditionally, on completion of acute hospital care, we undertake a multidisciplinary assessment of our frail older patients to determine their care needs on returning home. We assess kitchen function in a hospital kitchen, personal care capability in a hospital bathroom and so forth.

As a major Trust in Yorkshire and the Humber we have been at the forefront of these reforms. Our training needs analysis model has now been implemented and has been instrumental in working with Health Education Yorkshire and the Humber in investment in the training for Advanced Practitioner roles over the next three years.

Spend public money wisely

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 three years and Sheffield Teaching Hospitals NHS Foundation Trust is no exception.

The major financial concern for the Trust in 2013/14 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.

The UK's first Microsystem Coaching Academy has been established in Sheffield in partnership with the Dartmouth Institute (www.sheffieldmca.org.uk). The Institute is supporting the Quality and Efficiency Programme by training and support 15-20 new microsystem coaches, across clinical and corporate support areas, every six months. Using action learning theory, these coaches will then produce 15-20 new improvement microsystems every six months. Overall, the project will train around 205 coaches, with the hope of quality improvement work reaching all 16,000 employees.

At a weekly improvement meeting of health and social care staff from both the hospital and community settings, this way of working was rapidly called into question. 'Wouldn't it be better to assess patients in their own kitchen, bathroom, etc?' After only three weeks of testing, the pilot ward were so convinced of the new assessment method that they implemented 'discharge to assess' as a core way of working. They measured a six-day reduction in length of stay for patients discharged back to their own home. A number of patients also required a lower level of care when assessed in the familiar surroundings of their own home than would have been predicted from the hospital environment assessment.

Patients are involved in every microsystem project. This approach is part of our drive to encourage a culture of sustained patient-centred continuous quality improvement within and beyond the Trust.

Deliver excellent research, education and innovation

Without medical research, breakthroughs in medicine wouldn't be possible. As one of the largest teaching hospitals in the country, we are committed to improving patient care through research and innovation. We have a long and proud tradition of research – pioneering new treatments and technologies that are now routinely used in hospitals throughout the UK.

In 2013 the Trust was named as one of the UK's top 10 performing NHS Trusts for clinical research by the National Institute for Health Research, and we are continuing to provide more and more opportunities for patients to take part in clinical trials. During 2013/14 there was a 40 per cent rise in the number of people in Sheffield taking part in clinical trials.

More than 200 scientists and clinicians gathered for a three day global summit hosted by the Sheffield Institute for Translational Neuroscience (SITraN) looking at ways to improve treatment and diagnosis of motor neurone disease. Researchers from the Sheffield Kidney Institute launched a £1.2m study examining whether bicarbonate of soda can stop chronic kidney disease from worsening and investigators from the Trust discovered a new antibody which could help diagnose gluten ataxia, a neurological illness treatable through a gluten-free diet. These are just a small sample of the amazing breakthroughs in healthcare research and treatment which are originating here in Sheffield and the wider region.

Digital Avatar promises healthcare revolution

The Insigneo Institute for in silico medicine, a joint initiative with the University of Sheffield, is bringing together over 100 clinicians and academics from across Europe to improve diagnosis and treatment for patients through the creation of the 'virtual physiological human', where the entire human body will be recreated through powerful computers. Once built, the technology – which has the potential to be one of the biggest medical breakthroughs in living memory – will enable doctors to see how all the different parts of the body work and react together, improving diagnosis and treatment. The lifelike simulations will also enable more individuals to take charge of their own health, as the digital patient will be able to forecast how each individual will respond to therapies for a range of common complaints. Already computer simulations of 3D heart prototype have successfully predicted treatment outcomes for 20 patients with coronary heart disease at the Northern General Hospital.

£1.3 million boost for cancer research and treatment

Giving patients more opportunities to take part in research is vital if we are to further improve care, and the opening of a brand new research and treatment suite at Weston Park Hospital represents a significant opportunity for cancer patients living in Sheffield and beyond to access gold standard treatments in a warm and welcoming environment. Funded by Westfield Health, Weston Park Hospital Cancer Charity and Yorkshire Cancer Research, the £1.3m unit includes a main treatment area with 10 comfortable, reclining chairs and two private bedrooms, and a new private consulting room enabling hospital staff to give patients the latest information about chemotherapy treatments and research. The unit is to be officially opened in Spring 2014.



INSIGNEO

SITraN



NHS
National Institute for
Health Research
CLAHRC for South Yorkshire

Innovative networks transform care for region

The Trust continues to play a significant role in spearheading research and innovation by hosting a number of leading networks for the Yorkshire and Humber region.

The Yorkshire and Humber Academic Health Science, hosted by Sheffield Teaching Hospitals NHS Foundation Trust was given licence to operate by NHS England in May 2013, and will play a leading role in helping disseminate ideas and technologies so that they can reach the clinic faster. So far, the Network has been instrumental in helping three large NHS Trusts adopt an innovative workplace wellbeing programme which is saving the NHS £3 for every pound invested; create the modelling for a new painless way to diagnose way to diagnose reflux, which could save the region £25m; and introduce an effective falls intervention programme which has already seen a dramatic decrease in the number of inpatient falls at four acute wards at Leeds Teaching Hospitals NHS Trust.

In summer 2013 the Collaboration for Leadership in Applied Health Research and Care for Yorkshire and Humber, also hosted by the Trust, was one of 13 national collaborations awarded multi-million pound funding to tackle the most pressing health problems. The £24m funds, provided by the Department of Health and partner organisations, will enable researchers to answer specific clinical questions and address practice-related problems that will better support care for those with long-term conditions, the elderly and those with mental health problems.

Most recently the launch of the reconfigured Clinical Research Network: Yorkshire and Humber will give even more opportunities for local hospitals, doctors' surgeries

and other healthcare providers to collaborate in high quality clinical research studies that could lead to better treatments for NHS patients.

Partnerships

Partnership working enables us to realise benefits for our patients and staff much more efficiently and quickly than working alone on issues or ideas. We are fortunate to be part of a number of partnerships which are bringing about real transformation in a number of areas.

I will highlight just a few which during 2013/14 delivered tangible benefits for patients, our Trust and the wider NHS in some instances.

Through our Right First Time partnership with Sheffield City Council and other local health and social care providers we are able to give patients more appropriate care, tailored to their individual needs in the right place.

Through our wider partnerships, such as the regional Working Together programme and the national Shelford group, we are able to change practice for the better on a wider scale.

The Shelford Group comprises ten leading NHS multi-specialty academic healthcare organisations who deliver state-of-the-art training

and education opportunities for the UK's clinicians, as well as the fundamental infrastructure for the UK's medical research sector. The group was formed in 2011 to benchmark and share best practice in key service areas across the membership through working groups, and constructively engage with Government, Parliament and industry to represent the interests of large tertiary centres and the wider National Health Service. Sheffield has been a founding member of the Shelford Group and our Chief Nurse was co-author of the new Safer Nursing Tool which was developed in 2013 in response to the events at Mid Staffordshire NHS Foundation Trust.

The 'Working Together' partnership was formed between seven hospital Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. They work together on a number of common issues to allow the Trusts to deliver benefits that they would not achieve by working on their own. The aims of this innovative partnership are to strengthen each organisation's ability to:

- Deliver safe, sustainable and local services to people in the most appropriate care setting.
- Meet commissioner intentions to improve the health and wellbeing of the people being served in the most efficient and effective way.
- Make collective efficiencies where the potential exists.

In 2013, the Trust was pleased to be invited to "buddy" the Northern Lincolnshire and Goole NHS Foundation Trust and United Lincolnshire NHS Trust as part of the action plan arising from the Keogh reviews, (a review of clinical services carried out by the Medical Director of NHS England) of 14 trusts including these two Trusts.



A work programme to support identified aspects of clinical care is in place for both Trusts and has been devised as an additional activity without detriment to the work of our own organisation. The principle is that the Trust's support is driven by the needs of Northern Lincolnshire and Goole NHS Foundation Trust and United Lincolnshire NHS Trust and that each organisation has something to teach and something to learn from this arrangement.

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.

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

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 2014/15 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
22 May 2014



Our aim: to deliver the best clinical outcomes.

Strategic report

Sheffield Teaching Hospitals NHS Foundation Trust is one of the UK's busiest and most successful NHS Foundation Trusts. Above all, patients lie at the heart of everything we do.

With a turnover approaching £1 billion and around 2 million patient contacts each year, more than a million of those in the community, we are one of the largest NHS trusts in the UK.

During the past year we have seen and treated **1,017,451**, outpatients, **111,090** inpatients, **104,695** day case patients and **146,232** accident and emergency attendances. We have also had **879,484** contacts with community patients.

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 state-of-the-art £16m laboratories complex provides leading edge diagnostic services.

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 who 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 Fertility Unit. The world renowned Weston Park Cancer Hospital is also part of the Trust.

The Trust also provides community health services to provide care closer to home for patients and preventing admissions to hospital wherever possible.

Our award winning Drug and Alcohol addiction service and sexual health services also provide urgent and ongoing long term support for thousands of people every year.

We have around 16,000 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, the local authority, charitable bodies and GP's.

Our performance

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.

Activity levels increased significantly last year. Not only did we treat around 5.4% 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.

Despite this we achieved the majority of national and local targets and standards required. This included the national target for diagnosing, treating and discharging or admitting 95% of patients within four hours from the Accident and Emergency Department. As well as exceptional hard work by our staff we also invested £3m in expanding the A&E department at the Northern General Hospital to accommodate the increase in patients. A rigorous ward deep cleaning programme and higher uptake of the flu vaccination of staff also meant levels of Norovirus, *C.difficile* and flu were not as high as in previous years

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 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.

However for the last few years we have seen an increase in the number of patients choosing to have their treatment with us and this extra demand means we have had to look at improving the processes we currently use so that we can treat patients as efficiently and timely as possible. In 2013/14 we achieved the 90% of admitted patients receiving treatment within 18 weeks of GP referral but we narrowly missed the 95% non-admitted patients standard.

Some of the actions being taken include working with GPs to look at having predominantly electronic referrals, rather than paper, and ensuring certain parts of the process are done within a shorter time period - for example, ensuring a patient's first appointment takes place within five weeks of receiving the GP referral, to allow more time in the 18 weeks pathway to carry out tests and ultimately complete treatment.

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.

We have seen some success in reducing the number of non urgent operations which are cancelled on the day of surgery. We know this is very distressing for patients and their families and so work has been underway to understand the reasons for non urgent operations being cancelled at short notice and we are taking action to try and limit the chances of it happening. In many instances the operation is cancelled because the patient is not fit for surgery at that point or an emergency patient requires the theatre or bed instead.

In 2012/13 6.9% of planned non urgent operations were regrettably cancelled on the day (clinical and non-clinical reasons) of surgery. In 2013/14 this figure fell to 6.7% which is the lowest for 3 years.

We continue to have very low levels of hospital acquired infections, including MRSA, *C.difficile* and Norovirus. 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 4 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 cases.

We were also set a target of no more than 77 cases of *C.difficile* by our Commissioners and we recorded 80 for 2013/14. However this was a 23% reduction in the number of cases in the previous year. We had 104 cases in 2012-13. The reduction reflects the continuation of an enhanced deep cleaning programme on our wards, careful use of antibiotics, a rigorous approach to hand hygiene and the use of stronger cleaning agents.

We constantly monitor infection rates as part of our patient safety processes. During the year prompt action was taken to investigate a small rise in surgical site infections for a particular procedure which was carried out at two theatres at the Hallamshire Hospital. As a consequence of the investigation, refurbishment work in the anterooms between the theatres was carried out to further improve infection control in that area. Patients and their GPs were also informed of the incident and follow up reviews provided.

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, 2.3% 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 £17.6 million of our total Income. The Trust delivered the vast majority of its CQUIN targets for both local Commissioners and NHS England

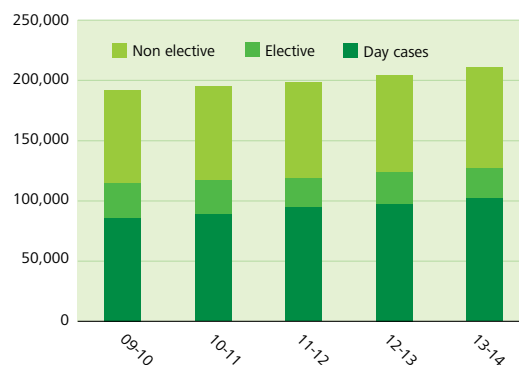
An area of improvement this year has been the reduction in the number of Never Events within the Trust. In 2012/13 we regrettably had seven Never Events. Clearly our aim is to do everything possible to limit the chances of Never Events happening at all and during 2013/14 the Trust developed and implemented a Never Event action plan which brought together the lessons learned and actions from each of the seven individual incidents. This improvement work has resulted in a drop in Never Events, with four incidents reported during 2013/14. However we aim to reduce this even further during 2014/15.

Further information about the principal risks facing the organisation and the processes in place to mitigate the risks can be found in the Annual Governance statement on pages 108 and 109.

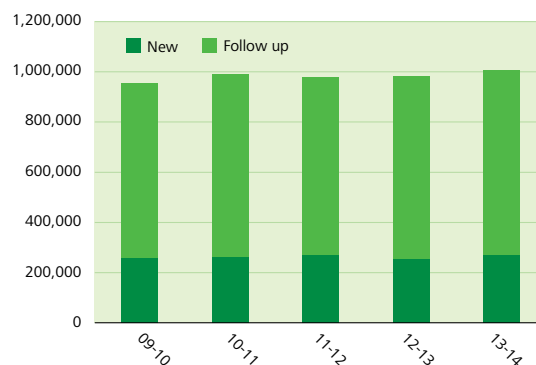
For further details of the Trust's performance see the tables on this page.

Activity trends

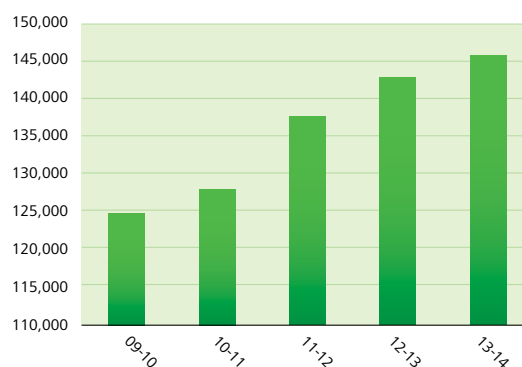
Number of completed inpatient spells



Number of outpatient attendances

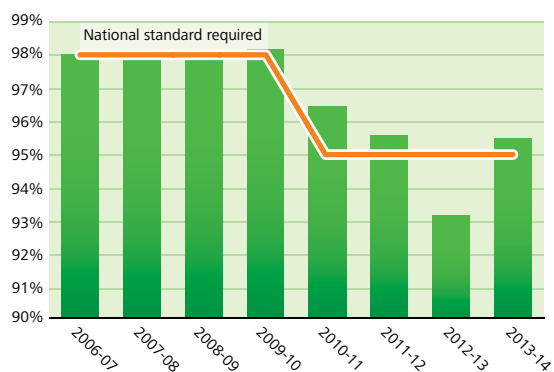


Number of A&E attendances

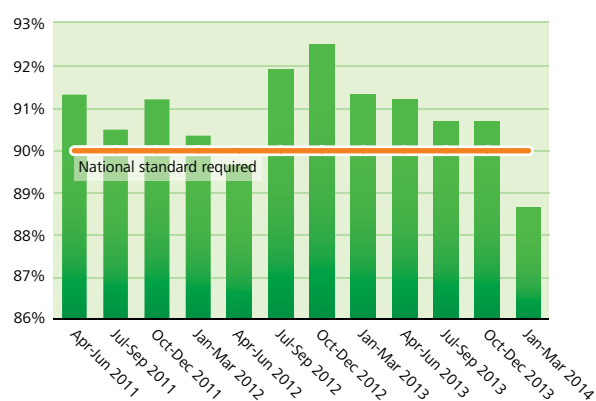


For further details of the Trust's performance see the tables on this page.

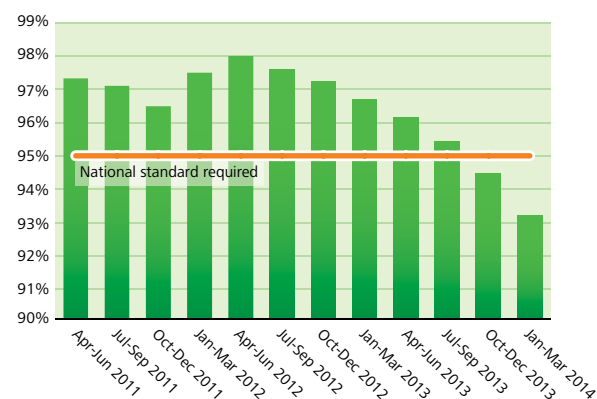
Percentage of patients treated within four hours in A&E



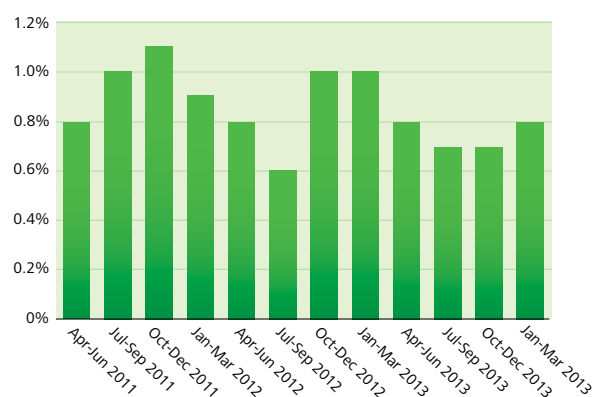
Percentage of patients starting admitted treatment within 18 weeks of referral (English Commissioners only)



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



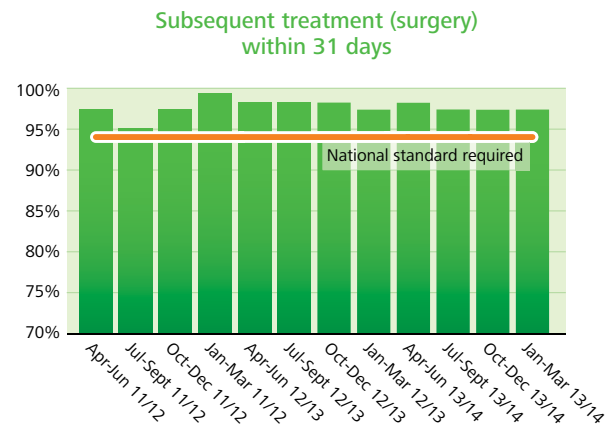
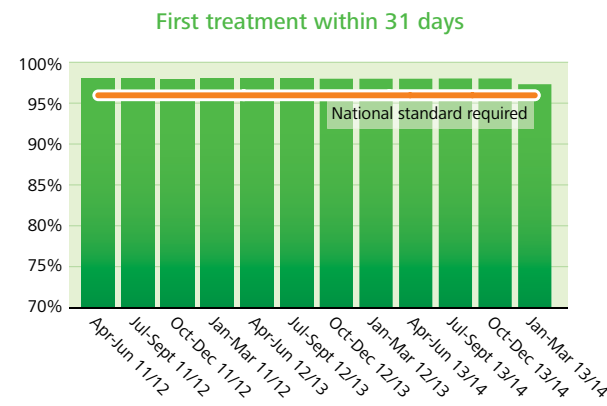
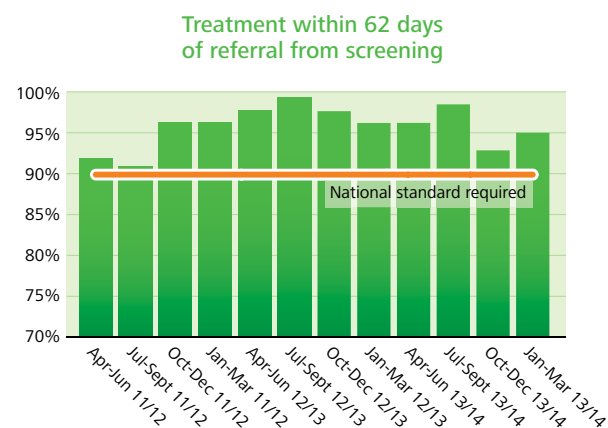
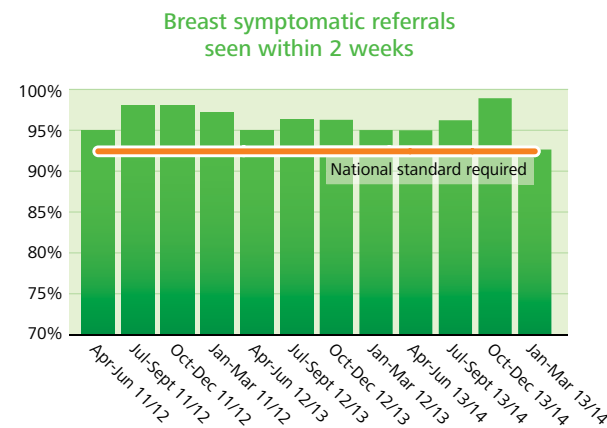
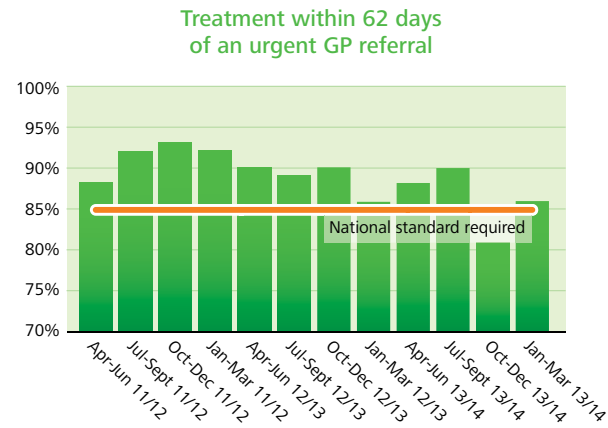
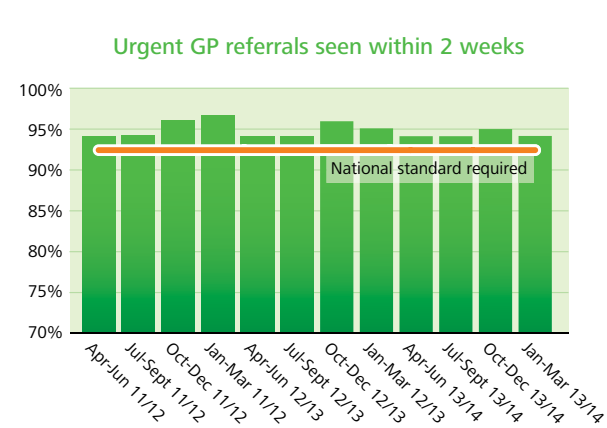
Percentage of non urgent operations cancelled due to non clinical reasons on the day of surgery

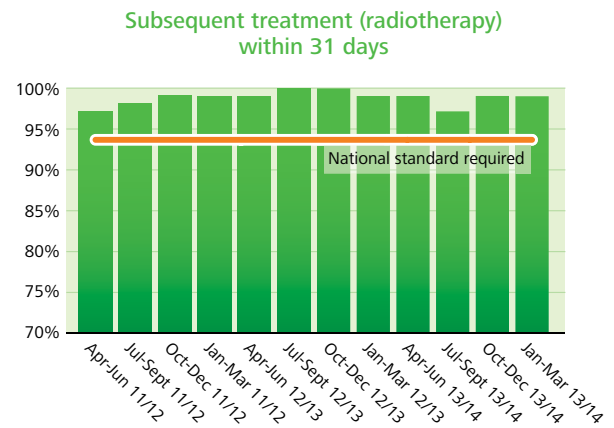
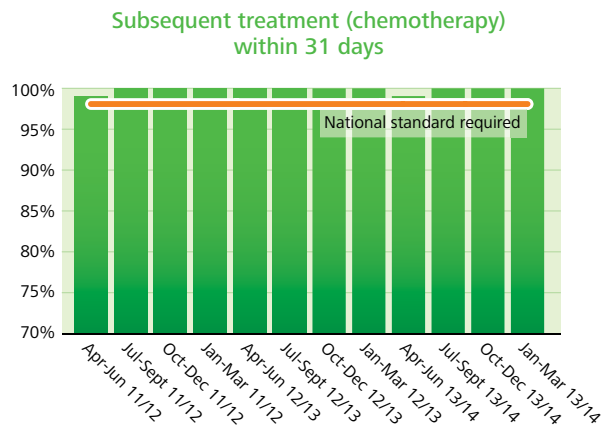


2013/14 – Community Performance

Service measure	Target	Q1	Q2	Q3	Q4
Intermediate Care Community Beds – number of admissions	N/A	298	329	361	458
Intermediate Care Community Beds – Average Stroke Length of Stay	35 days	35	37	40	39
Intermediate Care Community Beds – Average Orthomedical Length of Stay	35 days	42	44	40	45
Intermediate Care at home – patients assessed within required timescales	98%	97%	96%	96%	99%
Intermediate Care – number of packages delivered at home	Q1 – 1422 Q2 – 1422 Q3 – 1599 Q4 – 1680	1436	1508	1599	1562
Community Nursing Referrals	Q1 and Q2 – 5988 Q3 and Q4 – 7389	6804	6759	7052	6793
Community Nursing Contacts	N/A	114,410	117,010	115,299	109,054

Performance against cancer access targets





Regulatory performance

2013/14	Continuity of Services Risk Rating	Governance Rating
Quarter 1 ¹	4	Amber/Green
Quarter 2 ¹	4	Green
Quarter 3 ²	4	Green
Quarter 4 ²	4	Awaiting confirmation from Monitor

¹ For Q1 and Q2, the Trust was subject to regulation by Monitor under the Compliance Framework

² For Q3 and Q4, the Trust was subject to regulation by Monitor under the Risk Assessment Framework

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 36. The Quality Report contains details of our 2013/14 performance against clearly defined priorities and also sets out the priorities for 2014/15. The priorities have been developed in partnership with our Governors, Commissioners, Healthwatch and Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

The Quality Report also gives details of improvements and plans to encourage staff and patient involvement in the future development of services and facilities. It also provides information on clinical outcomes, listening to and responding to patient feedback, clinical audits, staff engagement and our leadership development programmes.

Patient experience

Seeking and acting on patient feedback remains a high priority for the Trust. Our overall performance in national surveys consistently compares well against other trusts and our Frequent Feedback surveys allow us to look in more detail at patient feedback at individual ward level. In the new Friends and Family Test, our scores consistently compare well nationally and we are now seeing improvements in our response rates through new initiatives including surveying some patients by text.

During 2014/15 we shall be working with the Patients' Association to survey all those who make a complaint to provide them with an opportunity to tell us about their experience.

Further information about the work undertaken to ensure we listen and respond to patient's views, complaints and suggestions please see the Quality Report.

Employ caring and cared for staff

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 PROUD values and behaviours will continue to underpin the way we lead and deliver through change in the next five years. If we are to flourish as an organisation we will need to rely on these values and ensure they guide how we work and deliver services.

The Trust has just over 16,000 employees whose skills, hard work and dedication play a significant part in the success of the Trust. We recognise the importance of positive staff engagement and good leadership to ensure good quality patient care.

During 2013/14, our Staff Engagement Strategy had a particular focus on improving both staff involvement and the appraisal rates for all staff across the Trust. During the year I am delighted to report that we increased the number of staff who had an appraisal to just over 97% and we began to introduce values and strengths based recruitment.

A number of new initiatives were introduced in 2013/14 to support health and well being (see the Directors' report). This has had a positive impact on the level of staff sickness but we are aware we have further improvements to make.

Staff sickness absence	2013/14 Number	2012/13 Number
Days lost (Long term)*	134,152	129,062
Days lost (short term)	66,097	89,279
Total days lost	200,249	218,341
Average working days lost	15.4	16.9
Total staff employed in period (headcount)	17,026	16,664
Total staff employed in period with no absence (headcount)	6,461	5,591
Percentage staff with no sick leave	37.9%	33.6%

On 31/3/14 the percentage of female staff employed was 77.89% compared to 22.11% male employees. This represented 11,808 female employees and 3,351 male employees. The Board of Directors comprised of 9 male Directors and 5 female Directors (see details of the Board of Directors on page 97 and in the Remuneration report on page 104).

Breakdown of female and male staff employed by the Trust at 31/3/2014

	%	Number
Female employees	77.89	11,808
Male employees	22.11	3,351
Female Board Directors		5
Male Board Directors		9

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 healthcare 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 2013/14 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 at:

www.sth.nhs.uk/about-us/equality-and-diversity/eliminating-discrimination-advancing-equal-opportunity-and-fostering-good-relations

In 2013 we renewed our 'two ticks' Positive About Disabled people standard and also maintained attention to the Trust as a Mindful Employer.

Sustainability and climate change.

We are proud to be a leader in the NHS when it comes to energy efficiency and sustainability, and we actively encourage our staff to support us through initiatives as diverse as recycling and walking to work.

Carbon Emissions

Emissions due to gas consumption

Annual Carbon Dioxide Emissions	tCO ₂
2007/08	26,647
2008/09	29,834
2009/10	27,677
2010/11	24,660
2011/12	19,071
2012/13	20,962
2013/14	18,274

Environmental impact performance indicators 2013/14

Area		Non-financial metric				Financial data (£,000)	Financial data (£,000)	Financial data (£,000)
		2013/14	2012/13	2011/12		2013/14	2012/13	2011/12
Waste minimisation and management	Clinical HTI	210 tonnes ⁴	183 tonnes	142 tonnes	Total Waste Cost	1,358 ³	1,164	1,179
	Clinical - Alternative	1,345 tonnes ²	1,343 tonnes	1,377 tonnes				
	Landfill	224 tonnes ¹	332 tonnes	342 tonnes				
	Recycling / Recovery	2,909 tonnes ¹	3,018 tonnes	2,285 tonnes				
Finite Resources	Water / Sewerage		318,198 m ³	374,976 m ³	Water / Sewerage			
	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							

All data in blue ex ERIC

All data in green ex STH Annual Report and Accounts 2012-13

¹ Calculated in accordance with Estates Return information Collection (ERIC) data.

² Data calculated 1.4.13-31.3.14.

³ Actual non-pay expenditure ex Integra Report for the period 1st April 2013 to 31st March 2014 = £1,358,295

⁴ Data includes Sharpsmart and waste electrical and electronic equipment (WEEE).

Emissions due to electricity consumption:

Annual Carbon Dioxide Emissions	tCO ₂
2007/08	35,133
2008/09	36,171
2009/10	34,712
2010/11	32,005
2011/12	30,038
2012/13	29,061
2013/14	29,270

Emissions due to electricity consumption have reduced by 17% since 2007/08.

Overall, energy consumption carbon emissions have been reduced by 23% since 2007/08, which exceeds the 2015 target reduction of 10% as required by the NHS Carbon Reduction Strategy.

During 13/14 the Trust invested in the following measures to reduce carbon emissions and energy consumption:

- **Replacement of power transformers at the Royal Hallamshire and Northern General Hospitals:** Replacement was necessary due to the age of the existing equipment and an increasing trend of failures. This provided an ideal opportunity for energy savings. The old transformers were replaced with new high efficiency transformers which enable voltage reduction and savings of between 6-10%.
- **Upgrading of the Food Central Production Unit at the Northern General Hospital:** The unit was refurbished and came into full production during 13/14. Systems have been installed which recover heat from refrigeration equipment and use this for heating incoming water for washing and space heating. In addition the steam system previously used for heating has been replaced by high efficiency gas condensing boilers.
- **Conversion of lighting systems to high efficient/ low energy LED (light emitting diodes) light fittings:** The following areas have been fitted with new lighting systems during 13/14 - all corridors in Brearley, Firth, Huntsman and Chesterman. The Nurses Home, M&SRC, Vickers Front Hall, Histopathology and Jessop Wing. These schemes improve lighting levels and reduce energy consumption by typically 85%.

- **Northern General Hospital – Conversion of the steam infrastructure to low temperature hot water:** This involves the replacing the existing steam systems (used for providing space heating and water heating) with a low temperature hot water system. The benefits of which are: reduced boiler house losses and distribution system losses, reduced backlog and maintenance, infrastructure modernisation and improved hygiene of domestic hot water systems and enables opportunities to consider using other low carbon technologies.

The Trust was successful in gaining a £3m contribution from the Department of Health awarded to the project which has enabled acceleration of the programme and provides saving benefits sooner than initially thought. From April 2014, the following ward blocks and buildings will be supplied from the new low temperature hot water system:

- Brearley
- Hadfield
- Day Surgery Unit
- Osborne
- Huntsman
- Firth
- Chesterman

On completion of the steam to hot water conversion, which will be achieved during 14/15; emissions will be reduced by around 4200 tonnes of CO₂ per year.

Over the next year the Trust will consider the targets post 2015, in particular, the aspiration for the NHS, Public and Social Care system to achieve a 34% reduction in CO₂ emissions from building energy use, travel and procurement of goods and services by 2020.

Trust energy and utility consumption in 2013/14 was:

Utility consumption	Energy
Water	523,348 M3
Electricity	53,685.4 GWh
Gas	98,755.25 GWh
District Heating	3,887 GWh

Financial Performance

The financial results for 2013/14 are very satisfactory in the context of the challenging period of constrained funding for public services and can be summarised as follows:

	2013/14 Plan £m	2013/14 Actual £m	Variance £m
Total income	925.9	932.9	7.0
Expenses excluding depreciation	-875.0	-880.7	-5.7
Depreciation	-30.9	-32.0	-1.1
Operating surplus	20.0	20.1	0.1
Public Dividend Capital dividend	-10.0	-9.6	0.4
Financing Costs (net)	-3.3	3.2	0.1
Surplus for the year	6.7	7.3	0.6

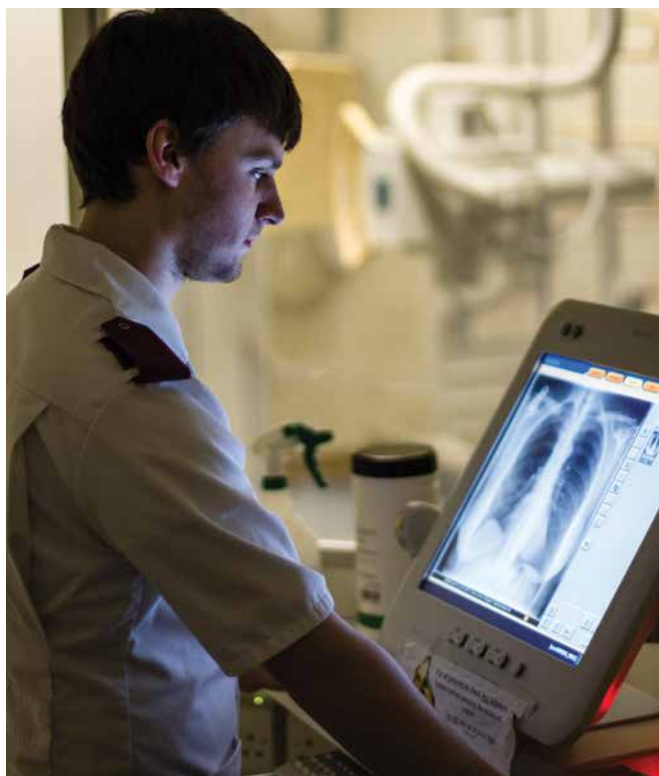
The Trust achieved a surplus from continuing operations of £7.26m (0.78% of turnover). This is marginally above the planned surplus of £6.7m. The funds generated from the surplus will be invested in the Trust's future Capital Programmes.

The Trust's income position for 2013/14 was as below:

	£m	% increase over 2012/13
Income from patient services	790.5	5.4
Other operating income	142.4	-10.8
Total Income	932.9	2.6

The Trust's income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. (See note 3.3 on page 131 in the Accounts section of this report). The Trust's other income (that which is derived from the provision of non-healthcare services) is reinvested into services / infrastructure projects for the furtherance and benefit of patient care.

Note 3.3 in the Accounts quantifies the amount of the total income of £932,870k which derives from Commissioner Requested Services, i.e. the amount received from NHS Commissioners for the provision of healthcare.



The growth in income from patient services is due to activity being significantly higher, particularly for non-elective patients, outpatients, critical care and cost per case episodes. NHS Sheffield again invested in enhancing community services but Private Patient income was marginally less than in 2012/13 at £3.7m. The decrease in other operating income is largely due to the high level (£15.4m) of reversed asset impairments (accounted for as income) in 2012/13. Education and Training income was £2.0m less than in 2012/13 following the introduction of new tariff arrangements. Charitable donations at £1.6m were lower than in 2012/13 but Research and Development income increased by £1.2m.

Pay costs rose by just under 2.5% over 2012/13 levels reflecting the significant activity increase and the general 1% pay award. Drugs costs increased by 26.0%, although it would have been nearer 10% without changed arrangements for commissioning some high cost drugs. There was a 3.2% increase in clinical supplies and services costs. Premises costs reduced by 2.5% reflecting the high level of maintenance expenditure in 2012/13. Clinical negligence costs reduced by 20.4% following the NHS Litigation Authority's introduction of new arrangements for calculating premiums which better reflect claims history. The combined depreciation, loan interest and PDC dividend charges reduced by 4.6%, largely due to lower accelerated depreciation charges than in 2012/13. There were impairment charges of £2.0m in 2013/14 compared to £18.8m in 2012/13.

Efficiency Savings

We again faced a major challenge to deliver the 4% national efficiency requirement and offset the losses on the new Education and Training tariffs. For 2013/14 the efficiency requirement was around £24m bringing the cumulative requirement for the 8 years up to 2013/14 to around £220m. We 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 additional income and contingencies. We continued to seek efficiency savings through its Efficiency Programme, with work streams under the broad headings of Clinical, Workforce, Corporate and Commercial; by developing Service Improvement capability and capacity within front-line staff; and by supporting Directorates to identify savings opportunities and deliver them. This will continue to be a key area in the future.

Capital Investment

Total capital expenditure for the year was £33.7m and is analysed below. As always, there has been a balance between promoting new service developments whilst maintaining investment in our existing infrastructure, information technology, medical equipment and statutory and regulatory needs in order to improve the service to patients across the Trust.

	£'000	£'000
Service Development	9,763	
Surgical Robot		2,272
A&E Expansion		1,877
Car Parks		1,167
NGH Clinical Skills Refurbishment		810
WPH Complex Therapies Unit		786
Urology OPD		637
Diabetes/Endocrinology Outpatients		632
6 Claremont Place Refurbishment		428
Other smaller schemes/adjustments		1,154
Infrastructure	9,241	
Low Temperature Hot Water System		4,067
Catering Infrastructure		2,318
Ward Refurbishments		1,509
Lift Refurbishment		303
Other		1,044
Medical Equipment	11,682	
Equipment Replacement Programmes e.g., Scopes, Patient Monitors, Anaesthetic Machines and Dialysis Machines		3,427
Linear Accelerator		1,155
RHH Angiography Rooms		1,479
NGH Vascular Angiography Rooms		1,351
Other		4,270
Information Technology	2,875	
IT Infrastructure Modernisation (including New Corporate Desktop)		1,241
Wi-Fi and Mobile Working		267
Electronic Patient Record		198
Electronic Document Management System		162
Clinical Portal		132
Other		875
Statutory Compliance	160	
Other (e.g. Fire Safety, DDA compliance etc.)		160
Total Expenditure	33,721	



Total capital income available to the Trust for the year was £43.0m. This can be analysed as follows:

	£'000
Resources available from the Department of Health / Internally Generated	41,358
Other Donations / External Income	1,626
Total Income	42,984

Overall, therefore, there was a £9.26m underspend on the Capital Programme due to slippage on schemes, particularly around the Trust's new IT Programme. The unused resources are carried-forward and will be used to complete the planned investments in due course.

Cash Flow and Balance Sheet

Our net assets employed at 31 March 2014 were £406.1m compared with £385.9m at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2014 was £433m including assets for community services now transferred from the former Sheffield PCT. Outstanding "borrowings" relating to Foundation Trust Financing Facility loans, a PFI contract and a Finance Lease totalled £51.6m at the year-end.

Net current assets at 31 March 2014 were £20.2m but there is around £20m of resources committed to capital schemes in future years. The cash balances of £76.2m are very healthy but in addition to the capital funding commitment referred to above there are many other liabilities. The Trust has had a strategy since its creation as a Foundation Trust to gradually improve its working capital position in order to provide a degree of financial security. This now looks particularly crucial given the difficult years ahead and its importance in Monitor's new Continuity of Services Risk Rating for assessing provider financial risks.

On the Continuity of Services Risk Rating of one to four, where one represents very high risk and four very low risk, the Trust achieved a risk rating of four for 2013/14.

Conclusion

Overall, therefore, our 2013/14 financial results are very satisfactory, particularly when set alongside excellent service performance and the challenging financial environment. However, it is abundantly clear that, along with the rest of the NHS, we face an immensely difficult future as demands on services continue to grow and funding seems likely to remain constrained.

We remain committed to delivering high quality services and to achieving real efficiency savings to address the future financial pressures and to protect and invest in our services. However, it is unclear if the current financial and service parameters for the NHS will remain sustainable for much longer and, as always, national policy will have a major impact on the Trust.

Further details on the financial performance of the Trust can be found on page 118. The accounts for the year ended 31 March 2014 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.

Pensions, retirement and senior employees' remuneration policies.

Heading

Accounting policies for pensions and retirements are set out in Note 1.3 of the Accounts. Policies and details of senior employees' remuneration are set out in the Remuneration Report on Pages 101 – 105, and in Notes 4.4 and 4.5 of the accounts.

Commissioning arrangements for clinical services

We have continued to develop close working relationships with our major commissioners during 2013/14, in particular NHS Sheffield Clinical Commissioning Group, NHS England and Sheffield City Council.

NHS Sheffield Clinical Commissioning Group (CCG) is a clinically-led membership organisation. It is the coordinating commissioner for a consortium of other CCGs in Yorkshire, Humberside and the East Midlands.

It published its five year Integrated Commissioning Plan in 2012. The plan has four priority aims:

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

The stated ambitions of the CCG over the next 5 years are:

- All those who are identified to have emerging risk of admission through risk stratification are offered a care plan, agreed between them and their clinicians
- To establish integrated primary care and community based health and social care services, care planning, and holistic long term conditions management to support people living independently at home and to reduce emergency admissions by up to 20%
- To minimise repeated trips to the GP and hospital for specialist diagnosis and monitoring of health problems, replacing them with community and home based services that make best use of technology, and keep people at the centre of their care
- To reduce the gap in life expectancy for people with mental health problems and learning disabilities
- To put in place support and services that will help all children to have the best possible start in life

NHS England (NHSE) published its commissioning intentions for prescribed specialised services in October 2013. Their strategic commissioning approach has six strands:

- Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit
- A Clinical Sustainability Programme with all providers, focused on quality and value
- An associated Financial Sustainability programme with all providers, focussed on better value
- A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.
- Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways
- A systematic rules-based approach to in-year management of contractual service delivery

We are working closely with NHSE to improve quality and outcomes for patients. We assessed our services against NHSE published service specifications during 2013, and for the majority of the specialised services we provide we meet the high standards required by NHSE. For a very small number of services we continue to work with NHSE to deliver full compliance.

A range of Public Health services including Integrated Sexual Health, Oral Health Promotion and community dietetics and clinical weight management programmes are commissioned by Sheffield City Council.

Commercial Development

During the year a small commercial team was established within the Strategy and Operations Directorate to focus on diversifying our income base and to provide expertise on commercial opportunities.

One of the first priorities was to establish a more robust approach to commercial tendering. This is in response to an increasing number of NHS contracts which are subject to a competitive procurement process. A new Trust policy is now in place, which enables the Trust respond more effectively to current and future tenders. In March 2013 the Trust was successful in being awarded the contract to provide an Occupational Health Service for Sheffield Hallam University for the next five years.

The Trust provides a number of services to patients who wish to pay separately for their care or who have private medical insurance. We have started to develop our existing services further and now offer a wider range of services to private patients, which will continue to expand over time. A new policy will be in place during 2014 to help govern our practice and to establish a basis for this growth. As part of this work, we have engaged with our consultants to ensure that our primary responsibility as an NHS provider remains our focus.

We have recently established links with Healthcare UK which is a joint initiative of the Department of Health, UK Trade and Investment and NHS England. Through these links we intend to build on our reputation for providing high quality care and clinical excellence and to begin scoping commercial opportunities working with overseas partners.



Sir Andrew Cash OBE
On behalf of the Board of Directors
22 May 2014



In hospital and in the community

proud to make a difference

Sheffield Teaching Hospitals **NHS**
NHS Foundation Trust

Annual Quality Report 2013/14



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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.

Part 1

1.1 Statement on quality from the Chief Executive



At Sheffield Teaching Hospitals we remain committed to delivering the best clinical outcomes and a high standard of patient experience to patients both in our hospitals and in the community. Thanks to the dedication and professionalism of our 16,000 staff we

have a strong track record in this area but we are never complacent and continually look to adopt best practice, drive innovation and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

This drive for improvement is embodied within the Trust's Corporate Strategy 'Making a Difference'. The strategy outlines five overarching aims:

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation.

These aims have resulted in a range of organisational objectives that guide the development of directorate business plans as well as personal objectives. This Quality Report details the achievements and performance during the second year of this strategy (2013/14).

Throughout 2013/14 there have been further improvements in the quality of our care such as a reduction in healthcare associated infections, specifically a reduction in *Clostridium difficile* rates which is now at an all-time low.

During 2013 more than £3m pounds was invested in expanding the Accident and Emergency Department at the Northern General Hospital to provide a better patient experience and to accommodate the growing numbers of people using our service. In this time attendance at our Accident and Emergency Department remained high, however our waiting times improved. In 2012/13, 93.2% of patients were seen within four hours or less, this improved in 2013/14 with 95.7% of patients being seen within four hours or less.

In September 2013 the Care Quality Commission (CQC) conducted a routine unannounced inspection of the Trust. Inspectors visited Jessop Wing, Royal Hallamshire Hospital, Northern General Hospital and Weston Park Hospital to observe care on wards and in theatres. The inspection reports were very positive and the Trust was found to be compliant with all the standards that had been inspected. Where the inspectors commented on areas where care or patient experience could be enhanced even further, we have developed our own internal action plan to achieve this wherever possible.

Ensuring waiting times are kept as low as possible is a priority as we know this is one of the things which patients tell us is important to them. We also want to make sure our waiting times processes and procedures are robust and enable our patients to receive swift and appropriate treatment. During 2013/14 we carried out a planned review of Cancer Waiting Times in response to the CQC inspection into Colchester Cancer Services and waiting times. The Trust is satisfied that similar issues are not present in our services and we continue to do all we can to ensure patients do not wait any longer than necessary for care.

We also take great care to accurately report waiting times for treatment to assist patients in making an informed choice about where to have their treatment. We have undertaken a review of our waiting lists to ensure that they correctly reflect the patients that still require treatment. We have also published a revised policy titled 'Access Policy - Managing the 18 Weeks Referral to Treatment Waiting Times'. Implementation of the revised policy will ensure we continue to provide fair and equitable access for patients.

An area of improvement this year has been the reduction in the number of Never Events within the Trust. In 2012/13 we regrettably had seven Never Events. Clearly our aim is to do everything possible to limit the chances of Never Events happening at all and during 2013/14 the Trust developed and implemented a Never Event action plan which brought together the lessons learned and actions from each of the seven individual incidents. This improvement work has resulted in a drop in Never Events, with four incidents reported during 2013/14. However we aim to reduce this even further during 2014/15.

Seeking and acting on patient feedback remains a high priority for the Trust. Our overall performance in national surveys consistently compares well against other trusts and, for key areas where performance is lower, actions are agreed to make improvements. Our Frequent Feedback surveys allow us to look in more detail at patient feedback at individual ward level. By focussing on a small number of important aspects of patient experience, we have seen improvements in these key areas. In the new Friends and Family Test, our scores consistently compare well nationally and we are now seeing improvements in our response rates through new initiatives including surveying some patients by text. We are planning work throughout the year to further improve the effectiveness of the complaints process. During 2014/15 we shall be working with the Patients' Association to survey all those who make a complaint to provide them with an opportunity to tell us about their experience.

Part 1

1.1 Statement on quality from the Chief Executive

The official Government response to the Mid Staffordshire Public Inquiry 'Hard Truths' has now been published outlining how the whole health and care system will prioritise and build upon the previous work already undertaken following the Robert Francis QC report. As a Trust we have outlined our response to the Mid Staffordshire Public Inquiry in Part 2 of this Quality Report. We have also selected one of our key quality objectives for 2014/15 directly from the Government's 'Hard Truths' report. This is to ensure that every hospital patient should have the name above their bed of the consultant and nurse responsible for their care. More details can be found in Part 2 of this Quality Report.

Good staff engagement and involvement is key to the Trust's ongoing delivery of high quality care. In response to staff feedback a number of initiatives have been taken up throughout the year including the introduction of uniforms for Nurse Directors, and senior nursing staff to ensure patients and staff can easily recognise senior nursing staff. All Nurse Directors and the Chief Nurse, already carry out clinical shifts on wards every month to ensure they continue to experience first-hand the care being delivered and also to understand the challenges and opportunities nursing teams face. Throughout 2014 this initiative will be expanded to involve other senior managers who will also work alongside members of staff from a variety of clinical and non-clinical departments in order to further their understanding of the patient and staff experience.

In 2013/14, the Trust approved a £35m investment in technology which will provide the opportunity to transform the way we deliver care both within the hospital and also in people's own homes and communities. This 5 year programme will also enable the organisation to become paperlight and support the work underway to develop integrated care teams and new models of care.

The programme will oversee the implementation of three major systems; an electronic patient record, an electronic document management system, and a clinical portal. This will provide clinicians with the information they need, at all times and in all locations. It will improve patient safety and our communication with patients, increase operational effectiveness (releasing time to care) as well as supporting clinical practice and research.

The following pages detail more of the improvements we have made during 2013/14 and also some of our key priorities for the coming year. However, across the entire organisation, a culture of learning and continual improvement will continue to be encouraged and I am in no doubt that this will lead to further developments which result in the delivery of high quality patient care for 2014/15.

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



Sir Andrew Cash OBE

Chief Executive

22 May 2014

Part 1

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 2013/14. 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 goes some way to reassure our patients and the public of our commitment to deliver safe, effective and high quality care.

As a Trust we have consulted widely on which quality improvement priorities we should adopt for 2014/15. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with representatives from NHS Sheffield Clinical Commissioning Group (CCG), Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. We have held several meetings with Healthwatch enabling us to incorporate their comments and feedback in the production of this Quality Report, and have also taken into account the comments and opinions of internal and external parties on the 2012/13 Report.

The Quality Report Steering Group, whose membership includes Trust managers, clinicians and 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 Trust, also forms part of this group's remit.

The proposed quality improvement priorities for 2014/15 were agreed by the Trust's Board of Directors, Healthcare Governance Committee, on 28 April 2014. The final draft of the quality report was sent to external partner organisations for comments in March 2014 in readiness for the publishing deadline of the 30 May 2014.

A handwritten signature in black ink, appearing to read 'D Throssell', written in a cursive style.

Dr David Throssell
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement 2012/13 and 2013/14

Our 2012/13 and 2013/14 priorities are summarised below and explained further in this section.

2012/13 Objectives	2012/13	2013/14
Optimise length of stay (see 2.1.1) Through a systematic process of review areas will be identified for improvement across the organisation. National benchmarks (Dr Foster benchmark comparators) will be used to assess areas where the length of stay could be appropriately reduced without impact on the quality of care or outcomes.	▼	▼
Discharge letters for GPs (see 2.1.2) 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.	=	▲
Giving patients a voice – Make it easier to communicate with the organisation (see 2.1.3) 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 more effective publicity to encourage patient feedback and communicating that improvements have been made as a consequence of patients views/suggestions,(e.g. 'you said – we did').	▲	See 2.1.3
Review mortality rates at the weekend (see 2.1.4) Review in detail the Trust's position with regard to mortality at the weekend and identify any significant differences, review causes and implement improvements if required.	▲	▲
Improve Dementia awareness (see 2.1.5) The Trust is dedicated to improving dementia awareness with our staff and meeting the needs of patients and carers with this condition. We will undertake environmental audits across all appropriate directorates so that improvement plans can be developed to address the needs of patients and carers experiencing dementia. (Link to the King's Fund Dementia work and ward essential maintenance programme).	▲	▲
2013/14 Objectives	2012/13	2013/14
Patient Experience: Cancelled Operations (see 2.1.6) Reduce the number of operations cancelled on the day of surgery.	New for 2013/14	▼
Patient Safety: Pressure Ulcers (see 2.1.7) Reduce the prevalence of Grade 2, 3 and 4 pressure ulcers reported within the Trust acute and community based services, including both ulcers acquired whilst receiving Trust care and community-acquired pressure ulcers.	New for 2013/14	▼
Clinical Effectiveness (outcomes): Improve discharge information for patients (see 2.1.8) Improve the provision of discharge information for patients by auditing the information provided and available for patients against Trust wide standards.	New for 2013/14	=

Key	= Almost achieved	▲ Achieved	▼ Behind schedule
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Priorities for Improvement and Statements of Assurance from the Board

Update on objectives 2012/13

2.1.1 Optimise length of stay

Trustwide performance

2011/12	2.9 days
2012/13	2.8 days
2013/14	2.7 days

A number of initiatives have been introduced to facilitate patient flow, including meetings where patients with a length of stay over 15, 35 and 56 days are reviewed and action taken to resolve any unnecessary delays. Daily and weekly review of patients who are medically fit for discharge and regular monitoring of medical outliers (where the patient is in a speciality bed which is different from their current condition) also takes place.

Detailed admission/discharge and bed occupancy reports are also available to directorate management teams to allow them to focus resources in the most appropriate areas. A number of new matron posts have been introduced to support improved flow across the organisation.

In addition, the Trust works with partners as part of the Right First Time city wide health and social care partnership to improve patient flow across the health economy. Furthermore, the Trust has committed to integrating the Community Services and Geriatric and Stroke Medicine Directorates during 2014 to help streamline pathways for older people. This should in turn help improve the seamlessness of pathways, and support efforts to reduce hospital length of stay.

Pharmacy has an ongoing comprehensive action plan to reduce delays in the provision of discharge medication which acknowledges that there is no single cause of delay so there is no simple quick fix available.

The installation of an electronic prescribing system in the Trust will alleviate many of the existing issues, but at present pharmacy action focuses on continuing to improve current systems and processes, supplemented by two major change initiatives, namely the installation of automated robotic dispensing at the Northern General Hospital and the outsourcing of outpatient dispensing at the Royal Hallamshire Hospital to Boots. This has permitted the redeployment of STH pharmacy staff to improve inpatient services.

The Trust has also set up a multidisciplinary Task and Finish Group under the chairmanship of a Deputy Medical Director to address wider issues which are outside of the scope of pharmacy to address.

Optimising length of stay will continue to be a priority for the Trust during 2014/15.

2.1.2 Discharge letters for GPs

The Trust has completed the rollout of e-discharge summaries which enable clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs. This is automatically populated with key patient information, a significant area for improvement which was identified in the original review. Each week reports are sent to consultants where discharge summaries have not been completed, so this can be rectified as a priority.

Sheffield Clinical Commissioning Group have surveyed GPs to look at the impact of the new e-discharge summaries with some very positive feedback being received.

Evaluation will continue and any areas for improvement will be addressed by the project team.

2.1.3 Giving patients a voice – Make it easier to communicate with the organisation

During 2013/14, 6,819 Frequent Feedback surveys and 684 comment cards were completed. This compared with 4,914 Frequent Feedback surveys and 2,857 comment cards completed during 2012/13. Whilst comment cards are still widely available across the Trust, we are no longer distributing these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to give the comment cards out at the same time as the FFT cards would be confusing for patients. In the FFT, we are now seeing improvements in our response rates through new initiatives including surveying some patients by text.

2.1.4 Review mortality rates at the weekend

The Trust has continued to review weekend mortality during 2013/14, finding that our Hospital Standardised Mortality Ratio for weekday and weekend emergency admissions is both 'within expected range'. However, given the importance of mortality rates and continual monitoring to ensure that any variance can be spotted quickly and acted upon, it has been agreed that this will again be a priority for improvement for 2014/15.

Working in collaboration with the Improvement Academy of the Yorkshire and Humber Academic Health Science Network the Trust is exploring the potential for external case note review of a sample of deceased patients. It is anticipated that this work will provide further insights and learning. This work also aligns with the stated intentions of NHS England in response to the Mid Staffordshire Public Inquiry outcomes.

Priorities for Improvement and Statements of Assurance from the Board

2.1.5 Improving Dementia Awareness

The Trust is dedicated to improving dementia awareness. A discreet symbol is being developed to enable staff to easily recognise patient suffering with dementia. This symbol will then prompt staff to refer to a booklet filled in by the patient, or anyone that may know them well such as their family or carers. This 'All About Me' booklet describes the patient's preferences, needs and routines and is kept by the bedside to allow staff easy reference during routine interactions.

At the Northern General Hospital, Vickers 4 is undergoing an improvement scheme which includes adding a bathroom to the building, as all other facilities are wetrooms with showers. Bedside televisions have been removed from certain areas to avoid causing some patients confusion and distress, though this is reviewed on an individual basis.

A specific session on dementia awareness is currently included in the Trust induction for all members of staff, both clinical and non-clinical with 1,256 staff having attended during 2013/14. More comprehensive training is also available for those who regularly care for people with dementia to ensure they are equipped to care for this patient group. There are six e-learning courses associated with dementia and these were completed by staff a total of 1099 times throughout 2013/14. Also 205 staff have attended the University of Sheffield bespoke study day for dementia and delirium during 2013/14.

Objectives 2013/14

2.1.6 Patient Experience – Cancelled Operations

In 2012/13 7% of planned operations were regrettably cancelled on the day (clinical and non-clinical reasons) of surgery. We fell short of our target to reduce this figure to 4% by April 2014 however, the number of cancellations was less than in 2012/13.

The target figure of 4% is a locally driven target and was agreed at the Trust's Surgical Board following an audit.

Year	Cancelled Operations for Clinical and Non-Clinical reasons	Total planned operations	% on day cancellation rate
2011/12	2,300	33,568	6.9%
2012/13	2,394	34,364	7%
2013/14	2,392	35,762	6.7%

*This data is for Main Theatres and the Day Surgery Units at the Northern General Hospital and the Royal Hallamshire Hospital.

The top five reasons for cancellations at the Trust account for 65% of all on-day cancellations at the Trust and these are:

- patient unfit - hospital decision: patients arriving with an infection, or having results of standard tests outside of expected ranges (e.g. high blood pressure)
- patient did not attend - the patient did not arrive for the scheduled appointment
- operation not required - symptoms that have improved or disappeared
- patient cancelled or refused treatment - patients changing their mind, or unable to attend the scheduled date for surgery
- lack of theatre time - previous cases on the list taking longer than expected; changes to the order of a list resulting in (or as a result of) delays

The top five reasons for cancellations at the Trust were the same for 2011/12 and 2012/13.

To achieve this target by 2015 a number of actions are underway, including trialling a system in Orthopaedics and General Surgery whereby nurses call patients at three days' notice to confirm their intended attendance. In high volume and cost areas such as Orthopaedic Surgery, Plastic Surgery, General Surgery and Ophthalmology, root cause analysis of cancellations will be a weekly exercise and key trends will be identified to inform improvement actions.

We have improved and shortened the patient letters in Orthopaedics and the Day Surgery Unit and patients are asked to confirm by telephone that they will be keeping their appointment. Instructions regarding not eating before an operation are clearer than before and much of the information that was previously in the letter is now sent out in an inpatient handbook so the letter is focused on the admission details only. A similar review of letters is taking place in General Surgery.

Posters providing patient information on how to ensure their operation goes ahead as planned have been displayed in pre-operative assessment areas. Plans are underway for a patient information campaign on cancellation avoidance and the cost and impact of on-day cancellations.

The Surgical Pathway Group will discuss, develop and implement a patient information campaign regarding avoidable on-day cancellations and also a trial of text messaging for admissions.

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A management of cancellation policy will be discussed by the Surgical Board to detail the actions to be taken where no verbal confirmation can be made with patients in the days before their planned admission.

On-day cancellations will continue to be a priority during 2014/15 as the Trust views this as a significant area of concern.

2.1.7 Patient Safety – Pressure Ulcers

In order to try to reduce the prevalence of pressure ulcers from 5.95% in 2012/13 to 5% the Trust has established a project board, strengthened the Hospital Tissue Viability Team, effectively managed the supply of pressure relieving devices and improved data quality and information.

2012/13 performance figures:

Monthly survey data for the period from October 2012 to March 2013:	
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.77%
Proportion with pressure ulcers prior to receiving care from the Trust	4.18%
Overall proportion	5.95%

2013/14 performance figures:

Monthly survey data for the period from October 2013 to March 2014:	
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.41%
Proportion with pressure ulcers prior to receiving care from the Trust	4.31%
Overall proportion	5.72%

Whilst the proportion of patients acquiring pressure ulcers whilst receiving care from the Trust has fallen by 0.36%, a 20% reduction, the proportion of patients acquiring pressure ulcers prior to receiving care from the Trust has increased by 0.13% which has meant the total reduction is 0.23%.

Further work within the hospitals is planned including the identification of patients at risk of developing a pressure ulcer, instigation of early intervention by the Pressure Ulcer Prevention Team, and targeted work with clinical areas with a high prevalence of pressure ulcers.

Initiatives have also been undertaken by the Hospital Tissue Viability Team in the community and include:

- an audit of practice against National Institute for Health and Care Excellence (NICE) recommendations for pressure ulcer prevention and pressure relieving equipment
- the implementation of an electronic wound template within the patient's electronic record (System1), where wound details and grade of pressure ulcer can be recorded
- the introduction of cameras to enable wound imaging, which can be attached to the electronic record and viewed remotely by the Tissue Viability Team
- work with the care home support team to develop, support and provide education to pressure ulcer link workers in care homes.

Further work is planned including a project for a Tissue Viability Nurse to work alongside a community team to understand the prevalence of pressure ulcers within their patient group.

The Tissue Viability Nurse will:

- consider the grade, chronicity and anatomical location of pressure ulcers
- evaluate the accuracy and completeness of risk assessments and review, and prevention care planning
- assess staff skills in pressure ulcer prevention, accuracy of reporting and grading and the use of the electronic template and wound images
- review progress with previous root cause analysis work and the implementation of the action plans developed as a result of previous pressure ulcers.

Work also continues to improve the quality of the data recorded and the information available to the clinical areas. Currently the information used to measure performance against the Commissioning for Quality and Innovation (CQUIN) target is taken from the Safety Thermometer (A national data collection instrument that collects incidence data once a month across all patients, hospital and community). This data collection tool has a number of limitations and work is underway in the Trust to enhance the information collected in order to better inform patient care. This will continue to be a priority for the Trust during 2014/15.

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2.1.8 Clinical Effectiveness (Outcomes) - Improving Discharge Information

Since May 2013, 628 patient information leaflets have been checked and revised. Of these 243 (39%) have had changes made to their discharge information. This work will be ongoing until all 1,500 leaflets within the Trust have been checked and updated. Due to the volume of leaflets it is anticipated that it will take a further 18 months before this work is completed.

Audit work identified two departments where discharge information could be more effective (Accident and Emergency Department and Urology Department). Both have received support to make improvements to their information.

All patient information leads/coordinators have been asked to review the practice of providing patients with information within their department/care group. In particular they have been asked to ensure that information is routinely given to patients upon discharge. A more robust mechanism for routinely providing discharge information is currently being investigated with the I.T department. This would involve adding details of patient information leaflets to the electronic discharge summary. This is likely to be a significant project and will need further planning during 2014/15.

Work is also currently underway to improve access to patient information via the Trust website. This will ensure patients and their families have access to leaflets after they have been discharged. Online access to patient information will be available by the end of April 2014.

2.1.9 Priorities for Improvement 2014/15

This section describes the Quality Improvement Priorities that have been adopted for 2014/15. These have been agreed by the Quality Report Steering Group in conjunction with patients, clinicians, Governors, Healthwatch and NHS Sheffield CCG. These were approved by the Trust Board of Directors, Healthcare Governance Committee, on 28 April 2014. 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 2014/15 are:

1. To ensure that every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time.
2. To improve complainant satisfaction with the complaints process.
3. To review mortality rates at the weekend and to focus improvement activity where necessary.
4. To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment).

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) Framework (see page 56).

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2.1.10 Detailed objectives linked to Improvement Priorities

Priority 1

Our Aim	To ensure that every hospital inpatient knows the name of the consultant responsible for their care during their inpatient stay and the name of the nurse responsible for their care at that time.
Past Performance	Whilst previously many ward areas used small notice boards above the bed to indicate the patient name and consultant, usage is now variable across the Trust. These were stopped in some areas due to concerns about confidentiality. However, where the boards are used they do not usually specify the nurse responsible for the patient's care on each shift.
Key Objectives	<ol style="list-style-type: none">1. To discuss this concept with senior sisters from across the Trust.2. To form a small working party to agree the standards for displaying the information about the consultant and the nurse, and to lead on delivering objectives 3-6 below.3. To consider options for practical ways of displaying this information, recognising that the physical environment of departments may differ.4. To ensure that procedures for gaining appropriate consent to display the patient's name are put in place, and that the patient or their family are consulted about how the patients name should be displayed, e.g. first name and surname or title and surname.5. To ensure that the initiative is implemented across hospital inpatient areas through 2014/15.6. To consider how compliance with this standard can be monitored.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. This will include measures delivered by the working party to demonstrate compliance and ongoing monitoring.
Board Sponsor	Professor Hilary Chapman Chief Nurse
Implementation lead	Chris Morley Deputy Chief Nurse

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Priority 2

Our Aim	To improve complainant satisfaction with the complaints process.
Past Performance	<p>The Trust remains committed to learning from, and taking action as a result of complaint investigations.</p> <p>Whilst satisfaction surveys of complainants are currently used, these are ad hoc and do not always provide enough detail to ascertain exactly where improvements are required. A new process was implemented in March 2014, whereby a sample of 30 complainants will be interviewed every 12 months, and from April, all complainants will receive the Patients' Association complainant satisfaction survey. This will provide baseline data and an ongoing measure of changes over the next 12 months. In addition, the survey will enable benchmarking against other trusts who also participate in the survey programme.</p>
Key Objectives	<ol style="list-style-type: none"> 1. To establish a baseline measure of complainant satisfaction for the following key measures: <ul style="list-style-type: none"> • % of respondents who feel their complaint against the Trust has been resolved • % who feel their complaint was dealt with quickly enough • % who were 'very satisfied' with the final response • % who feel that overall their complaint was handled 'very well' 2. To benchmark performance in relation to key measures with other trusts. 3. To set improvement targets for each measure and agree an action plan to work towards achieving these. 4. To measure and report performance against improvement targets.
Measurement and Reporting	<ol style="list-style-type: none"> 1. Working with the Patients' Association, baseline satisfaction will be measured from April 2014 by means of a survey sent to all complainants. In addition, a sample of 30 complainants will be interviewed during March 2014 and January 2015. 2. An interim report will be provided in October 2014, when the first survey baseline and benchmark data is available. 3. A report on performance against targets will be produced when the next survey data is available in April 2015.
Board Sponsor	Professor Hilary Chapman Chief Nurse
Implementation lead	Mrs Sue Butler Head of Patient Partnership

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Priority 3

Our Aim	<p>To review mortality rates at the weekend and to focus improvement activity where necessary.</p> <p>The review of weekend mortality rates will also include a review of bank holiday mortality rates.</p>
Past Performance	<p>This theme was a Quality Objective for the Trust in 2012/13 at which time the Trust reported:</p> <p><i>'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)'</i></p> <p>Quality Report 2012/13 page 39.</p> <p>Since this time the Trust has continued to develop its methods of analysis and there is a possibility that further understanding could be gained. In addition, it has become clear during discussions with Governors that some patients are reluctant to undergo surgical procedures on Fridays because of a perception that the risk of postoperative problems will be higher over the following weekend. Some patients decline surgery at the end of the week for this reason.</p> <p>Working in collaboration with the Improvement Academy of the Yorkshire and Humber Academic Health Science Network the Trust is exploring the potential for an external review of a sample of case notes of deceased patients. It is anticipated that this work will provide further insights and learning. This work also aligns with the stated intentions of NHS England in response to the Mid Staffordshire Public Inquiry outcomes.</p>
Key Objectives	<ol style="list-style-type: none">1. In collaboration with the Mortality Steering Group, to put in place a process to which will allow the external review of a sample of patient notes to be carried out.2. To analyse and interpret the findings to establish if any lessons can be learnt.3. Depending on the findings, to establish improvement work streams to address the areas for improvement.
Measurement and Reporting	<p>Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. This will include mortality ratio measurements, for example Hospital Standardised Mortality Ratio (HSMR) data.</p>
Board Sponsor	<p>Dr David Throssell Medical Director</p>
Implementation lead	<p>Dr Andrew Gibson Deputy Medical Director</p>

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Priorities for Improvement and Statements of Assurance from the Board

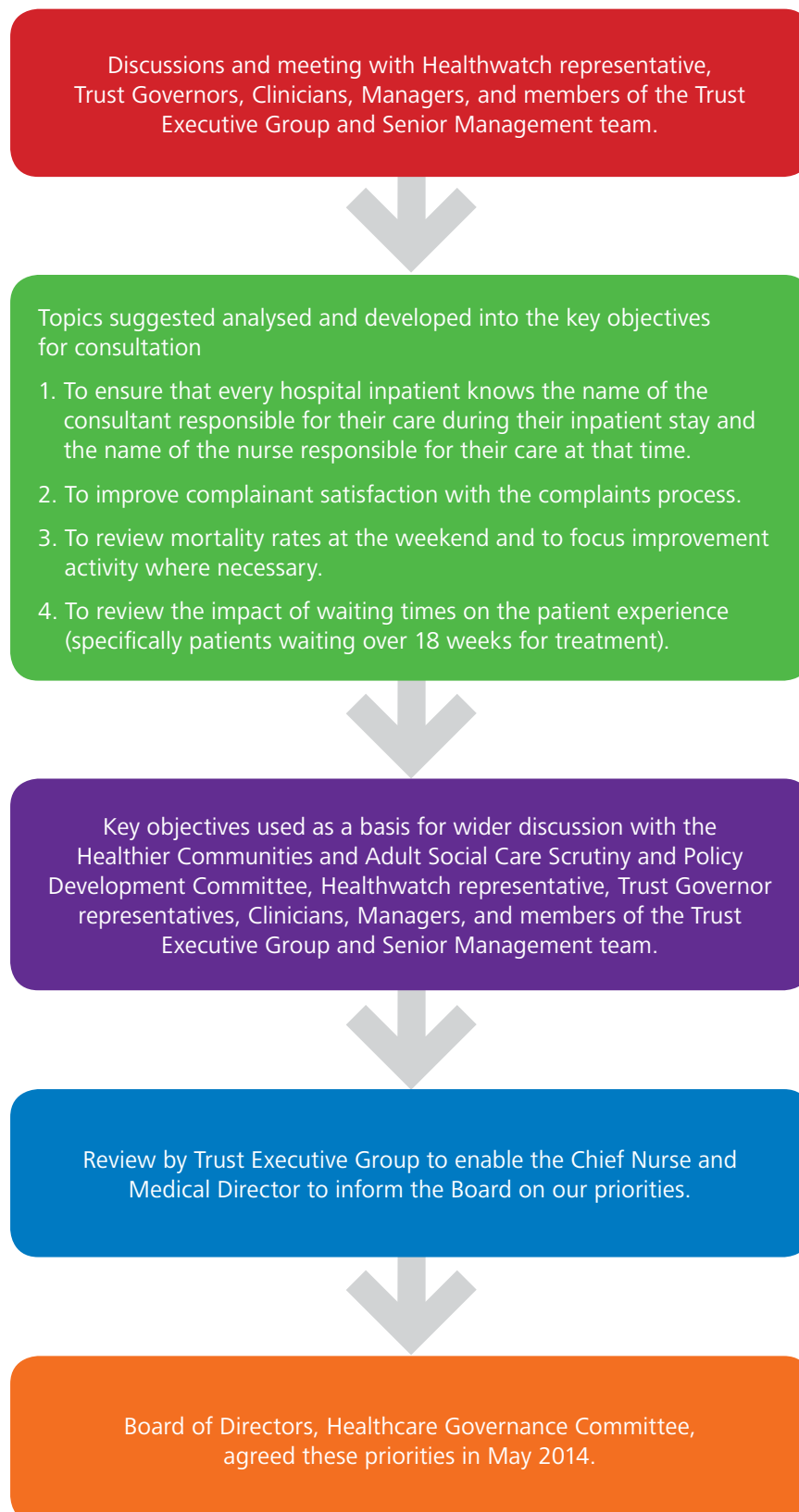
Priority 4

Our Aim	To review the impact of waiting times on the patient experience (specifically patients waiting over 18 weeks for treatment).
Past Performance	<p>Waiting for an appointment or treatment can be stressful for the patient and their carers and may significantly impact on the overall patient experience. There is a national target which specifies that the length of time between first referral and treatment should be no longer than 18 weeks. The Trust has a number of plans and strategies in place to reduce the length of time spent waiting for an appointment or treatment.</p> <p>Our current 18 week performance is detailed on page 74.</p> <p>Patient experience information can be obtained from</p> <ul style="list-style-type: none"> • Inpatient and outpatient questionnaires • Frequent Feedback surveys • Friends and Family Test information • Analysis of Complaints <p>However this information is not specific to patients waiting over 18 weeks for treatment and may not be representative of the overall situation.</p>
Key Objectives	<p>April – June</p> <ul style="list-style-type: none"> • Review all the feedback sources and identify a suitable method of obtaining patient feedback in relation to waiting for an appointment or treatment. • This may include designing and implementing a bespoke survey to further understand the impact on patient experience for patients. • Baseline data to be collected using the most appropriate method. <p>July – Sept</p> <ul style="list-style-type: none"> • Analyse and interpret the findings to establish if any lessons can be learnt. • Areas for improvement identified during this process will be addressed by improvement activities at Directorate and Trust level. <p>Oct – Dec</p> <ul style="list-style-type: none"> • Resurvey where indicated and consider the appropriateness of putting in place systems and processes to provide a consistent method of reviewing the experiences of patients who wait for treatment.
Measurement and Reporting	Regular update reports will be provided to the Trust Executive Group and final outcomes will be reported in the Quality Report 2014/15. Qualitative outcomes will be reported and where available performance measures will be used to demonstrate change.
Board Sponsor	Professor Hilary Chapman Chief Nurse
Implementation lead	Mrs Sue Butler Head of Patient Partnership

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2.1.11 How did we choose these priorities?



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Priorities for Improvement and Statements of Assurance from the Board

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) Commissioning for Quality and Improvement (CQUIN) Framework
- e) Care Quality Commission
- f) Data Quality
- g) Patient Safety Alerts
- h) Staff Engagement
- i) Annual Patient Surveys
- j) Complaints
- k) Eliminating mixed sex accommodation
- l) Coroners Regulation 28 Report (previously Rule 43 report)
- m) Response to The Mid Staffordshire NHS Foundation Trust Public Inquiry

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 2013/14 the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 40 relevant health services.

The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 40 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2013/14.

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

b) Clinical Audit

During 2013/14 37 national clinical audits and four national confidential enquiries covered relevant health services that Sheffield Teaching Hospitals NHS Foundation Trust provides.

During that period Sheffield Teaching Hospitals NHS Foundation Trust participated in 94.6% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2013/14 are documented in Table 1. The 2 national clinical audits and the Trusts reason for non-contribution this year are detailed later in this section.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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Priorities for Improvement and Statements of Assurance from the Board

Table 1

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Adult Critical Care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death (NCEPOD) studies:		
Lower Limb Amputation	Yes	100%
Tracheostomy Care	Yes	100%
Subarachnoid Haemorrhage	Yes	74%
Alcohol Related Liver Disease	Yes	79%
National Audit of Seizures in Hospitals (NASH)	Yes	100%
National Joint Registry (NJR)	Yes	99%
Paracetamol overdose (care provided in emergency departments) (CEM)	Yes	100%
Severe sepsis and septic shock (CEM)	Yes	100%
Severe trauma (Trauma Audit and Research Network, TARN)	Yes	76%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme (NHS Blood and Transplant) Includes:		
National Comparative Audit of the Use of Anti D	Yes	100%
National Comparative Audit of the Management of patients in neuro critical care	No	See statement
Cancer		
Bowel cancer (NBOCAP)	Yes	91%*
Head and neck oncology (DAHNO)	Yes	89%*
Lung cancer (NLCA)	Yes	93%*
Oesophago-gastric cancer (NAOGC)	Yes	96%*
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	99%
Cardiac Rhythm Management (CRM)	Yes	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	100%
Coronary angioplasty	Yes	100%
National Adult Cardiac Surgery Audit	Yes	99%
National Cardiac Arrest Audit (NCAA)	No	See statement
National Heart Failure Audit	Yes	89%
National Vascular Registry Elements include:		
National Carotid Interventions Audit	Yes	83%
Abdominal Aortic Aneurysm (AAA)	Yes	60%
Peripheral Vascular Surgery – Lower limb angioplasty/stenting.	Yes	78%
Peripheral Vascular Surgery – Lower limb bypass	Yes	70%
Peripheral Vascular Surgery – Lower limb amputation	Yes	54%
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	100%

Table continues overleaf:

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Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Long Term Conditions		
Diabetes (Adult) ND(A)	Yes	100%
National Diabetes Inpatient Audit (NaDIA)	Yes	100%
Diabetes (Pregnancy) (NPID)	Yes	100%
Diabetes (Paediatric) (NPDA)	N/A	N/A
UK Inflammatory bowel disease (IBD) Includes:		
Inflammatory bowel disease Inpatient Care Audit	Yes	100%
Inflammatory bowel disease Biologics Audit	Yes	77%
Paediatric bronchiectasis (British Thoracic Society) Previously part of the Bronchiectasis audit 2010-13	N/A	N/A
Renal replacement therapy (Renal Registry)	Yes	100%
Mental Health		
Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	N/A	N/A
National audit of schizophrenia (NAS)	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	N/A	N/A
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Yes	98%*
Sentinel Stroke National Audit Programme (SSNAP)	Yes	97%**
Other		
Elective surgery (National PROMs Programme). Procedures include:	Yes	
Groin hernia surgery		
Questionnaire 1 received		74.8%
Questionnaire 2 returned		57.9%
Varicose vein surgery		
Questionnaire 1 received		72.7%
Questionnaire 2 returned		41.5%
Hip replacement/revision surgery		
Questionnaire 1 received		87%
Questionnaire 2 returned		46.8%
Knee replacement/revision surgery		
Questionnaire 1 received		96.2%
Questionnaire 2 returned		37.6%

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Priorities for Improvement and Statements of Assurance from the Board

Audits and Confidential Enquiries	Participation N/A = Not applicable	% Cases Submitted
Women's and Children's Health		
Child health clinical outcome review programme (CHR-UK)	N/A	N/A
Epilepsy 12 audit (Childhood Epilepsy)	N/A	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Moderate or severe asthma in children (care provided in emergency departments) (CEM)	N/A	N/A
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	N/A	N/A
Paediatric intensive care (PICANet)	N/A	N/A

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.

** This is normally reported in 'bands' in the SSNAP quarterly reports.

Supporting Statements:

1. National Comparative Audit of the Management of patients in neuro critical care

Due to the short time frame given the Trust was unable to put in place appropriate resources to participate.

2. National Cardiac Arrest Audit (NCAA)

Work continues to improve compliance with completion of local Resuscitation Audit forms. The Trust Resuscitation Committee has deferred NCAA enrolment until 2015 when the changes in the audit process will enable benchmarking with other organisations.

The reports of 24 national clinical audits were reviewed by the Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Some examples of which are included below:

- The Trust has introduced two major initiatives to help with assessments based around foot care following participation in the National Diabetes Inpatient Audit, the 'Think Glucose' educational programme and the 'Think Foot' initiative. This has included the introduction of a daily foot assessment tool to facilitate timely referrals of patients with foot problems to the multi-disciplinary team and the prevention of new foot problems developing in hospital inpatients.
- Following the National Audit of Dementia the Trust has developed a personal information booklet 'All About Me' which is specifically tailored for use by patients with confusion/dementia and their carers, based on the Alzheimer's Society 'This is Me' booklet. This will provide information for staff to facilitate individualised communication with and care for these patients. The booklet has been piloted on six wards and has been positively evaluated. It is to be introduced across the Trust and incorporated into the Trust's Dementia Training Strategy.
- The Trust has introduced a new Bronchiectasis specific clinic at the Northern General Hospital following completion of the British Thoracic Society National Bronchiectasis audit. The clinical team has also developed a Bronchiectasis Long Term Care Proforma (BLTCP) to ensure all appropriate information is collected at a patient's first consultation. This will improve overall patient care as well as compliance with the British Thoracic Society National Bronchiectasis audit.

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Confidential Enquiries

The Trust has in place a process for the management of National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD) and puts action plans together as reports are issued. It is a standing agenda item at the Clinical Effectiveness Committee which provides a forum for updates, and if any action plan requires an audit this is included on the Trust Clinical Audit Programme.

Data is also continually collected and submitted to MBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom – see table 1 for participation rate).

Local Clinical Audits

The reports of 140 local clinical audits were reviewed by the Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Actions have been implemented following an audit to improve surgical procedure counts. Pre-printed white boards which identify all the accountable items have been displayed in all theatres, and revised local guidance has been introduced into the Trust. Three-monthly re-audits are to take place as well as feedback and training for staff.
- A three audit cycle on the length of time between referral and completion of dental treatment for children with suspected infective endocarditis found the average time to have halved to 14 weeks in the third cycle. To reduce this even further the 'Fast-track' patient care pathway (previously introduced in February 2010 following the first audit) has now been updated and is available on all Dental Hospital computers. A re-audit is planned for July 2014.
- After auditing practice against national and local venous thromboprophylaxis guidelines in spinal surgical patients in 2012 a spinal 'inpatient checklist' of tasks required to be undertaken for spinal inpatients has been introduced to improve compliance. A new trust drug prescription chart was also produced to act as a reminder and aid prescription of surgical stockings. Practice was re-audited in September 2013 with all areas seeing an improvement. The audit will be repeated again in June 2014 to ensure compliance is being maintained.

c) Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospitals NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 14,665 (2012/13 – 12,142).

International Clinical Trials Day provides a key focus for clinical research. It is an annual global event celebrating the day that James Lind began his famous trial which led to the prevention of scurvy. This year the Trust will once again be raising awareness of the importance of clinical research, what it means, and how to get involved through a series of directorate events focused on the role of research nurses.

The Clinical Research Office and Sheffield's National Institute for Health Research (NIHR) Clinical Research Facility marked International Clinical Trials Day 2014 with a series of fun and interactive events at the 'Life: A festival celebrating medicine, dentistry, health and wellbeing'.

Researchers from across the Trust, including Sheffield's NIHR Clinical Research Facility, opened their doors on International Clinical Trials Day so that members of the public, staff and visits could find out about the vital role clinical research plays in helping us understand how medical conditions work, improve care for patients, and deliver better and more advanced treatments to the clinic quicker and faster.

d) Commissioning for Quality and Improvement (CQUIN) Framework

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust income in 2013/14 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 relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=327

In 2013/14, 2.5% of our contractual income (£17.5m) was conditional on achieving Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals NHS Foundation Trust and NHS Sheffield CCG. During 2012/13 the Trust secured £14.8m on achieving Quality Improvement Innovation goals.

For 2013/14 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

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- reduction in the prevalence of pressure ulcers acquired whilst receiving hospital or community care
- improved communication with GPs following a patient's attendance at the Accident and Emergency Department.

e) Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Sheffield Teaching Hospitals NHS Foundation Trust during 2013/14.

Sheffield Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Routine Inspections

The Care Quality Commission carried out a routine two-week inspection at the Northern General Hospital, Royal Hallamshire Hospital, Jessop Wing and Weston Park Hospital in September 2013. The Care Quality Commission found the Trust to be meeting all of the standards that were inspected and found evidence of good care and robust governance. No action plan was required.

f) Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

— which included the patient's valid NHS number was:

- 99.7% for admitted patient care;
- 99.7% for out patient care; and
- 97.2% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care;
- 99.8% for out patient care; and
- 98.7% for accident and emergency care.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 68% and was graded green and satisfactory.

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

- 8% primary diagnosis incorrect
- 10% secondary diagnosis incorrect
- 7% primary procedures incorrect
- 23% secondary procedure incorrect

To note: The figures above relate to the correct recording of patient diagnosis and procedures from case notes, not an error in clinical practice. The standard is 90% correct recording of the primary diagnosis and procedure, and 80% correct recording of the secondary diagnosis and procedure.

The results should not be extrapolated further than the actual sample audited. Areas audited were taken from a section of specialities specified nationally and by NHS Sheffield CCG, which were:

- 100 sets of case notes with a code of 'Digestive System Procedures and Disorders', with a specified level of complications and co-morbidities.
- 100 sets of case notes from an emergency admission with a code of 'Other Specified Admission and Counselling' with intermediate or major complications and co-morbidities.

An action plan and training is being developed to address the mistakes in recording of secondary procedures, which mainly relates to the correct coding of CT scans.

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

1. Working in collaboration with Leeds Teaching Hospitals NHS Trust, establish a network of Data Quality professionals across Yorkshire and the Humber. Meet as a forum to share good practice and ideas.
2. Undertake a Trust-wide audit of all information systems, in order to establish how many are in existence, who manages them and what data quality controls are already in place.
3. Analyse the audit results and develop an action plan to introduce some standardisation of data quality control.
4. Undertake a project during 2014/15 to scope the potential for improved data recording in order to maximise Trust income.
5. The Trust is currently in the process of developing standard operating procedures for administrative functions that will standardise the processes around data capture and data entry. This will help in the drive to improve data quality.

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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 2 below details the Alerts and Rapid Response Reports which have been received during the year 2013/14.

Table 2: Alerts received during 2013/14

Ref	Title	Issued	Deadline	Closed
NHS/PSA/W/2013/001	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	05/12/2013	08/01/2014	08/01/2014
NHS/PSA/W/2014/001	Risk of hypothermia in patients receiving continuous renal replacement therapy	06/02/2014	06/03/2014	06/03/2014
NHS/PSA/D/2014/002	Non-luer spinal (intrathecal) devices for chemotherapy	20/02/2014	20/08/2014	Currently open
NHS/PSA/W/2014/003	Risks of associating ECG records with wrong patients	04/03/2014	04/04/2014	04/04/2014

h) Staff Engagement

Staff Engagement

The Trust recognises the importance of positive staff engagement and good leadership to ensure good quality patient care. The strategic direction for staff engagement is set and monitored by the Staff Engagement Executive Group, chaired by the Executive Director of Human Resources and Organisational Development which reports to the Finance, Performance and Workforce committee, a subcommittee of the Board of Directors.

During 2013/14, the implementation of the Trust Staff Engagement Strategy has been ongoing with a particular focus on improving both staff involvement and the appraisal rates for all staff across the Trust.

Staff Involvement

The Trust has numerous mechanisms in place to encourage and learn from staff feedback.

The Chief Executive undertook several staff open sessions to share and discuss the opportunities and challenges facing the organisation. He also spends time with a number of clinical and non-clinical departments each month to take the opportunity to chat with staff and listen to their feedback. The Chairman meets regularly with the Staff Governors and the whole Board visit a department every month to meet staff and recognise their efforts.

A number of 'Let's talk' engagement events have been held in directorates across the Trust in order to seek staff views and encourage ideas for service improvements.

In addition some directorates are now using the Microsystems Coaching Academy approach to improving services. Many areas have introduced staff suggestion boxes after these were successfully piloted in the Hotel Services Directorate during 2012/13.

The Clinical Assurance Toolkit in use in clinical areas includes a Staff Survey (based on the engagement questions in the NHS Staff Survey) and some other departments e.g. Pharmacy and Professional services undertake their own Staff Surveys. Furthermore, the Trust conducted a full census NHS Staff Survey in autumn 2013 to give all staff the opportunity to contribute their views and suggestions.

The Trust has worked with NHS England on the introduction of staff 'friends and family' testing, which will be introduced into the Trust on a quarterly basis in 2014/15. This will give more staff the opportunity to give more frequent feedback on how patient services can be improved.

Appraisal

During 2013/14 a significant investment in appraisal training was made to support the performance, values and behaviours based appraisal process (based on the PROUD values) which was simplified and rolled out across the Trust to more staff.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

The PROUD values are:

- **Patients First**
Ensure that the people we serve are at the heart of what 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

There has been a significant rise in the number of staff receiving an appraisal during 2013/14. This stands at 97.3%.

Health and Wellbeing

Health and Wellbeing festivals, which provide staff with a range of information on how to improve their health and wellbeing, continue to be held across the Trust. 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 have expanded this service across the whole Trust effective from April 2014. The Trust is looking to 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. It is anticipated that this reduce sickness absence rates within the Trust and improve staff health and wellbeing overall.

The outcome of research undertaken in conjunction with Sheffield Hallam University regarding the provision of staff health checks proved promising and we are currently undertaking a larger scale research programme across the Trust to determine the efficacy of the service.

The purchasing annual leave scheme has again proved extremely popular with nearly 200 staff taking advantage of the scheme in the last year alone. Further developments in respect of this scheme are under consideration.

The Trust launched a Health and Wellbeing Lottery in 2013/14, with the intention of providing funds to improve the health and wellbeing of staff in the Trust via bids for funding.

Leadership and Management Development

The first leadership forum of the year held in May 2013, focused on the Trust's response to the recommendations in the Francis report, with over a hundred leaders from across the Trust attending. A second forum was held in November 2013 which had an emphasis on sharing knowledge across the Trust, particularly that gained by from colleagues whilst undertaking an MBA or an MSc in leadership.

The Trust's coaching capacity has been strengthened during 2013 with the first cohort of 14 people trained to be coaches and a further cohort commenced in the spring of 2014.

A Human Resources development programme was introduced during the year which was well supported and has already been repeated with plans for further cohorts in 2014.

A further two cohorts of staff have attended the Senior Leaders programme developed in conjunction with Sheffield Hallam University along with a further two cohorts of the level 3 ILM programme. Both these programmes now include sessions on the importance of good staff engagement and the leader's / manager's role in this.

The 'Effective Manager' rolling management programme and the Leadership Guest Lecture Series continue to be well received. A senior sisters' development programme is being developed in response to recommendations in the Francis report for introduction in 2014.

NHS 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 the overall Trust staff engagement score (3.71) as reported in the benchmarked NHS Staff Survey, improved during 2013, despite this being a challenging year. This improvement means that the Trust compares well to other acute trusts. It is very pleasing to note that 72 % of our staff would recommend the Trust to family and friends for treatment which is well above the NHS average of 65%.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Response rate

	2012/13		2013/14		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	52%	50%	55%	49%	3% Improvement

Top five ranking scores:

Key Finding	2012/13		2013/14		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Staff working unpaid extra hours (%)	64	70	64	70	No change
Staff experiencing harassment/bullying/abuse from staff (%)	23	24	21	24	Improvement (2%)
Staff experiencing harassment/bullying/abuses from patients (%)	32	30	26	29	Improvement (6%)
Staff believing trust provides equal opportunities for career progression/promotion (%)	86	88	91	88	Improvement (5%)
Staff recommending Trust to work/for treatment	3.65*	3.57	3.79	3.68	Improvement (0.14)

Bottom five ranking scores:

Key Finding	2012/13		2013/14		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Staff having well structured appraisals in the last 12 months (%) **	26	36	28	38	Improvement (2%)
Staff agreeing their roles make a difference to patients (%)	87	89	87	91	No change
Staff motivation at work	3.68*	3.84	3.72	3.86	Improvement (0.04)
Received equality and diversity training in last 12 months (%)	39	55	43	60	Improvement (4%)
Staff feeling satisfied with the quality of work and patient care they are able to deliver (%)	78	78	74	79	Deterioration (4%)

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Most improved

Key Finding	Trust 2012	Trust 2013
Staff recommendation of the Trust as a place to work or receive treatment	3.65	3.79

* 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 percentage of staff appraised, and this issue is being addressed via the roll out of the simplified PROUD performance values and behaviours appraisal system and the increased investment in training for managers in appraisal skills.

The Trust has a staff engagement lead who works with staff in directorates to promote the sharing of good practice across the Trust. A Trust action plan has been drawn up to address the areas for improvement highlighted in the Staff Survey which is further supported by individual directorate staff engagement action plans. The focus for 2014/15 will be to ensure more staff have a well structured appraisal and to continue to improve staff involvement. In addition directorates which have shown a deterioration in the key finding relating to the percentage of staff feeling satisfied with the quality of work/patient care they are able to deliver, are required to investigate this further in order to identify what improvements need to be made. Progress with the Trust and Directorate action plans is monitored via the Staff Engagement Executive Group.

A staff engagement score template has been developed based on the NHS Staff Engagement Toolkit which, using the full Staff Survey census data has enabled a staff engagement score to be calculated for every directorate for the first time. This is further broken down into staff involvement, advocacy and motivation which enables each directorate to focus on addressing their particular issues. Directorate staff engagement scores and staff friends and family test scores are also monitored via the Care Group performance review process.

Although the Trust was benchmarked in the best 20% of acute Trusts for the key finding related to the percentage of staff working extra unpaid overtime the Trust acknowledges that at 64% this is still high and possible causes of this have been discussed at the Staff Engagement Executive Group and will continue to be monitored.

It was pleasing to note the improvement in the percentage of staff being bullied/abused by staff which resulted in the Trust being benchmarked in the best 20% of acute Trusts however work is continuing to address this further. A new 'Acceptable Behaviour at Work' policy was introduced in the summer of 2013 supported by literature and briefings.

This policy incorporates a process of tackling bullying and harassment as well as a range of informal measures to tackle concerns early. Bullying and harassment is also included in mandatory training. In addition 'Respect for others' is one of the core PROUD values being rolled out throughout the Trust which are included in both appraisal and recruitment.

i) Annual Patient Surveys

The Trust undertakes a wide range of activities to gain feedback from patients regarding the services they receive. Survey work during 2013/14 included participation in the national survey programme for inpatients, maternity and cancer services. In addition, our extensive programme of local surveys has continued, with around 400 patients each month participating in the 'frequent feedback' survey programme in which the views of patients about a wide range of services are gathered by trained volunteers. The new Friends and Family Test (FFT) has also been implemented across in-patients, accident and emergency and maternity services.

In the National In-Patient Survey 2013, our scores compare very well against other trusts. Areas where our scores were high include questions relating to cleanliness of rooms, wards and toilets and having trust and confidence in doctors and nurses. Areas identified where further improvements can be made include offering healthy food choices and ensuring patients have the opportunity to give us their views on the quality of care.

In the National Maternity Survey 2013 areas achieving high scores include women having a contact number for any worries post natally, and the partner being involved enough during labour and birth. Questions where further improvements could be made include provision of information regarding emotional changes post natally and continuity of midwife support during post natal care.

The third National Cancer Survey was carried out in 2013. 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 always providing privacy for patients when being examined or treated. Areas where scores were lower include the provision of written information about the type of cancer they had and the patient's family having the opportunity to talk to the doctor.

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.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Friends and Family Test

The Friends and Family Test (FFT) was introduced nationally from April 2013 for all adult acute in-patients and patients discharged from Accident and Emergency Departments, and from October 2013 for maternity services.

The test asks a simple, standardised question with response options on a 5-point scale, ranging from 'extremely likely' to 'extremely unlikely'. This Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response.

Nationally, a variety of methods are being used by Trusts to collect FFT data, including paper/postcard, online, texting and electronic tablet methods. The method currently used to collect data within this Trust is a postcard at the point of discharge, which can be posted in a box on the ward/department or returned by freepost. The cards also contain a smartcode which allows patients to complete their response online. In addition, since mid-December 2013, SMS texting has been used to survey patients discharged from the Accident and Emergency Department.

Since July 2013, FFT scores and response rates have been published nationally each month, enabling trusts to compare feedback down to ward and service level. This Trust's scores and response rates are outlined in Part 3.

j) Complaints

Improving the experience and learning from complaints

The Trust values 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 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.

During 2013/14 we received 1205 concerns and enquiries which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) which staff feel can be dealt with quickly by taking direct action or by putting the enquirer in touch with an appropriate member of staff such as a matron or service manager, contacts are made and the enquiry is recorded on the complaints database as a PST contact. If the concern or issue is not dealt with within two days, or if the enquirer remains concerned, the issue is re categorised as a complaint and processed accordingly.

1378 complaints requiring more detailed and in depth investigation were received. Table 3 provides a monthly breakdown of complaints and concerns received.

Table 3

	Apr-13	May-13	June-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
New Complaints Received	121	118	83	114	112	111	105	137	95	130	139	113	1378
Patient Services Team (PST) Concerns	94	106	90	113	106	85	100	103	61	124	115	108	1205
Complaints and PST Enquiries combined	215	224	173	227	218	196	205	240	156	254	254	221	2583

The Trust works to a target of responding to 85% complaints within 25 working days. The performance this year was 72% falling short of the target for the first time. The high number of complaints received in January – March 2013 saw a backlog develop which has meant that performance dropped in May, and has remained below the target level for the rest of the year. Chart 1 shows a monthly breakdown of performance against the Trust target per month.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

Chart 1

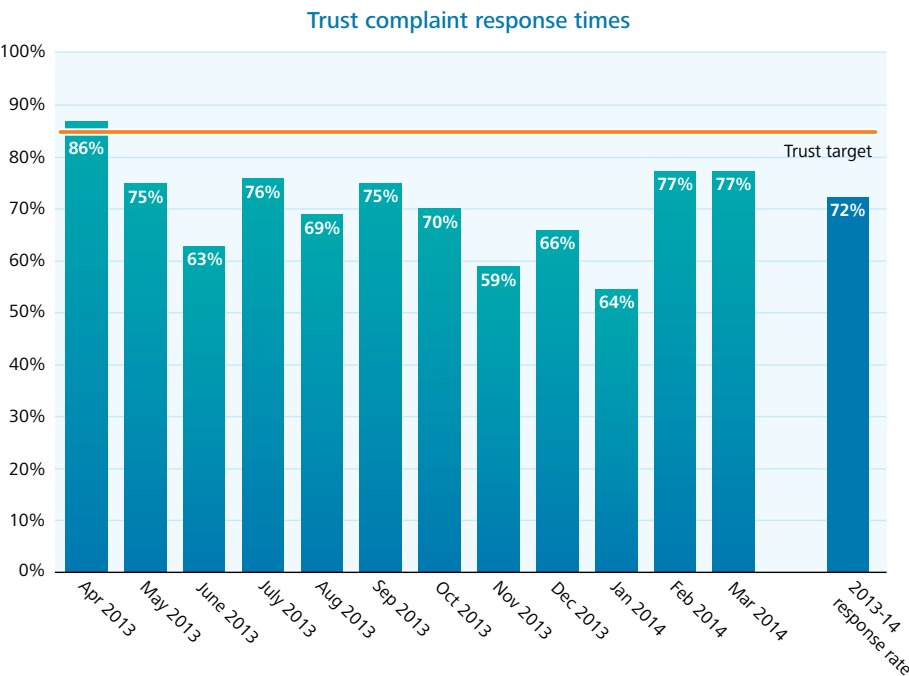
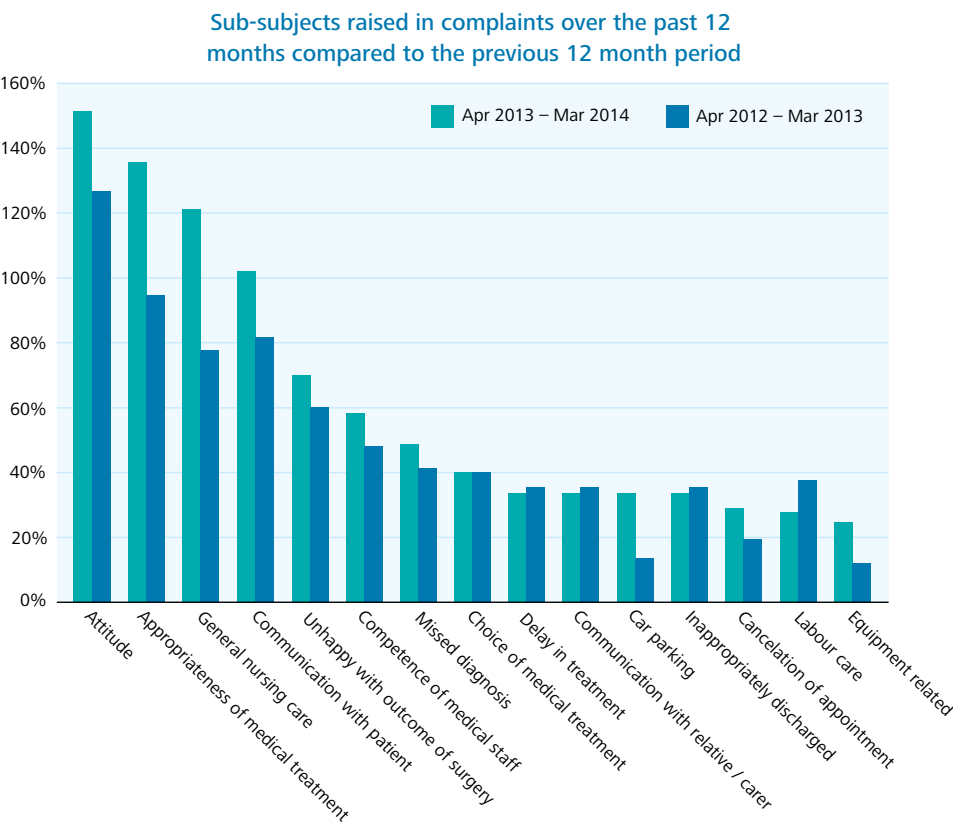


Chart 2



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. Chart 2 (left) shows the breakdown of complaints by theme. The findings show the top five themes are the same as those identified last year. Staff attitude continues to be the most commonly raised subject in complaints.

Priorities for Improvement and Statements of Assurance from the Board

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. A formal process is in place which monitors and follows up actions agreed to ensure any changes have been made and implemented as planned. This process is supported by Trust Governors who visit wards and departments to 'spot check' progress against action plans.

Staff attitude is of high importance to patients and continues to feature frequently in complaints. A number of actions are being taken to improve issues identified around staff attitude. These include:

- **The launch of the PROUD values**

The values were developed by staff and were launched two years ago to promote attitudes and behaviours which support an excellent patient experience. The values are now linked to staff appraisal, and staff are expected to demonstrate how they deliver the PROUD values.

- **Customer Care Training**

The Patient Partnership Department worked with a multi-disciplinary team in Orthopaedics to deliver a customer service programme which has providing staff training and facilitated discussions with staff to explore how their working environment could change to improve their ability to provide excellent customer care. The project is now being rolled out more widely in Surgical Services and across other care groups.

Key Priorities for 2014/15

Following a number of national reviews published last year including the Francis Inquiry¹, the Clwyd Hart Review², and Keogh³ a comprehensive review of the complaints management process is planned for 2014. The review will identify a process which is responsive to the needs of patients and families using the complaints service. The review will ensure a responsive and timely process is implemented, which meets with recommendations made in the national reviews.

A programme of training for senior nursing and medical staff is to be introduced in 2014 to support the new complaints process and ensure a consistent approach when investigating and responding to complaints. Staff leading complaints investigations will receive training to ensure complaint investigations are carried out thoroughly with findings communicated to patients and families in a clear, comprehensive way.

A new approach to auditing the quality of the complaints service against the standards we have set and patients' expectations will be developed and introduced in 2014. The Trust will interview patients and families to understand their experience of the complaints process, and will carry out a review of the complaint file in order to ensure it complies with the standards we have set. We will use the findings of this audit to continually improve and develop our complaints service.

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 clinical best interest or reflects their personal choice. As a result we have not identified any breaches of the Eliminating Mixed Sex Accommodation during 2013/14.

l) Coroners Regulation 28 Report (previously Rule 43 report)

In July 2013 the Coroners and Justice Act 2009 came into force, together with accompanying Rules and Regulations, which represents an overhaul of the law in relation to inquests. There are changes to timescales, deadlines and associated fines, disclosure of evidence and also Rule 43 reports, which now come under Regulation 28 of the Coroner (Investigations) Regulations 2013.

The importance of these reports has been emphasised by changing the coroner's previous discretion to make a report, to a "duty" to make a report, where a matter giving rise to concern is identified.

These reports generally are written when the Coroner feels further improvement action needs to be implemented following a death. The Chief Coroner has also given additional guidance to coroners on these, and expressed his commitment to encourage changes which may prevent future deaths intended to improve public health and safety and have a practical effect.

The Trust has received no Regulation 28 Reports during 2013/14.

¹Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

²Clwyd and Hart (2013) A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture

³Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

Part 2

Priorities for Improvement and Statements of Assurance from the Board

m) Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry

Hard Truths: The Journey to Putting Patients First publication builds on the Government's initial response: *Patients First and Foremost*, which was published in March 2013. The publication explains the changes that have been put in place since the initial response, and sets out how the whole health and care system will prioritise and build on this.

The Trust has reviewed the *Hard Truths: The Journey to Putting Patients First* publication and drawn up an extensive action plan highlighting approximately 20 new actions which the Trust is currently taking forward. These matters will be incorporated into the Trust's Final Response Plan. Other partners will be involved in the development of this plan, such as, Healthwatch, Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

The final Trust plan is not due to be considered by the Trust Board of Directors until May 2015 to enable a period of consultation to take place, however the actions required include implementation of the new Duty of Candour, publication of nurse staffing levels and improved information regarding how to make a complaint. Details of the plan and the actions undertaken will be included in the Quality Report 2015/16.

Our collective approach to quality improvement and governance, supported by a robust performance management framework, ensures that quality matters are monitored and, where deficits occur, that timely and proportionate action is taken to address these. Under the direct lead of an Executive Director, a thorough root cause analysis and risk assessment is undertaken and a mitigating action plan developed and implemented. The Trust Executive Group and the Board of Directors monitor the implementation of the action plan (and any responsive changes to the plan) via regular progress reports by the nominated leads.

Part 3

Review of Services in 2013/14

3.1 Quality Performance Information 2013/2014

These are the Trust priorities which are encompassed in the mandated indicators that the organisation is required to report and have been agreed by the Board of Directors.

The indicators include:

- 6 that are linked to patient safety;
- 11 that are linked to clinical effectiveness; and
- 13 that are linked to patient experience.

For 2013/14 the Trust undertook a review of the priorities reported in the Annual Quality Report, mindful of the volume of activity reported it was agreed that the priority relating to 'Patients who receive Primary Percutaneous Coronary Intervention within 150 minutes of calling for help' would continue to be monitored at a local level within the speciality care group. It was therefore removed from the Quality Report template.

i) Mandated Indicators – Department of Health (Gateway reference 18690 and 00931)

Prescribed Information	2011/12	2012/13	2013/14
1. Mortality (a) The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period. National average: 1.0 Highest performing Trust score: 0.63 Lowest performing Trust score: 1.19	.92 Banding: 'as expected'	.88 Banding: 'lower than expected'	.89 (Oct 12 – Sept 13) Banding: 'lower than expected'
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. National average: 20.9 Highest Trust score: 44.9 Lowest Trust score: 0 The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is 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: <ul style="list-style-type: none">• 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 actions are taken. The SHMI 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. Oct 2011 – Sept 2012. SHMI results are published six months and three weeks in arrears because of the need to validate the data nationally. The value for April 2012 – March 2013 was released at the end of October 2013 and reported as 0.88. This can be validated via the NHS Choices website.	17.5%	18.4%	18.5% (Oct 12 – Sept 13)

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
2. Patient Report Outcome Measures (PROMs)			April-Sept 2013/14
The Trust's patient reported outcome measures scores for:			
(i) Groin hernia surgery			
Sheffield Teaching Hospitals' score:	0.081	0.108	0.068
National average:	0.086	0.084	0.085
Highest score:	0.143	0.157	0.131
Lowest score:	-0.002	0.015	0.019
(ii) Varicose vein surgery			
Sheffield Teaching Hospitals' score:	0.065	0.076	*
National average:	0.094	0.093	0.101
Highest score:	0.167	0.138	0.094
Lowest score:	0.049	0.023	0.058
(iii) Hip replacement surgery primary	**		
Sheffield Teaching Hospitals' score:	0.386	0.406	0.39
National average:	0.415	0.437	0.447
Highest score:	0.463	0.543	0.545
Lowest score:	0.306	0.319	0.373
(iv) Hip replacement surgery revision	**		
Sheffield Teaching Hospitals' score:	0.386	0.236	*
National average:	0.415	0.272	0.260
Highest score:	0.463	0.35	*
Lowest score:	0.306	0.164	*
(v) Knee replacement surgery primary	**		
Sheffield Teaching Hospitals' score:	0.315	0.308	0.345
National average:	0.302	0.318	0.338
Highest score:	0.385	0.409	0.429
Lowest score:	0.181	0.231	0.264
(vi) Knee replacement surgery revision	**		
Sheffield Teaching Hospitals' score:	0.315	0.211	*
National average:	0.302	0.251	0.255
Highest score:	0.385	0.369	*
Lowest score:	0.181	0.194	*

Table continues overleaf:

Review of Services in 2013/14

<p>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.</p> <p>* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received.</p> <p>** 2011/12 data presents primary and revision combined for both Hips and Knee procedures. 2012/13 and 2013/14 now present primary and revision separately therefore this data is not comparable.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from national Information Centre PROMs data set.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by:</p> <ul style="list-style-type: none"> • Continuing to review in detail a breakdown of EQ-5D and OHS data for hips and undertaking improvement work as necessary. • Monitoring scores at directorate and Trust level to respond to feedback from patients and incorporating their views into quality improvements. • Increasing the involvement and understanding of staff in how we use the information received through PROMs and working with staff to increase participation rates. <p>To further understand and improve PROMS scores, work has been initiated to map the process of questionnaire distribution to relevant patients and to work closely with clinicians to identify opportunities for improvements in the patient pathway.</p>			
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Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
<p>3. Readmissions</p> <p>The percentage of patients aged:</p> <ol style="list-style-type: none"> 0 to 15; and 16 or over, <p>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 during the reporting period.</p> <p>Comparative data is not available.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the Trust's Patient Administration System.</p> <p>*These figures are different from subsequent years as the way the data is calculated has changed (Data definition).</p> <p>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 readmissions 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 city wide health and social care partnership.</p>	<p>0%</p> <p>10.7%*</p>	<p>0%</p> <p>11.36%</p>	<p>0%</p> <p>10.8%</p>
<p>4. Responsiveness to personal needs of patients</p> <p>The trust's responsiveness to the personal needs of its patients during the reporting period.</p> <p>National average: 72.8%</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor.</p> <p>*2013/14 scores represent the four 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. Prior to 2013/14, scores were based on five questions; the question regarding recommending friends and family to the Trust has been removed since the introduction of the national Friends and Family Test.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services. As in previous years the Trust and NHS Sheffield CCG have agreed that, whilst important, the areas highlighted in the national survey were not as important as some fundamental areas. These include:</p> <ul style="list-style-type: none"> • help to go to the toilet • controlling pain • help with nutrition • being treated with dignity. <p>These are the areas on which the Trust's Patient Experience is being measured through an ongoing programme of patient interviews (approximately 400 each month).</p>	<p>72%</p>	<p>68.6%</p>	<p>79.3%*</p>

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
<p>5. Patients risk assess for Venous Thromboembolism (VTE)</p> <p>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</p> <p>Comparative data is not available.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as we have processes in place to collect the data internally as part of the CQUIN work, which is regularly monitored. We then report the data externally to the Department of Health.</p> <p>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 Trust, feedback to Directorates on performance and carrying out analysis of cases of VTE which are thought to be hospital associated.</p>	91.1%	93.33%	95.16%
<p>6. Rate of <i>Clostridium difficile</i></p> <p>The rate per 100,000 bed days of cases of <i>C.difficile</i> infection reported within the Trust amongst patients aged two or over during the reporting period.</p> <p>Comparative data is not available.</p> <p>*The rate shown is provisional until the Public Health England denominator figures are published. The denominator used is the 2012/13 figure as this is unlikely to change significantly.</p> <p>During 2013/14 there have been 80 cases of <i>C.difficile</i> infection reported within the Trust. The national threshold for 2013/14 was 77.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as it is provided by the Health Protection Agency.</p> <p>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 its Infection Prevention and Control Programme to continue to reduce the rate of <i>C.difficile</i> experienced by patients admitted to the Trust.</p>	30.0	17.8	13.68*

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
7. Rate of patient safety incidents The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	10,192	9951*	11299
Number of Incidents reported The incident reporting rate is calculated from the number of reported incidents per hundred admissions and the comparative data used is from the first 6 months of 2013/14. Full information for the financial year is not available from the National Reporting and Learning System until mid 2014. Cluster** average: 7.9 Highest performing Trust score: 12.84 Lowest performing Trust score: 4.87	5.2	5.1*	4.87
and the number and percentage of such patient safety incidents that resulted in severe harm or death. Cluster** reporting data: 552 (0.3%) Highest reporting Trust: 46 (0.9%) Lowest reporting Trust: 1 (<0.1%) * The figures for 2012/13 are different to those documented in last year's Quality Report as they have now been validated. **Comparative data is sourced from the National Reporting Learning System, data is split into cluster/peer groups with Sheffield Teaching Hospitals being part of the 'Acute Teaching Hospitals' cluster. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the National Reporting and Learning System (NRLS). The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate by continuing to embed the web based reporting tool throughout the Trust. 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.	46 (0.4%)	51* (0.5%)	21 (0.4)

Part 3

Review of Services in 2013/14

Prescribed Information	2011/12	2012/13	2013/14
<p>8. Friends and Family Test – Staff who would recommend the Trust.</p> <p>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.</p> <p>National average: 64%</p> <p>Highest performing Trust score: 94%</p> <p>Lowest performing Trust score: 40%</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by national CQC survey contractor.</p> <p>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 improvement in the quality of patient services.</p>	75%	70%	72%
<p>9. Friends and Family Test – Patients who would recommend the Trust</p> <p>The scale* of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.</p> <p>*A scale of -100 to +100 is, using the Net Promoter Score calculation.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Picker Institute Europe, verified by UNIFY and reported by NHS England.</p> <p>The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by using FFT scores to trigger deeper action planning around low scoring wards.</p>	New indicator	New indicator	71

Part 3

Review of Services in 2013/14

ii) Mandated Indicators – Monitor Risk Assessment Framework (Table 2: Targets and indicators for 2013/14)

Measures of quality performance	2011/12	2012/13	2013/14
10. Percentage of patients who wait less than 31 days from decision to treat to receiving their treatment for cancer Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Data Source: Exeter National Cancer Waiting Times Database	98% 96%	98% 96%	98% 96%
11. Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Data Source: Exeter National Cancer Waiting Times Database	91% 85%	89% 85%	88% 85%
12. 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 NHS Foundation Trust achievement National Standard Data Source: Exeter National Cancer Waiting Times Database	95% 93%	95% 93%	94% 93%
13. All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Anti-cancer drug treatments: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Radiotherapy: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Data Source: Exeter National Cancer Waiting Times Database	97% 94% 99% 98% 98% 94%	97% 94% 100% 98% 99% 94%	97% 94% 99% 98% 99% 94%
14. Accident and Emergency maximum waiting time of 4 hours from arrival to admission/transfer/discharge Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard	95.6% 95%	93.2% 95%	95.7% 95%
15. MRSA blood stream infections Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust Sheffield Teaching Hospitals NHS Foundation Trust threshold	2 10	3 1	4 0

Part 3

Review of Services in 2013/14

Measures of quality performance	2011/12	2012/13	2013/14
16. Patients who require admission who waited less than 18 weeks from referral to hospital treatment Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard	90% 90%	90.6% 90%	90.4% 90%
17. 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 NHS Foundation Trust achievement National Standard	97% 95%	96.6% 90%	94.9% 95%
18. Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard	90.4% 92%	93.2% 92%	92.5% 92%
19. Data Completeness for Community Services Referral to treatment information: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Referral information: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard Treatment activity information: Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard	New indicator	60% 50% 100% 50% 100% 50%	66% 50% 100% 50% 100% 50%

Part 3

Review of Services in 2013/14

iii) Additional Indicators

Measures of quality performance	2011/12	2012/13	2013/14
20. Never Events Sheffield Teaching Hospitals NHS Foundation Trust Performance Data Source: National Patient Safety Agency Unfortunately the Trust has experienced 4 Never Events during the year; 3 retained objects and 1 misplaced nasogastric tube. Although there were fewer Never Events than during 2012/13, one such event is too many and an external review of theatre Never Events was jointly commissioned with the NHS Sheffield CCG. Findings from this review will then be used to plan future improvement activity. The Trust is actively promoting incident reporting to further enhance the safety culture of the Trust. This will ensure incidents are investigated, trends analysed and lessons are learnt across the Trust.	3	7	4
21. Hospital Standardised Mortality Ratio (HSMR) Sheffield Teaching Hospitals NHS Foundation Trust Performance National Benchmark. A lower figure represents a better mortality rate. *This figure is different from last year as it represents the whole year (April 2012 – March 2013) rather than April 2012 – January 2013 as reported in last year's Quality Report. **This is within the expected range. Data Source: Dr Foster	98% 100%	96%* 100%	103%** (April 13- Jan 14) 100%

4.1 Response to partner organisation comments 2012/13

Sheffield Healthwatch, NHS Sheffield CCG, Trust Governors and the Sheffield Health and Community Care Scrutiny Committee commented in the 2012/13 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 Clinical Commissioning Group (2012/13)

Abridged comments	Our response
1. 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's scores have remained similar year on year and consistently compare well against other Trusts nationally. The number of responses where our results were 'significantly better than average' was lower in the 2012 In-patient Survey than in previous years, although overall our scores remained high. We carefully reviewed the results of the survey and identified areas where actions were required to make improvements and, following this, we hope to see a higher number of responses achieving 'significantly better than average' scores in the 2013 In-patient Survey.
2. The Trust has unfortunately experienced a number of never events during 2012/2013, and we are working closely with them to reduce the risk of recurrence.	In 2012/13 the Trust experienced seven Never Events Following these Never Events the Trust developed a wider ranging Never Event action plan which brought together the lessons learned and actions from each of the individual incident action plans into a single overarching document. This has been shared within the Trust and also externally to the NHS Sheffield CCG, the Care Quality Commission and Monitor. A reduction in the number of Never Events has been evident in 2013/14 and further work continues to limit the chances of Never Events happening within the organisation.
Three of these priorities are worthy of specific comment: 3. 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 18 week waiting times.	Causes of cancellations are reviewed on a directorate by directorate basis with the actions designed to address the causes drawn up by each directorate. These are then taken forward by the Surgical Board. The Service Improvement team is working with Operating Services and Critical Care and the Surgical Specialties to address on the day cancellations. In several areas patients are routinely called three days prior to their admission to ensure they are fit, ready and willing to attend, to reduce the chances of any issues arising on the day that may prevent surgery taking place. Please see section 2.1.6 in Part 2 of this report for more information.

Abridged comments	Our response
<p>4. There has been a reduction this year in the overall number 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.</p>	<p>The Trust has worked hard to reduce the number of pressure ulcers in both the hospital and community setting and is monitoring progress using both incident reporting and the NHS Safety Thermometer. This work has continued into 2013/14 and will also continue during 2014/15.</p>
<p>5. 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.</p>	<p>The project to improve discharge information has progressed this year.</p> <p>Please see section 2.1.8 in Part 2 of this report for more information.</p>
<p>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. These include:</p> <p>6. Optimising length of stay – achievement of clinically appropriate length of stays in line with national and local benchmarks in key areas.</p>	<p>All directorates are working towards Dr Foster benchmarks and understand the specialty level variance. All specialties are working with detailed information showing actual length of stay by diagnosis and procedure (against Dr Foster benchmarked levels) to help them identify which particular patient pathways they should be focusing on.</p> <p>Please see section 2.1.1 in Part 2 of this report for more information.</p>
<p>7. 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.</p>	<p>The subject of nutrition and hydration is recognised as being a fundamental basic care need for patients within STH. The Hydration and Nutrition Assurance Toolkit, (HANAT) has been developed using the expertise of the Trust Nutrition Steering Group. The HANAT had been tested, refined and evaluated (positively) on two wards. HANAT serves to bring together practices, staff and audits to benchmark clinical areas against good practice standards in nutrition and hydration. There is an intention to roll HANAT out to all acute ward areas in 2014/15. It is intended that the annual audit of nutritional screening practices, including MUST screening and the associated care planning will be included as part of HANAT.</p>

Healthwatch Sheffield (2012/13)

Abridged comments	Our response
<p>1. 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.</p>	<p>The Trust is committed to producing a summary version of the Quality Report for wider circulation. For the 2012/13 Quality Report this had been produced. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch.</p>
<p>Optimise length of stay</p> <p>2. 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.</p>	<p>Ensuring that length of stay is appropriate for the patients who receive care and treatment is a key priority for the Trust.</p> <p>We are continuing to work with our clinical teams and also with partners to optimise length of stay.</p> <p>Please see section 2.1.1 in Part 2 of this report for more information.</p>
<p>Discharge letters for GPs</p> <p>3. 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.</p>	<p>The Trust has completed the rollout of e-discharge summaries which enable clinicians to fill in an electronic discharge template, helping to speed up the delivery and improve the discharge information available to GPs.</p> <p>NHS Sheffield CCG have surveyed GPs to look at the impact of the new e-discharge summaries with some very positive feedback being received. Evaluation will continue and any areas for improvement will be address by the project team.</p>
<p>Giving patients a voice</p> <p>4. We welcome the increased feedback through forms and comment 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.</p>	<p>Whilst comment cards are still widely available across the Trust, we are no longer actively giving these to patients through our volunteers, as the new Friends and Family Test (FFT) is now the priority. We decided that to also give the comment cards out at the same time as the FFT cards would be confusing for patients.</p>

Abridged comments	Our response
<p>Holistic care to promote a good experience for patients who have dementia</p> <p>5. 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.</p>	<p>A key area of focus in 2014 will be the Trust's commitment to improving patient centred care. Accordingly we are developing a discrete symbol to enable staff to recognise people suffering with dementia. This will then prompt staff to refer to the 'All About Me' booklet.</p> <p>Improvement work on Vickers 4 is in progress. Please see section 2.1.5 in Part 2 of this report for more information.</p>
<p>Reduce hospital acquired infections</p> <p>6. We commend the Trust on a reduction in the number of cases of <i>C.difficile</i> in 2012/2013 and hope this will be continued. We would be interested to know what further improvements are under consideration.</p>	<p>In 2013/14 the Trust will continue to work to reduce the number of cases of <i>C.difficile</i>. In addition the Trust will aim to reduce the number of cases of MRSA Bacteraemia and increase the amount of Surgical Wound Surveillance to reduce the number of wound infections.</p>
<p>7. 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 2013/2014, but it is not in the summative list of priorities.</p>	<p>This comment is noted and the Trust will ensure that on-going priorities are reported in the 2013/14 report.</p>
<p>8. We are surprised that Accident and Emergency waiting times are not a priority, as the Trust has failed to meet the 95% target in 2012/2013.</p>	<p>Waiting times in the Accident and Emergency department are a priority within the Trust. As a Trust we have concentrated a substantial amount of effort into bringing about changes which will help us to meet the four hour target and maintain that performance consistently. The Trust is pleased to note that we have met the four hour target during 2013/14.</p>
<p>9. 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 Quality Account.</p>	<p>The Trust reports all appropriate Quality and Safety measures to ensure it provides a comprehensive overview of the services provided. These include community data.</p>

Abridged comments	Our response
<p>Clinical Audit</p> <p>10. 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?</p>	<p>The lockers we use to store medicines have to be secured to the wall or bedside locker to ensure the security of the medicines and the safety of other patients. Insulin is a high risk medicine which can cause death if given inappropriately. So the availability of the option to self administer insulin is governed by which ward the patient is admitted to and whether that ward has individual patient lockers.</p> <p>Currently 83% of wards (excluding critical care areas where it is not anticipated that patients will be fit to self administer) have individual patient lockers for medicines. That means there are 17% wards which currently do not have this facility. Pharmacy staff are working with a number of these wards to find funding to have lockers installed. We also continue to try to find a suitable portable, lockable container which can be locked into place at the patient's bedside but so far we have not been able to find an appropriate container which meets with the security and infection control requirements.</p>
<p>11. 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.</p>	<p>The Trust is pleased that its joint commissioners, the local authority and NHS Sheffield CCG have agreed to continue funding this much needed service for a further two years. The team will have more of a focused approach in supporting those care homes with highest need from April 2014 as well as providing ongoing training pertinent to the needs of care homes.</p>
<p>12. 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.</p>	<p>After a routine visit from the Mental Health Act Inspector during March 2013, some areas for improvement were identified and the Trust has been working closely with Sheffield Health and Social Care Trust to address these. The Healthcare Governance Committee is overseeing the implementation of the improvement plan. Most actions were completed by September 2013.</p> <p>The remaining actions include internal review and evaluation of the changes that have been made. The findings will inform a revision of the Trust's Detention under the Mental Health Act policy and procedures which is due to be completed by July 2014.</p>

Abridged comments	Our response
<p>13. Data Quality. We are surprised that patients' unique NHS numbers are not used in every case/document; this presents a potential for serious confusion.</p>	<p>The Trust completion of NHS number in HES data is one of the highest in the country. The NHS Number benchmark is against all other hospital providers, amalgamated into a national figure. The benchmark figures for the period of April to December 2013 are:</p> <p>99.1% for admitted patient care 99.3% for outpatient care 95.8% for Accident and Emergency Care</p> <p>The Trusts figures for 2013/14 are:</p> <p>99.7% for admitted patient care 99.7% for outpatient care 97.2% for Accident and Emergency Care</p> <p>Connecting for Health produced a leaflet that explains that it is not always reasonable or practical to expect 100% completion. The most common patient groups to not have an NHS Number are those from overseas, or from elsewhere within UK that do not use the English NHS Number.</p> <p>The Trust undertakes rigorous processes to ensure we have the highest level of NHS number completion. These include nightly automated traces for all unvalidated NHS numbers held in our PAS system against the National Spine service. Any numbers that still remain untraced or unvalidated then have an attempted manual trace performed to try and resolve possible issues or conflicts.</p>
<p>14. We would also like to see reported in Quality Accounts information of any Coroners Rule 43 Requests that were received by the Trust in 2012/2013 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.</p>	<p>In July 2013 the Coroners and Justice Act 2009 came into force, together with accompanying Rules and Regulations, which represents an overhaul of the law in relation to inquests. It had some quite significant practical implications in terms of timescales, deadlines and associated fines, disclosure of evidence and also Rule 43 reports, which now come under Regulation 28 of the Coroner (Investigations) Regulations 2013.</p> <p>The Trust reports any Section 28 reports received within the Annual Quality Report. All Regulation 28 (Rule 43) requirements are reported in Part 2 of the Quality Report.</p>

Abridged comments	Our response
<p>15. 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.</p>	<p>The Trust has introduced a structured performance, values and behaviours appraisal process incorporating the PROUD values which although initially introduced for senior managers is in the process of being rolled out for all staff across the Trust.</p> <p>The evaluation of the initial pilot highlighted the importance of appraisal training to ensure good quality so the Trust has invested significantly in appraisal training with all appraisers being trained in the new PROUD appraisal process before implementing it.</p> <p>The Trust is committed to achieving a 95% staff appraisal rate by the year end.</p>
<p>16. Patient Surveys and complaints. We note that one of the identified areas of 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.</p>	<p>The Emergency Department has been working closely with the Patient Partnership Department to review and standardise the existing written and electronic information for patients. This process has been clinically led from within the Emergency Department, and is in line with the Trust guidelines for patient information. All of the priority leaflets have now been reviewed and republished.</p> <p>Leaflets can also be made available in other languages and formats on request. Work has now started on a generic discharge leaflet for patients and the Trust Patient Information Manager will involve Healthwatch in this process during 2014/15.</p>
<p>17. Complaints. We are surprised that number of complaints, their nature and actions taken as a result are not reported, which we feel are essential to the Quality Account.</p>	<p>The complaints section of the Quality Report 2013/14 has been expanded to ensure greater detail of actions following complaints can be reported.</p>
<p>18. Mandated Indicators. It would be helpful if the relevant years were repeated at the top of each page as aide memoire.</p>	<p>This was completed in the final published report.</p>

Sheffield Health and Community Care Scrutiny Committee (2012/13)

Abridged comments	Our response
1. The committee recognizes 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.	Within the 2013/14 Quality Report steps have been taken to ensure that the process of the Quality Objectives can be tracked over time.

Trust Governor Involvement (2012/13)

Abridged comments	Our response
1. We noted that not all the priorities for 2012/2013 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.	The Trust continues to focus on the priorities detailed within earlier Quality Reports. Progress is this reported in the 2013/14 Quality Report.
2. 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.	Through the Quality Report Steering Group a selection of Trust Governors have assisted in producing the 2012/13 summary Quality Report. This will be repeated for the 2013/14 Quality Report, working in collaboration with Trust Governors and Healthwatch.

4.2 Statement from our partners on the Quality Report 2013/14

Statement from NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG has 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, the CCG 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.

During 2013-14 key quality performance requirements have been delivered in challenging areas such as A&E and Cancer waiting times. Within the Acute setting reductions in the incidence of *Clostridium Difficile* have continued to be achieved and the trust should be commended for this performance.

The trust has unfortunately experienced challenges during 2013-14 with regard to delivery of the 'admitted' 18 weeks waiting time standards. The CCG welcomes the high priority being given to this key area of service delivery into 2014-15.

Our overarching view is that Sheffield Teaching Hospitals NHS Foundation Trust continues to provide services to a high standard. This quality account evidences that the Trust has achieved positive results against the majority of its key objectives for 2013/14. Where issues relating to clinical quality have been identified in year, the trust has been open and transparent and the CCG have worked closely to provide support where appropriate to allow improvements to be made.

The CCG is in agreement with the identified priority areas for improvement in 2014-15. Our aim is to proactively address issues relating to clinical quality so that standards of care and clinical governance are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. The CCG will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Submitted by Beverly Ryton on behalf of:

Kevin Clifford
Chief Nurse

and

Ian J Atkinson
Contract Lead STHFT

May 9th 2014

Healthwatch Sheffield 2013/14

Healthwatch Sheffield (HWS) were pleased to have been involved in the later parts of the process in drawing up the Quality Account; we acknowledge the challenges faced by the Trust in providing a suitable product required by Monitor and other Regulatory bodies, as well as making it fit for purpose for the general public.

We have asked for an “easier to read” version of the long and detailed account a number of times and this year we are promised that one will be delivered simultaneous to the publication of this formal Quality Account / Quality Report. The “easier to read” document, as identified in the Department of Health guidance, is intended to be more suited to a general public audience, and be available on request. It should report at least, in an easily read format, what the Trust said it would do, what it did, and the results of those actions.

We notice that customer satisfaction as indicated by Complaints is not showing appreciable improvement. The total number of complaints has increased, in particular the top five reasons for complaint, and this is a concern. We understand why the target (Trust determined?) of 85% of complaints being dealt with within 25 days was missed, but look for improvement on this poor record next year. We see customer satisfaction as being important to the public of Sheffield.

It is noted that ‘Community Services’ are now substantially within the remit of the Trust but the reporting does not always make this clear. There is a need to raise public awareness about the linkages and for there to be clearer reporting of those linkages made in future Quality Accounts.

We can find no mention of what has happened to the recently re-commissioned Care Home Support Team who support the care of those with dementia and end-of-life care in the home. We raised this in last year’s comments.

We would like to have seen greater emphasis on Giving patients a voice. Although this was one of last year’s priorities, we feel it ought to be on-going and form an important element of feedback in the Quality Account.

Improving discharge is of national importance and we would like to see how the Trust has improved the experience and outcomes in next year’s account.

The mandatory part of the document (the Quality Report) contains required comparative data; this is very helpful to readers and ought to be repeated throughout the document, as well as, in an appropriate form, in the easier to read document.

We understand the Trust’s priorities must reflect a wide range of interests and demands, nevertheless, HWS and the public of Sheffield would like to influence and to help in the determination of those priorities much earlier in the process.

Priority One: It is important that patients know who is treating and supporting them in hospital at all times, so we approve of this priority. Arranging for patients’ names and those of the consultant / lead nursing staff, consistently throughout the hospital is a step towards improvement, but other measures such as suitable, clear and legible name badges, with title, might help.

Priority Two: Producing benchmark information is important to indicate improvement or otherwise over time, but the aim should be about dealing with the complaints faster and more appropriately, and making serious attempts to minimise complaints overall. We would be grateful to see the interim report when it is produced in October 2014.

Priority Three: We are pleased that attention continues to be placed on this national target as it is of concern to the Public. The Public’s perception of the level of care at weekends or over bank holidays is that it is different to that received during the ‘normal’ working week - work to alleviate that concern or to rectify identified differences will be well received.

Priority Four: We were not quite sure of the importance of this priority given that the Trust has achieved the national standard; nevertheless increased waiting times are important to patients and their carers; it could be argued that lengthy waiting times increase stress levels and may even exacerbate existing conditions, thus negatively affecting the Patient Experience. What is important is to reduce all waiting times to less than the agreed national standard which currently stands at 18 weeks.

We would like to thank the Trust for caring for the public and patients of Sheffield and for the work involved in producing this report. Significant improvements to the Quality Account have been made over time and this must be acknowledged.

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

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

The Committee feel that the Quality Account priorities for 2013/14 capture the main concerns of Sheffield people. The Committee is pleased to see that both formal and informal feedback channels are reflected in the priorities and welcomes the Trusts planned improvements to their feedback systems as outlined in Priority 2, which aims to improve complainant satisfaction with the Trusts complaints process. The Committee also welcomes the planned publication of an "easier to read" version of the document and thanks Healthwatch Sheffield for their involvement in this.

The Committee welcomes the focus on reducing the number of operations cancelled on the day of surgery (Objective 2.1.6 Patient Experience - Cancelled operations) and commends the level of analysis the Trust is undertaking in this area. In addition, the Committee support the Trusts commitment to ensure clear and effective communication with patients and their family and friends throughout the admissions process.

In particular, the Committee recognises the work that the Trust has already undertaken to try and reduce the amount of time patients being discharged wait for their medication. The Committee appreciates the complexity of this issue and welcomes the multidisciplinary approach that the Trust has adopted to ensure further progress is made. The Committee also welcomes the planned information technology developments such as moving towards electronic communication approaches, which should ensure quicker and safer information exchanges.

With regards to priority principle 3 "To review mortality rates at the weekend" there remains a level of concern amongst the general public regarding differences in mortality rates at weekends. The Committee is therefore pleased to see that the Trust is planning further analysis around this national target and welcomes any action that will be taken to restore public confidence or address any identified differences. In addition the Committee would like to request that this analysis also includes mortality rates at Bank Holidays.

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 the Trust over the coming year both in terms of the Quality Account and across a wider range of issues.

Governor involvement in the Quality Report Steering Group

A number of governors attended the Quality Report Steering Group during the year. We enjoyed our participation in the group and we 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 there were proposals both from within the Trust and from outside. Those chosen had to be both relevant and meaningful, preferably patient centered and also, very important, measurable.

We were happy with the final choices for 2014/15. They are a good and representative sample from a number of choices and the intention is that, one way or another, they should all significantly improve patient experience.

As before, we feel that it is essential to continue to work on those priorities from previous years that have not been achieved and we understand that this carries the risk that the amount of work may increase each year, since priorities may take longer than a year to achieve.

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. Last year's summary version was a worthwhile attempt, but there is room for improvement and we look forward to the contribution from Healthwatch members this time round.

Andrew Manasse
28 April 2014

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 NHS foundation Trust boards should put in place to support 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 2013/14;
- 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 2013 to June 2014
 - papers relating to Quality reported to the Board over the period April 2013 to June 2014
 - feedback from commissioners dated 9th May 2014
 - feedback from governors dated 28th April 2014
 - feedback from local Healthwatch organisations dated 30th April 2014
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22nd May 2014
 - the latest national inpatient survey February 2014, the latest National Cancer Patient Experience survey October 2013 and the National Maternity Survey December 2013
 - The latest national staff survey dated February 2014
 - the head of internal audit's annual opinion over the trust's control environment dated 22nd May 2014
 - CQC quality and risk profiles dated April 2013-March 2014.
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information 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 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) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board



Tony Pedder OBE
Chairman
22nd May 2014



Sir Andrew Cash OBE
Chief Executive
22nd May 2014

4.4 Independent Auditors' Report to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust on the 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 2014 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 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; and
- 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 the Detailed Guidance for External Assurance on Quality Reports; 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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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 2014, 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 2014:

- 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

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

22 May 2014



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

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 holding the Non-Executive Directors to account for the performance of the Board of Directors; representing the interests of Trust members and members of the public; appointing the Chairman and other Non-Executive Directors; and deciding on their remuneration. It receives the Trust's Annual Report and Accounts and the Auditor's Report and has input into the Trust's Annual Plan. The Council must approve any significant transactions, mergers and acquisitions and changes to the Trust's constitution.

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 new Governors in the public and patient constituencies took place in Spring 2013.

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. Governors also contribute to a number of Trust committees, workstreams and specific projects.

Our membership

We have 27,196 members, of whom 4,146 are patient members, 7,805 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 four membership constituencies:

- **Patients:** anyone aged 12 or over and has been a patient of the Trust within the five years preceding their application.
- **Public:** residents of Sheffield aged 12 years or over.
- **Public outside Sheffield:** residents of England or Wales, outside of Sheffield, aged 12 or over
- **Staff:** employees contracted to work for the Trust for at least one 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:

Membership Manager
Foundation Trust Office
Sheffield Teaching Hospitals
NHS Foundation Trust
Northern General Hospital
Herries Road,
Sheffield S5 7AU
Telephone: 0114 271 4322
Email: jane.pellegrina@sth.nhs.uk

Our organisational structure

Council of Governors membership and attendance

	Elected from	Attendance (actual / possible)
Patient Governors		
Richard Barrass	1 July 2011	4/4
Roz Davies	1 July 2011	1/4
Caroline Irving	1 July 2013	3/4
David Owens	1 July 2012	3/4
Kath Parker	1 July 2012	4/4
Graham Thompson	1 July 2011	4/4
Michael Warner	1 July 2012	4/4
Public Governors		
Jo Bishop	1 July 2011	3/4
George Clark	1 July 2011	4/4
Anne Eckford	1 July 2013	3/4
Joyce Justice	1 July 2012	3/4
John Laxton	1 July 2011	4/4
Andrew Manasse	1 July 2012	4/4
Kaye Meegan	1 July 2013	2/4
Hetta Phipps	1 July 2013	4/4
Shirley Smith	1 July 2012	2/3
Sue Taylor	1 July 2013	2/3
Paul Wainwright	1 July 2012	3/4
John Warner	1 July 2011	4/4
Staff Governors		
Frank Edenborough (Medical and Dental)	1 July 2012	4/4
Christina Herbert (Nursing and Midwifery)	1 July 2012	3/4
Chris Monk (Allied Health Professionals, Scientists and Technicians)	1 July 2012	3/4
Craig Stevenson (Ancillary, Works and Maintenance)	1 July 2012	4/4
Claudia Westby (Management, Administration and Clerical)	1 July 2012	3/4
Appointed Governors		
Jayne Dunn (Sheffield City Council)		0/1
Heather MacDonald (Sheffield College)		1/4
Nicola Smith (Voluntary Action Sheffield)		3/4
Leigh Sorsbie (Sheffield Clinical Commissioning Group)		1/3
Jeremy Wight (Sheffield City Council)		3/4

Nomination and Remuneration Committee of the Council of Governors

The Nomination and Remuneration Committee of the Council of Governors makes recommendations to the Council 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.

Over the year, the Committee met four times. The Council of Governors approved the Committee's recommendations to appoint two new Non-Executive Directors: Annette Laban and Martin Temple.

Nominations and Remuneration Committee of the Council of Governors membership and attendance

Name	Designation	Attendance * (actual / possible)
George Clark (Vice Chairman)	Public Governor	2/2
Christina Herbert	Staff Governor	4/4
John Laxton	Public Governor	2/2
Heather MacDonald	Appointed Governor	1/2
Andrew Manasse	Public Governor	4/4
Chris Monk	Staff Governor	4/4
Tony Pedder (Chairman)	Trust Chairman	4/4
John Warner	Public Governor	4/4
Jeremy Wight	Appointed Governor	2/4

Annual Public Meeting

On 10 September 2013, around 125 people attended our first Annual Members' Meeting where members of the Trust, members of the public and other stakeholders had an opportunity to meet and ask questions of the Board of Directors.

The event was held in the Medical Education Centre at the Northern General Hospital and included presentations on progress over the last year and plans for the future. The event was followed by a visit to the new state-of-the-art Laboratories Centre.

Board of Directors

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

The Board's role is to promote the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public. It does this by

- ensuring compliance with its licence, its constitution and statutory, regulatory and contractual obligations;
- setting the strategic direction within the context of NHS priorities which provides the basis for overall strategy, planning and other decisions
- monitoring performance against objectives
- providing robust financial stewardship to ensure the Trust functions effectively, efficiently and economically
- ensuring the quality and safety of health care services, education and training and research;
- applying best practice standards of corporate governance and personal conduct;
- promoting effective dialogue between the Trust and the local communities we serve.

The Trust is satisfied that the Board of Directors and its committees have the appropriate balance of skills, experience and knowledge of the Trust to enable them to discharge their respective duties and responsibilities effectively.

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 use a number of ways to understand the views of our governors and members, including

- The Annual Members 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
- Joint meetings between the Board of Directors and Council of Governors on significant issues.
- Active involvement of Governors in key decision making groups such as the Quality Report Steering Group.

Board of Directors membership and attendance

Name	Position	Attendance (actual / possible)
Tony Pedder	Chairman	11/11
Andrew Cash	Chief Executive	11/11
David Throssell	Medical Director	11/11
Hilary Chapman	Chief Nurse	11/11
Neil Priestley	Director of Finance	11/11
Mark Gwilliam	Director of Human Resources and Organisational Development	11/11
Kirsten Major	Director of Strategy and Operations	11/11
Vic Powell	Non-Executive Director	10/11
Tony Weetman	Non-Executive Director	9/11
Vickie Ferres	Non-Executive Director	10/11
Shirley Harrison	Non-Executive Director	9/11
John Donnelly	Non-Executive Director	10/11
Annette Laban*	Non-Executive Director	9/9
Martin Temple*	Non-Executive Director	8/9

*Appointed 1 July 2013.

The Assistant Chief Executive, the Communications and Marketing Director and the Corporate Development Director also attend all Board of Directors meetings.

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 Assistant Chief Executive. Members of the public can access to the registers by making a request in writing to:

Assistant Chief Executive,
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, Metalysis Malaysia Ltd, EEF Ltd, JSW Ltd (India), University and Colleges Employers Association Ltd, Cutlers Hall Preservation Trust and HCF International Advisors Ltd. He is Chairman of TPRB 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 Director of Finance, the Assistant

Chief Executive, the Head of Internal Audit and a senior representative of the Trust's External Auditors KPMG normally attend the meeting. Membership of the Board of Director's Finance, Performance and Workforce Committee includes two members of the Audit Committee and the Director of Finance.

The committee provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides assurance by 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 considered the following matters:

- Going Concern papers received (Initial assessment January 2014 and updated assessment March 2014 meeting). The committee agreed that the 2013/14 Annual Accounts be prepared on a "going concern basis"
- Accounting Policies for completion of 2013/14 Financial Statements paper, including the appropriate accounting treatment for Charitable Funds, received and approved (January, 2014).
- Process and timetable for approval of 2013/14 Financial Statements and Annual Report paper received and approved (January, 2014).
- Assurance Framework received and noted (March 2014) prior to submission to Board of Directors.
- Statutory Financial Statements and Annual Report and Accounts 2012/13 (including the Quality Report) received and approved by the committee prior to being submitted to the Board of Directors for final approval (May 2013).

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	4/5

- Internal Audit Annual Report including the Head of Internal Audit Opinion received and noted. The report found significant assurance on the Trust's system of internal controls (May 2013)
- External Audit Annual Governance Report (ISA 260) including the Letter of Representation and Audit Opinion received and noted (May 2013). The report found no material errors in the financial statements and no matters to suggest the Trust did not have adequate arrangements for securing economy, efficiency and effectiveness. The report was subsequently presented to the Council of Governors (August 2013).
- External Audit External Assurance Report on the 2012/13 Quality Report received and noted (May 2013). It gave a limited assurance opinion that the Quality Report was compliant and accurate. The report was subsequently presented to the Council of Governors (August 2013).
- Losses and Compensations Report received and noted (July 2013). Further actions were outlined to minimise future losses and compensations including the production of a Debt Management Policy.
- Audit Committee 2012/13 Annual Report and 2013/14 Work Plan and Terms of Reference received and approved (May 2013).
- Local Counter Fraud Services progress reports received and noted (all meetings except May 2013); 2013/14 Annual Report (March 2014); 2014/15 Work Plan and Risk Assessment (March 2014).
- Single Tender Waiver Reports received and noted (all meetings except May 2013).
- Registers of Gifts and Hospitality reports received and noted (all meetings except May 2013).
- Risk-based Internal Audit Draft Plan 2014/15 received and approved (January and March 2014).
- Risk-based External Audit Plan received and approved (October 2013).
- Internal Audit Progress Reports received and noted (all meetings except May 2013).
- External Audit Progress Reports received and noted (all meetings except May 2013).
- Insurance Arrangements paper received and noted (July 2013).
- Internal and External Audit Relationship paper including Protocol between Internal and External Audit received and noted (October 2013).
- Progress Report against the Action Plans for D and E Grade audits.¹ Received and noted (all meetings except May 2013). The following audits were discussed and actioned as appropriate:
 - Supplies (May 2013, July 2013, October 2013, January 2014, March 2014)
 - Bereavement Services (July 2013)
 - Encryption Process (October 2013, January 2014, March 2014)
- Progress report on the reconfiguration of Internal Audit received and noted (July 2013). From 1st July 2013 Assure and EMIAS merged to form 360 Assurance.
- Report on a Review of External Audit Services carried out by the Trust was received and approved (July 2013). The review concluded that the Trust was receiving a satisfactory service and recommended the re-appointment of KPMG for 2013/14 to the Council of Governors. The Council of Governors approved that recommendation (August 2013).
- Report on an Extension of Appointment of External Auditor carried out by the Trust was received and approved (January 2014). The report recommended to the Council of Governors the extension of the External Audit contract to September 2016. That recommendation was approved by the Council of Governors (February 2014).

¹Internal Audits are graded. D grading indicates the presence of medium-high risks/ internal control weaknesses, where immediate action is required. E grading denotes systems which contain significant risks requiring immediate attention and reporting to management.

Nomination and Remuneration Committee of the Board of Directors

The Nomination and Remuneration Committee of the Board of Directors makes recommendations on the appointment and remuneration of Executive Directors, including the Chief Executive. The committee met on 15 May and 6 September 2013.

Nomination and Remuneration Committee of the Board of Directors membership and attendance

Name	Position	Attendance (actual / possible)
Tony Pedder (Chair)	Chairman	2/2
Vic Powell (Deputy Chairman)	Non-Executive Director	0/2
John Donnelly	Non-Executive Director	1/2
Vickie Ferres	Non-Executive Director	1/2
Shirley Harrison	Non-Executive Director	1/2
Tony Weetman	Non-Executive Director	0/2
Annette Laban*	Non-Executive Director	1/1
Martin Temple*	Non-Executive Director	1/1

*Appointed 1 July 2013.

Other Committees of the Board

There are 2 other committees of the Board of Directors:

Committee	Chairman
Healthcare Governance Committee	Vickie Ferres (Chair), Tony Pedder, Tony Weetman, Shirley Harrison, Andrew Cash, Hillary Chapman, David Throssell, Mark Gwilliam, Kirsten Major, Annette Laban*
Finance, Performance and Workforce Committee	Vic Powell (Chair), Tony Pedder, John Donnelly, Andrew Cash, Neil Priestley, Kirsten Major, Mark Gwilliam, Martin Temple*

*Appointed 1 July 2013.



Sir Andrew Cash OBE

Chief Executive

22 May 2014

Board of Directors 2013/14



Chairman
Tony Pedder OBE

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
Professor Hilary Chapman CBE

Hilary is the Chief Nurse 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
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.



Director of Strategy and Operations
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 and Organisational Development
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 £1.25m.

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 was in marketing and public relations both

as a practitioner and an academic. She led courses in business strategy for Leeds Business School and the Institute of Directors, among others. Previous public appointments include Chair of the Human Fertilisation and Embryology Authority, Chair of the Human Tissue Authority and membership at board level of a number of organisations ranging from broadcasting to consumer affairs.

Following cancer treatment in 2000 and again in 2011 she has represented patients on a number of local, regional and national bodies, largely concerned with cancer education and research. She is currently a Board Member of the National Cancer Research Institute, sits on a NHS England Clinical Reference Group, and works with both Cancer Research UK and Breast Cancer Care on a number of projects.



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.



Annette Laban

Annette has more than 35 years' experience working within the NHS and

local government in senior positions and throughout her career she has been responsible for overseeing many innovations which have directly impacted on frontline NHS care. Her past roles have included, Chief Executive for NHS Doncaster, Director of Performance and Operations at NHS North of England – Strategic Health Authority and Executive Director of Performance and Delivery at NHS Yorkshire and the Humber.



Martin Temple CBE

Martin was the Director-General and is now the Chairman of EEF. He was also

a Non-Executive Director and Chairman of The 600 Group and he is the Chairman of the Design Council. Martin is on the Council of the University of Warwick as well as the Board of Warwick University Business School and he currently sits on the Catapult Oversight Board. Martin was previously Vice President of Avesta-Sheffield AB, a major producer of stainless steel. He has served on the boards of a wide range of companies around the world. He has extensive experience covering senior roles in production, marketing, operations and strategy in an international context.

Other Directors who attend the Board



Assistant
Chief Executive
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. Neil was appointed to the post of Assistant Chief Executive at Sheffield Teaching Hospitals NHS Foundation Trust in 2002 and has incorporated the duties of Trust Secretary within his role since 2006.



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.

Remuneration report

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is determined by the Nominations and Remuneration 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 Assistant Chief Executive (in his capacity as 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 and Non-Medical staff groups, together with Executive Directors' remuneration data from comparative Teaching Hospitals, particularly the Shelford Group. 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. The Trust does not operate a system of performance related pay. In the course of 2013/14 the Chairman, on behalf of the Remuneration Committee, commissioned HAY to review Executive Director remuneration within the Trust. The outcome of this report will be rigorously considered by the committee and will form the basis for any decisions concerning remuneration in 2014/15. The cost of this review was less than £20k.

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.

Remuneration Report

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

Name	Term of Office – Start	Term of Office – End
Tony Pedder	Appointed 1 Jan 2012	31 Dec 2016
John Donnelly	Reappointed 1 July 2010	30 June 2014
Vickie Ferres	Reappointed 1 July 2013	30 June 2014
Shirley Harrison	Reappointed 1 Nov 2011	31 Oct 2015
Annette Laban	Appointed 1 July 2013	30 June 2017
Vic Powell	Reappointed 1 July 2011	30 June 2015
Martin Temple	Appointed 1 July 2013	30 June 2017
Tony Weetman	Appointed 1 July 2013	30 June 2017

Attendance at Committee meetings

Members	Meeting dates		
	15 May 2013	6 September 2013	19 March 2014
Tony Pedder	✓	✓	✓
John Donnelly	✓	✗	✓
Vickie Ferres	✗	✓	✓
Shirley Harrison	✓	✓	✓
Annette Laban	n/a	✓	✓
Vic Powell	✗	✗	✓
Martin Temple	n/a	✓	✗
Tony Weetman	✗	✗	✓

Expenses for Executive and Non Executive Directors and Governors

	2013/14	2012/13
Executive and Non Executive Directors		
Number who claimed expenses during the year	10	10
Number of Executives / Non Executives who held office during the year	14	15
Amount claimed in total	£12,150.93	£8,352.47
Governors		
Number who claimed expenses during the Year	10	8
Number of Governors who held office during year	29	39
Amount claimed in total	£1,696.13	£1,491.27

Pay Multiple Statement

	2013/14	2012/13	2011/12
Highest-paid Director Total Remuneration (mid point banded remuneration in multiples of £5k)	£217.5k	£217.5k	217.5k
Median Total Remuneration	£25,852	£25,721	£25,506
Ratio	8.35	8.39	8.46

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 2013/14 were less than £14k.

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 2013/14 was £217.5k (2012/13, £217.5k). This was 8.35 times (2012/13, 8.39) the median remuneration of the workforce, which was £25,852 (2012/13, £25,721). The figures are shown in tabular format above.

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 2013/14 and 2012/13

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 2013/14 owing to pay rises for members of staff on certain Agenda for Change pay grades. The increase in total median pay in 2013/14 and the 'freeze' in the pay of the highest-paid Director serves to explain the decrease in the multiple from 2012/13 in the above table.

Disclosure of highly paid and/or senior Off-Payroll Engagements

The Trust had no highly paid/and or senior off-payroll engagements during 2013/14 which require disclosure.

Remuneration Report

Single Total Remuneration – 2013/14

Single Total Remuneration – 2013/14	Salary (Bands of £5k)	Taxable benefits (£)	Annual Performance Related Bonuses (£)	Long term Performance related bonuses (£)	Increase in Pension Related benefits in Year (Bands of £2.5k)	Single Total Remuneration (Bands of £5k)
Sir A J Cash OBE Chief Executive	215-220				12.5-15	225-230
Mr N Priestley Director of Finance	170-175				17.5-20	190-195
Dr D Throssell Medical Director	145-150				97.5-100	245-250
Professor H Chapman CBE Chief Nurse	170-175				12.5-15	185-190
Ms K Major Director of Strategy and Operations	140-145				55-57.5	195-200
Mr M Gwilliam Director of Human Resources	145-150				60-62.5	205-210
Mr J P Donnelly Non-Executive Director	15-20					15-20
Ms V R Ferres Non-Executive Director	15-20					15-20
Mr V G W Powell Non-Executive Director	15-20					15-20
Ms S Harrison Non Executive Director	15-20					15-20
Professor A P Weetman Non-Executive Director	15-20					15-20
Mr M J Temple Non-Executive Director (from 1st July 2013)	10-15					10-15
Ms A Laban Non-Executive Director (from 1st July 2013)	10-15					10-15
Mr A Pedder Chairman	55-60					55-60

For defined benefit schemes, the amount included here is the annual increase (expressed in £2,500 bands) in pension entitlement determined in accordance with the 'HMRC' method*. In summary, this is as follows:

$$\text{Increase} = ((20 \times \text{PE}) + \text{LSE}) - ((20 \times \text{PB}) + \text{LSB})$$

Where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year

PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

*The HMRC method derives from s229 of the Finance Act 2004, but is modified for the purpose of this calculation by paragraph 10(1)(e) of schedule 8 of SI 2008/410 (as replaced by SI 2013/1981).

Single Total Remuneration – 2012/13

Single Total Remuneration – 2012/13	Salary (Bands of £5k)	Taxable benefits (£)	Annual Performance Related Bonuses (£)	Long term Performance related bonuses (£)	Increase in Pension Related benefits in Year (Bands of £2.5k)	Single Total Remuneration (Bands of £5k)
Sir A J Cash OBE Chief Executive	215-220				12.5-15	230-235
Mr N Priestley Director of Finance	170-175				187.5-190	360-365
Dr D Throssell Medical Director (from 1st September 2012)	85-90				95-97.5	180-185
Professor M Richmond Medical Director (1 April 2012 – 31 August 2012)	75-80				17.5-20	90-95
Professor H Chapman CBE Chief Nurse	170-175				15-17.5	190-195
Ms K Major Director of Strategy and Operations	135-140				55-57.5	190-195
Mr M Gwilliam Director of Human Resources	135-140				45-47.5	180-185
Mr J P Donnelly Non-Executive Director	15-20					15-20
Ms V R Ferres Non-Executive Director	15-20					15-20
Mr V G W Powell Non-Executive Director	15-20					15-20
Ms S Harrison Non Executive Director	15-20					15-20
Professor A P Weetman Non-Executive Director	15-20					15-20
Mr I Thompson (term of office expired 30 April 2012)	0-5					0-5
Professor R Billingsley (resigned 31 December 2012)	10-15					10-15
Mr A Pedder Chairman	55-60					55-60

Other Information

Please refer to the notes in the 2013/14 Accounts contained in this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Changes in Pension at age 60 during 2013/14

- Value of the cash equivalent transfer value at the beginning of the year
- Changes in the cash equivalent transfer value during 2013/14.

Andrew Cash

Sir Andrew Cash OBE

Chief Executive

22 May 2014

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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; 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
 22 May 2014



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.

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 2014 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 its licence, its constitution and statutory, regulatory and contractual obligations.

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, Performance and Workforce Committee
- Nomination and Remuneration Committee of the Board of Directors.

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 Assistant Chief Executive, 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.

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 and chaired by the Assistant Chief Executive, membership of the group includes the Medical Director, the Chief Nurse and the 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.

The directorate investigation report and action plan is reviewed and approved by the SUI Group, subject to any further change it considers necessary. 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 six monthly written report. A Trust policy which formalises the systems and processes for managing SUIs ensures a standard approach is followed.

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 Trust continues to build upon its Quality Governance arrangements following a review using Monitor's Quality Governance Framework that was undertaken in 2011/12.

The Healthcare Governance Committee provides Board level oversight for quality issues using a focused agenda built around the Darzi definition of quality and a structured annual work plan. It receives regular reports from key risk-based committees including the Safety and Risk Management Board, Patient Experience Committee and Clinical Effectiveness Committee.

A Quality Strategy which supports the corporate strategy *Making a Difference* has well-defined goals to strengthen quality governance. Implementation of the strategy is the responsibility of the Quality Board which reports to the Healthcare Governance Committee.

A far reaching programme of quality improvement to address priority areas identified in the Quality Strategy is well underway. With support from The Health Foundation, the Trust has established an Academy to train and support staff to work as coaches to front line teams using Clinical Microsystems methodology to introduce quality improvements. The Academy has trained 64 coaches across a range of clinical and corporate areas.

Using action learning theory these coaches will produce new improvement Microsystems. Patients will be involved in every microsystem.

The Trust has actively considered the findings of Robert Francis *Report of Mid Staffordshire NHS Foundation Trust Public Inquiry* and the government's final response *Hard Truths: The Journey to Putting Patients First*. Each of the *Hard Truths* recommendations has been reviewed to better understand which will require new action, which will require an adjustment of existing workstreams and which will require a watching brief. The Trust has launched an exercise to communicate and discuss the issues with staff and its external partners such as Healthwatch and Scrutiny Committee in preparing its Final Response Plan which will be monitored by the Healthcare Governance Committee.

The Trust employs a wide range of methods to capture feedback from patients and their families and visitors including comment cards, real-time patient surveys, website feedback, complaints and the new Friends and Family Test. Feedback is reported via regular Patient Experience Reports and complaints reports at ward, directorate, group and Trust-level to the Trust Executive Group, the Healthcare Governance Committee and the Board of Directors.

Following a number of national reviews in 2013/14 including the Francis Report, the Clywd-Hart Review and the Keogh Review, the Trust plans a comprehensive review of its complaints management service which will ensure a more timely and responsive process that meets the recommendations of the reviews. A programme of training for senior clinical staff will be introduced to support the new complaints process and ensure a more consistent and thorough approach when investigating and responding to complaints. The new process will be audited using input from the complainants' experience to ensure the standards we set are being met. The findings will be used to further improve and develop the complaints service.

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 its 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 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 2013/14.**
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.**
Following a challenging year in 2012/13, the Trust faced further increases in A&E attendance, acuity and admissions during 2013/14, especially during Q4, and introduced a number of actions in addition to those already underway. For example, the national Emergency Care Intensive Support Team visited in September 2013 and an action plan was integrated into the Trust's Winter Plans; one of three newly appointed Deputy Medical Directors took the lead in improving patient flow; twice daily SITREP meetings were introduced; and, a capital scheme to improve the Clinical Decision Unit was completed. The Trust successfully met the target.
- **Infection prevention and control.**
The Trust faced a significant challenge to meet the reduced target cases for *C.Difficile* it was set for 2013/14. In addition to the annual Infection Prevention and Control work programme, an action plan to deliver the *C.Difficile* target was developed in October 2013. The action plan focused on improving cleanliness and optimising infection prevention and control practice and antibiotic prescribing and usage. It was managed under the executive leadership of the Chief Nurse with oversight by TEG and the Board of Directors. The Trust successfully met the target.
- **Failure to meet elective waiting times targets.**
The Trust did not meet the 18 week wait targets for non-admitted pathways in the four months from November 2013 to February 2014 and for admitted pathways in February 2014. Whilst the target for incomplete pathways has been met, performance has worsened. The causes of the deterioration of performance against all 18 week wait targets in 2013/14

are an increase in referrals unmatched by planned activity levels agreed with commissioners in the contract and sub-optimal administrative and management arrangements for 18 week waits target performance management. A board approved action plan is in place and includes the implementation of an Access Policy, staff re-training, work to validate incomplete pathways, improved performance management reporting, a Waiting List task and finish group chaired by a Non-Executive Director and the approval of directorate recovery plans, identifying additional capacity and support for service design where necessary. Progress with the plan will be overseen by TEG and the Board of Directors. The Trust action plan anticipates returning to target in June 2014.

- **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 (2014/15 onwards)** which will be managed and mitigated by detailed annual planning; an efficiency programme; enhanced performance management and reporting; effective negotiation and engagement with commissioners; and, robust oversight by relevant board committees.
- **Care of patients in an inappropriate setting.**
The Trust will continue to work with its partners through the Right First Time project and particularly to increase the pace at which issues are resolved.
- **Future configuration of acute services at sub-regional level ensuring clinical and financial services going forward.**
The Trust has made significant investment in the Working Together initiative as a means of addressing the issues.

The Trust formally assesses the risk of compliance with the conditions of its licence and the sufficiency of controls in place via a quarterly report to the Trust Executive Group and the Board of Directors. The report provides the basis of Board assurance about the validity of the

Corporate Governance Statement, supplemented by further assurances gained from oversight of the Annual Planning process, (including involvement of the Council of Governors), the Top Risk Report, the Assurance Framework and other assurance reports and papers to the Board and its committees.

The principal risks to compliance with Condition FT4 (Foundation Trust governance arrangements) are:

- The planned replacement of two Non-Executive Directors who have been long-standing members of the Board. This follows the appointment of two new Non-Executive Directors in 2013. The Trust has well established and effective processes for Non-Executive Director appointment and induction and looks forward to refreshing the Board.
- The scale and complexity of the Board agenda is becoming evidently more intense in the face of significant challenges and uncertainties for the NHS. The Board is aware of the need to continuously evaluate the way the Board and its committees work to ensure it continues to be effective, efficient and economic in managing its agenda.

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

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

The Board of Directors receive a monthly Performance Report which includes performance against national targets, CQUIN standards, the Trust's KPIs and inpatient and outpatient activity. This report is supplemented

by more detailed reports on matters such as patient experience and exception reports where performance requires closer monitoring. The Board is assured of the quality of information included in the performance report via a number of sources including routine scrutiny by the Committees of the Board and through internal quality assurance systems, internal and external audit reports.

Work is underway to introduce a more structured and integrated performance monitoring framework and reporting to the Board in 2014.

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.

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 after implementation of the Trust's 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.

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 City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
- Healthwatch Sheffield
- 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 Shelford Group, the Foundation Trust Network, the NHS Confederation and the 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 standards of safety and quality for all its regulated activities across all its locations.

In November 2013, as part of the annual business planning process, all clinical directorates reviewed their local governance arrangements and verified compliance with the CQC standards.

The process was overseen by the department of Patient and Healthcare Governance and reported to the Healthcare Governance Committee.

The department of Patient and Healthcare Governance has further developed the Trust's programme of internal Quality Governance Inspections which are triggered by potential areas of concern identified in reports to the Healthcare Governance Committee and simulate a CQC inspection. The programme has been evaluated and updated in response to changing CQC standards and inspection methodology. Quality Governance Inspections use direct observation, structured interviews with patients and staff and a review of relevant internal intelligence sources such as patient and staff survey results, incidents, complaints, eCAT, external visits and inspections etc. Senior managers in 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 regular update on the programme.

The Healthcare Governance Committee receives a monthly update report on Quality Governance Inspections. The report also includes surveillance information from the CQC Intelligent Monitoring Reports, issues that the Trust is formally notified of and development news from the CQC. The committee also receives all CQC inspection reports in full for discussion and action, if necessary.

During the year, the CQC made one unannounced routine inspection of the Trust. Between 9 and 20 September 2013, the inspectors visited the Northern General Hospital, the Royal Hallamshire Hospital, Jessop Wing and Weston Park Hospital. The CQC found the Trust to be compliant with all the standards covered by the inspection and no concerns were raised. Following the visit, the Trust developed an improvement plan which has been overseen by the Healthcare Governance Committee.

In partnership with Sheffield Health and Social Care NHS Foundation Trust, the Trust is implementing an improvement plan that was developed to address the findings of the CQC's report on systems in place to monitor people detained under the Mental Health Act 1983, following a routine visit to the Northern General Hospital in March 2013.

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 Inclusion Steering Group (reporting to TEG and the Healthcare Governance Committee and chaired by the Assistant Chief Executive) and an Operational Leads Group (responsible to the steering group and including representatives from each care group) which ensures good practice in equality, diversity and inclusion is identified and shared across the organisation. In addition the Trust has policies, 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 continues to meet specific requirements set out under the Equality Act 2010, including implementation of its Equality Objectives, (which can be found on the Trust's website); publishing its Equality and Human Rights Annual Report (which communicates progress on the Public Sector Equality Duty); and, publishing equality information relevant to people who use the Trust's services and Trust staff.

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

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, Performance and Workforce Committee. An Annual Plan is submitted to Monitor, reflecting finance and governance (including service and quality aspects), each of which is assessed by Monitor. This plan incorporates projections for subsequent 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. Financial plans are underpinned by the Trust's Business Planning processes which also drive strategic and operational planning at Directorate and service level.

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. The Trust's Service Improvement function drives this work with a key principle that the programme seeks improvements to the quality of 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 risk ratings and the Care Quality Commission's Intelligent Monitoring Report 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 three quality priorities that were agreed for 2013/14 and has identified three new priorities for 2014/15 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 City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, Healthwatch Sheffield, NHS Sheffield Clinical Commissioning Group and the Council of Governors and approved by the Board of Directors.

Relevant specialists or managers in the Trust were approached to provide supporting data using established data sources which are subject to internal information quality assurance. A draft Quality Report was sent to the Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, Healthwatch Sheffield 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 NHS Foundation Trust 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 receives and monitors 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 Risk Ratings 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 City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, Healthwatch Sheffield 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 (360 Assurance) 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 Risk Ratings by Monitor.
- DH reports such as Performance Indicators.
- Ongoing compliance with CQC's Essential Standards of Safety and Quality for all regulated activities across all its locations, as part of the registration process, CQC reports on its visits and inspections and its Intelligent Monitoring Report.
- 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

22 May 2014

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

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2014 on pages 118 to 154. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

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 Council 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 106 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. 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 2014 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 2013/14.

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

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

Matters on which we are required to report by exception

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

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

Certificate

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



Trevor Rees

For and on behalf of KPMG LLP Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

22 May 2014

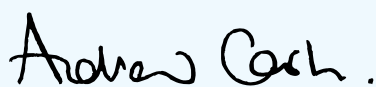
10 Financial statements

Foreword to the accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2014 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

22 May 2014

Statement of Comprehensive Income for the year ending 31 March 2014

	NOTE	2013/14 £'000	2012/13 £'000
Operating Income from continuing operations	3.1	932,870	909,487
Operating Expenses from continuing operations	4.1	(912,723)	(893,810)
OPERATING SURPLUS		20,147	15,677
FINANCE COSTS			
Finance income	7.1	218	178
Finance expense- financial liabilities	7.2	(3,400)	(3,449)
Finance expense-unwinding of discount on provisions		(58)	(64)
Public Dividend Capital Dividends payable		(9,643)	(9,926)
Net Finance Costs		(12,883)	(13,261)
SURPLUS FROM CONTINUING OPERATIONS		7,264	2,416
Other comprehensive income			
Gain from transfer by absorption from demising bodies		9,134	0
Impairment		(316)	0
Revaluation		2,184	7,371
Other reserve movements		3	0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		18,269	9,787

The notes on pages 122 to 154 form part of these accounts

All income and expenditure is derived from continuing operations

Statement of Financial Position 31 March 2014

		31 March 2014	31 March 2013
	NOTE	£'000	£'000
Non-current assets			
Intangible assets	8.1	2,517	1,199
Property, plant and equipment	9.1	430,571	419,402
Investments	11.0	0	0
Trade and other receivables	13.1	4,889	6,242
Total non-current assets		437,977	426,843
Current assets			
Inventories	12.1	13,141	12,991
Trade and other receivables	13.1	39,157	27,204
Current asset investments	14	0	0
Cash	22	76,214	71,089
Total current assets		128,512	111,284
Current liabilities			
Trade and other payables	15.1	(88,334)	(81,355)
Borrowings	17	(2,484)	(2,445)
Provisions due within one year	20	(3,336)	(3,289)
Other liabilities	16	(14,202)	(9,995)
Total current liabilities		(108,356)	(97,084)
Total assets less current liabilities		458,133	441,043
Non current liabilities			
Borrowings	17	(49,113)	(51,598)
Provisions due after one year	20	(2,224)	(2,165)
Other liabilities	16	(737)	(1,340)
Total non-current liabilities		(52,074)	(55,103)
Total assets employed		406,059	385,940
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		326,507	324,657
Revaluation reserve	21	32,697	31,765
Income and expenditure reserve		46,855	29,518
Total Taxpayers' equity		406,059	385,940

The financial statements on pages 118 to 154 were approved by the Board on 22 May 2014 and were signed on behalf of the Board by



Sir Andrew Cash OBE,
Chief Executive
22 May 2014

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2013	385,940	324,657	31,765	29,518
Surplus for the year	7,264			7,264
Transfers by modified absorption: Gains/(losses) on 1 April transfers from demising bodies.	9,134			9,134
Transfers by modified absorption: transfers between reserves	-		1,339	(1,339)
Transfers between reserves			(2,275)	2,275
Impairments	(316)		(316)	
Revaluation gains on property, plant and equipment	2,184		2,184	
Public Dividend Capital received	2,883	2,883		
PDC adjustment for cash impact of payables/receivables transferred from legacy teams	(1,033)	(1,033)		
Other Reserve Movements	3			3
Taxpayers' Equity at 31 March 2014	406,059	326,507	32,697	46,855
Taxpayers' Equity at 1 April 2012	376,153	324,657	27,733	23,763
Surplus for the year	2,416			2,416
Revaluation gains on property, plant and equipment	7,371		7,371	
Impairments	0		0	
Other recognised gains and losses	0		(3,339)	3,339
Taxpayers' Equity at 31 March 2013	385,940	324,657	31,765	29,518

Statement of Cash Flows 31 March 2014

	NOTE	2013/14 £'000	2012/13 £'000
Cash flows from operating activities			
Operating surplus from continuing operations		20,147	15,677
Non-cash income and expenditure			
Depreciation and amortisation		30,058	31,743
Impairments		1,969	18,803
Reversals of impairments		(623)	(15,387)
Gain on disposal		(59)	(29)
Non cash donations / grants credited to income		(228)	0
(Increase) in Trade and Other Receivables		(8,958)	(189)
(Increase) / decrease in Inventories		(150)	683
Increase in Trade and other Payables		6,814	9,304
Increase / (decrease) in Other Liabilities		3,604	(1,854)
Increase in Provisions		48	824
Other operating cashflows		(1,359)	(2,724)
NET CASH GENERATED FROM OPERATIONS		51,263	56,851
Cash flows from investing activities			
Interest received		216	190
Purchase of intangible assets		(150)	(257)
Purchase of Property, Plant and Equipment		(33,773)	(37,265)
Sales of Property, Plant and Equipment		59	64
Net cash used in investing activities		(33,648)	(37,268)
Cash flows from financing activities			
Public Dividend Capital received		2,883	0
Public Dividend Capital (Cash adjustment for modified absorption transfers)		(1,033)	0
Loans repaid		(1,445)	(1,445)
Capital element of finance lease rental payments		(395)	(380)
Capital element of Private Finance Initiative Obligations		(605)	(601)
Interest paid		(1,341)	(1,397)
Interest element of finance lease		(140)	(155)
Interest element of Private Finance Initiative obligations		(1,928)	(1,895)
Public Dividend Capital Dividend paid		(9,196)	(10,179)
Cash flows from other financing activities		710	2,425
Net cash used in financing activities		(12,490)	(13,627)
Increase in cash and cash equivalents		5,125	5,956
Cash and Cash equivalents at 1 April	22	71,089	65,133
Cash and Cash equivalents at 31 March		76,214	71,089

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 2013/14 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 Consolidation

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is not a corporate Trustee of any of its supporting/linked charities, it does not have the power to exercise control so as to obtain economic benefits. Additionally the transactions are immaterial in the context of the Trust and so transactions have not been consolidated.

1.2 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.

1.3 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 the valuation 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.

1.4 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.

1.5 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. An interim three yearly valuation 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 that 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-Statement of Financial Position' by the Trust. In accordance with IAS17, the underlying assets are recognised as Property, Plant and Equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as Property, Plant and Equipment and/or intangible assets as appropriate.

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.

1.6 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.

1.7 Revenue, government and other grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups 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.

1.8 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.

1.9 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.

1.10 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.

1.11 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 (NHS LA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHS LA, which, in return, settles all clinical negligence claims. Although the NHS LA 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 NHS LA 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.

1.12 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.

1.13 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 (including lottery funded assets), average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, for 2013/14 only, net assets and liabilities transferred from bodies which

ceased to exist on 1 April 2013, 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.

1.14 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.

1.15 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all their activities.

1.16 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.

1.17 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.

1.18 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.

1.19 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. For the 1 April 2013 transfer of assets from Sheffield PCT, the net gain corresponding to the net assets transferred from Sheffield PCT is recognised within the income and expenditure reserve.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entities accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

The different accounting policy on Information Technology assets between the Trust and the former PCT has been harmonised immediately following transfer of the assets, with an adjustment of £356k being made against taxpayers' equity.

1.20 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 1.5 & note 9
- Income Estimates - see paragraph 1.2. 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 1.9 & note 13.2
- Expenditure Accruals - see paragraph 1.4 & note 15.1
- Provisions - see paragraph 1.11 & note 20

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 2013/14:

- IAS 27 Separate Financial Statements - effective date of 2014/15
- IAS 28 Investments in Associates and Joint Ventures - effective date of 2014/15
- IAS 32 Financial Instruments Presentation (amendment) - effective date of 2014/15
- 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 date of 2014/15
- IFRS 11 Joint Arrangements - effective date of 2014/15
- IFRS 12 Disclosure of Interests in Other Entities - effective date of 2014/15
- IFRS 13 Fair Value Measurement - effective date of 2013/14, but not yet adopted by HM Treasury.

The application of the Standards as revised would not have a material impact on the accounts of the Trust for 2013/14, were they applied in that year.

2 Segmental analysis

The Trust has determined that the Chief Operating decision maker (as defined by IFRS 8: Operating Segments) is the Board of Directors, on the basis that all strategic decisions are made by the Board.

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

3. Income

3.1 Income from Activities

Income from Activities	2013/14	2012/13
	£'000	£'000
Elective income	156,884	158,775
Non Elective income	177,439	177,204
Outpatient income	123,789	113,776
A&E Income	15,306	14,423
Other NHS Clinical income	252,538	226,109
Income re Community Services	60,863	55,786
Private Patient Income	3,692	3,762
Total income from activities	790,511	749,835
Other operating income	2013/14	2012/13
	£'000	£'000
Research and development	12,872	11,666
Education and training	63,623	65,608
Received from NHS Charities:		
Receipt of grants / donations for capital acquisitions	296	100
Received from other bodies:		
Receipt of grants / donations for capital acquisitions	1,271	2,624
Charitable and other contributions to expenditure		
Non-patient care services to other bodies	49,476	49,870
Other	13,886	14,084
Gain on disposal	59	29
Operating lease income	253	284
Reversal of impairments of property, plant & equipment	623	15,387
Total other operating income	142,359	159,652
TOTAL OPERATING INCOME	932,870	909,487

3.2 Operating lease income

	2013/14 £'000	2012/13 £'000
Rents recognised as income in the period	240	284
Contingent rents recognised as income in the period	13	0
	253	284
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.	606	647
TOTAL	606	647
Re Buildings		
- not later than one year;	1	3
- later than one year and not later than five years;	296	334
- later than five years.	1457	1470
TOTAL	1,754	1,807
Total - All categories		
- not later than one year;	1	3
- later than one year and not later than five years;	296	334
- later than five years.	2063	2117
TOTAL	2,360	2,454

3.3 Operating Income (by type)

Income from activities	2013/14 £'000	2012/13 £'000
Strategic Health Authorities	0	3,358
Primary Care Trusts	0	737,481
Clinical Commissioning Groups and NHS England	774,969	0
NHS Foundation Trusts	2	0
Local Authorities	8,723	344
NHS Other	1,850	1,511
Non NHS: Private patients	3,081	2,936
Non NHS: Overseas patients (non-reciprocal)	611	403
NHS injury scheme (formerly the Road Traffic Act Scheme)	1,114	3,656
Non NHS: Other*	161	146
Total income from activities	790,511	749,835

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

Other Operating Income	2013/14 £'000	2012/13 £'000
Research and Development	12,872	11,666
Education and Training	63,623	65,608
Received from NHS Charities:		
Receipt of grants / donations for capital acquisitions	296	100
Received from other bodies:		
Receipt of grants / donations for capital acquisitions	1,271	2,624
Charitable and other contributions to expenditure	0	0
Non patient care services to other bodies	49,476	49,870
Reversal of impairments of property, plant & equipment	623	15,387
Operating lease income	253	284
Other **	13,886	14,084
Gain on disposal	59	29
Total Other income	142,359	159,652

**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

Commissioner Requested Services for the year totalled £849,165k (2012-13 £808,302k).

Non-Commissioner Requested Services were £83,705k (2012-13 £101,185k).

4. Operating Expenses

4.1 Operating expenses comprise:

	2013/14	2012/13
	Total	Total
	£'000	£'000
Services from other NHS Foundation Trusts	9,370	8,848
Services from other NHS Trusts	273	25
Services from Primary Care Trusts	0	463
Services from CCGs and NHS England	449	0
Services from other NHS bodies	139	6,364
Purchase of healthcare from non NHS bodies	18,550	14,855
Executive Directors' costs	1,244	1,235
Non-Executive Directors' costs	176	165
Staff costs	561,851	548,304
Drugs costs	114,974	91,237
Supplies and services - clinical	89,763	86,990
Supplies and services - general	9,125	8,109
Establishment	9,513	8,966
Research and Development	4,261	3,424
Transport	660	735
Premises	34,969	35,881
Increase / (decrease) in bad debt provision	226	(840)
Change in provisions discount rate	95	0
Depreciation on property, plant and equipment	29,525	31,355
Amortisation of intangible assets	533	388
Impairments of property, plant and equipment	1,952	18,785
Impairments of intangible assets	17	18
Operating lease costs	1,587	1,842
Audit services - statutory audit	59	56
Further audit assurance services	11	11
Clinical negligence	10,308	12,946
Legal fees	1,892	2,106
Consultancy costs	2,965	3,175
Training, courses and conferences	2,510	2,312
Redundancy	931	1,757
Insurance	902	993
Other Services	2,812	1,174
Losses, ex gratia & special payments	127	442
Other	954	1,689
Total	912,723	893,810
	£'000	£'000
Limitation on Auditors' liability	1,000	1,000

4.2 Arrangements containing an operating lease

	2013/14	2012/13
	£'000	£'000
Minimum lease payments	1,587	1,842
Contingent rents	0	0
Less sublease payments received	0	0
Total	1,587	1,842

4.3 Arrangements containing an operating lease

	2013/14 £'000	2012/13 £'000
Future minimum lease payments due:		
Within 1 year	152	328
Between 1 and 5 years	1,703	2,794
After 5 years	729	791
Total	2,584	3,913

4.4 Salary and Pension entitlements of senior managers

a) Remuneration

Name and Title	To 31 March 2014		To 31 March 2013	
	Salary	Employee Short term benefits - Employer's National Insurance	Salary	Employee Short term benefits - Employer's National Insurance
	(bands of £5,000) £'000	Rounded to the nearest £100	(bands of £5,000) £'000	Rounded to the nearest £100
Sir A J Cash, OBE, Chief Executive	215-220	28,600	215-220	28,600
Mr N Priestley, Director of Finance	170-175	21,900	170-175	21,900
Professor M Richmond, Medical Director (1 April 2012 to 31st August 2012)	N/a	N/a	75-80	14,000
Dr David Throssell, Medical Director (from 1st September 2012)	145-150	18,500	85-90	10,800
Professor H Chapman, CBE, Chief Nurse	170-175	21,900	170-175	22,000
Ms K Major, Director of Strategy and Operations	140-145	17,500	135-140	16,400
Mr M Gwilliam, Director of Human Resources	145-150	18,200	135-140	16,400
Mr I Thompson, Non-Executive Director (term of office expired 30 April 2012)	N/a	N/a	0-5	100
Mr J P Donnelly, Non-Executive Director	15-20	1,100	15-20	1,100
Ms V R Ferres, Non-Executive Director	15-20	1,100	15-20	1,100
Mr V G W Powell, Non-Executive Director	15-20	1,400	15-20	1,500
Mr M J Temple, Non-Executive Director (from 1st July 2013)	10-15	800	N/a	N/a
Professor R Billingsley (resigned 31 December 2012)	N/a	N/a	10-15	800
Ms S Harrison, Non-Executive Director	15-20	1,100	15-20	1,100
Professor A P Weetman, Non-Executive Director	15-20	1,100	15-20	1,100
Ms A Laban, Non-Executive Director (from 1st July 2013)	10-15	800	N/a	N/a
Mr A Pedder, Chairman	55-60	7,000	55-60	7,000

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 2014 (bands of £2500) £'000	Cash Equivalent Transfer Value at 31 March 2014 £'000	Cash Equivalent Transfer Value at 31 March 2013 £'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	n/a	n/a	n/a
Mr N Priestley, Director of Finance	2.5 - 5	265 - 267.5	1,262	1,188	48	24,500
Professor H Chapman, CBE, Chief Nurse	0 - 2.5	300 - 302.5	1,678	1,273	377	24,500
Mr M Gwilliam, Director of Human Resources	10 - 12.5	72.5 - 75	332	271	55	20,700
Ms K Major, Director of Strategy and Operations	7.5 - 10	132.5 - 135	481	424	47	20,000
Dr D Throssell, Medical Director (from 1 September 2012)	17.5 - 20	207.5 - 210	994	867	108	21,000

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.

The total accrued pension and related lump sum figure at 31/03/14 comprises an annual pension amount and a lump sum equivalent to three times that annual pension.

5.1 Employee expenses

	2013/14			2012/13		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	458,932	445,572	13,360	455,512	443,164	12,348
Social Security Costs	32,461	32,461	0	32,009	32,009	0
Employer contributions to NHSPA	51,262	51,262	0	49,734	49,734	0
Other pension costs	0	0	0	41	41	0
Agency / contract staff	20,440	0	20,440	13,939	0	13,939
Total	563,095	529,295	33,800	551,235	524,948	26,287

The above figure of £563,095k is net of the amount of £2,221k (2012/13 £1,696k) 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)

	2013/14			2012/13		
	Total	Permanent	Other	Total	Permanent	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	1,754	1,605	149	1,729	1,616	113
Administration and estates	2,749	2,498	251	2,723	2,542	181
Healthcare assistants and other support staff	1,487	1,356	131	1,442	1,361	81
Nursing, midwifery and health visiting staff	5,674	5,264	410	5,432	5,140	292
Scientific, therapeutic and technical staff	2,414	2,340	74	2,358	2,302	56
Total	14,078	13,063	1,015	13,684	12,961	723

5.3 Employee benefits

	2012/13	2011/12
	£'000	£'000
Benefits	0	0
	<u>0</u>	<u>0</u>

5.4 Staff Exit Packages

	2013/14		Total Number of Exit packages by cost band
Exit package cost band	Number of Compulsory redundancies	Number of other departures agreed	
<£10,000	0	9	9
£10,000 - £25,000	0	6	6
£25,001 - £50,000	1	6	7
£50,001 - £100,000	3	7	10
£100,001 - £150,000	2	1	3
£150,001 - £200,000	1	1	2
Over £200,000	1	0	1
Total Number of Exit Packages by type	8	30	38
Total Cost (£'000)	942	1,102	2,044

5.4 Staff Exit Packages

Exit package cost band	2012/13	Number of other departures agreed	Total Number of Exit packages by cost band
	Number of Compulsory redundancies £'000		
<£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
£100,001 - £150,000	0	6	6
Total Number of Exit Packages by type	1	64	65
Total Cost (£'000)	65	2,520	2,585

5.5 Early Retirements Due to Ill Health

	2013/14	2013/14	2012/13	2012/13
	£'000	Number	£'000	Number
Number of early retirements agreed on the grounds of ill health		11		18
Cost of early retirements agreed on grounds of ill health	656		1,368	

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:

	2013/14	2012/13
Number of non NHS invoices paid	181,135	174,065
Number of non NHS invoices paid within 30 days	176,132	167,620
Percentage of invoices paid within 30 days	97.24%	96.30%
	£'000	£'000
Value of non NHS invoices paid	372,454	311,509
Value of non NHS invoices paid within 30 days	360,510	296,413
Percentage of invoices paid within 30 days	96.79%	95.15%
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

	2013/14 £'000	2012/13 £'000
Bank account interest	218	178
Total	218	178

7.2. Finance costs - interest expense

	2013/14 £'000	2012/13 £'000
Loans from the Foundation Trust Financing Facility	1,332	1,399
Finance Lease interest	140	155
Finance Costs in PFI Obligations		
Main Finance Costs	1,316	1,353
Contingent Finance Costs	612	542
Total	3,400	3,449

7.3 Impairment of assets

	2013/14 £'000	2012/13 £'000
Loss or damage from normal operations	779	537
Abandonment of assets in course of construction	448	75
Changes in market price	1,125	18,191
Impairments charged to expenses	2,352	18,803
Reversal of impairments credited to income	(690)	(15,387)
TOTAL	1,662	3,416

8.1 Intangible fixed assets 2013/14

	Total £'000	Software licences £'000
Gross Cost at 1 April 2013	3,259	3,259
Reclassifications (from assets under construction)	1,963	1,963
Additions - purchased	143	143
Additions - donated	7	7
Disposals	(109)	(109)
Gross cost at 31 March 2014	5,263	5,263
Amortisation at 1 April 2013	2,060	2,060
Provided during the year	533	533
Impairments	17	17
Reclassification	245	245
Disposals	(109)	(109)
Amortisation at 31 March 2014	2,746	2,746
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
Net book value		
- Purchased at 31 March 2014	2,432	2,432
- Donated at 31 March 2014	85	85
Total at 31 March 2014	2,517	2,517

8.2 Intangible fixed assets 2012/13

	£'000	£'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

Note 8.3 Intangible assets acquired by government grants

	2013/14
	£'000
Initial fair value	0
Carrying amount at 31 March 2013	0
Carrying amount at 31 March 2014	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 2013/14

	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 2013	550,258	13,887	348,409	1,582	13,289	121,347	1,157	25,100	25,487
Transfers by absorption (Modified)	8,096	600	5,576	0	0	1,087	27	527	279
Additions - purchased	32,197	0	5,604	0	17,618	8,027	86	705	157
Additions - donated	1,580	0	30	(5)	798	757	0	0	0
Impairments charged to operating expenses	(1,047)	0	(535)	(44)	(468)	0	0	0	0
Impairments charged to revaluation reserve	(383)	0	(358)	(25)	0	0	0	0	0
Reversal of impairments credited to operating income	623	0	623	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	67	0	67	0	0	0	0	0	0
Reclassifications	(1,963)	0	12,477	33	(21,125)	3,872	0	877	1,903
Other Revaluations	405	0	(2,838)	0	0	2,130	68	821	224
Disposals	(9,477)	0	(396)	(55)	0	(6,204)	(172)	(2,344)	(306)
Cost or valuation at 31 March 2014	580,356	14,487	368,659	1,486	10,112	131,016	1,166	25,686	27,744
Accumulated Depreciation at 1 April 2013	130,856	0	15,588	83	0	73,911	658	20,422	20,194
Provided during the year	29,525	0	17,121	78	0	9,112	121	1,900	1,193
Impairments recognised in operating expenses	905	0	107	55	0	228	17	357	141
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	(245)	0	127	0	0	(800)	0	(245)	673
Other Revaluations	(1,779)	0	(5,022)	0	0	2,130	68	821	224
Disposals	(9,477)	0	(396)	(55)	0	(6,204)	(172)	(2,344)	(306)
Depreciation at 31 March 2014	149,785	0	27,525	161	0	78,377	692	20,911	22,119

9.2 Analysis of Property, Plant and Equipment

Net book value									
- Purchased at 31 March 2014	378,413	13,866	296,200	1,183	10,109	46,696	415	4,743	5,201
- Finance Leases at 31 March 2014	3,255	0	0	0	0	3,255	0	0	0
- PFI at 31 March 2014	15,237	0	15,237	0	0	0	0	0	0
- Government granted assets at 31 March 2014	3,509	0	3,021	0	0	443	0	10	35
- Donated at 31 March 2014	30,157	621	26,676	142	3	2,245	59	22	389
Total at 31 March 2014	430,571	14,487	341,134	1,325	10,112	52,639	474	4,775	5,625

9.3 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
Cost or valuation 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
Additions - government granted	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	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	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	367,009	13,266	288,218	1,343	13,116	41,148	426	4,628	4,864
- 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 grant 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

9.4 Analysis of Property, Plant and Equipment

Net book value	
- Purchased at 31 March 2013	367,009
- Finance leases at 31 March 2013	3,689
- PFI at 31 March 2013	14,573
- Government grant assets at 31 March 2013	3,771
- Donated at 31 March 2013	30,360
Total at 31 March 2013	419,402

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

9.6 Non-Property Valuations

Net Book Value covered by each method for determining fair value

	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Method For Determining Fair Value	£'000	£'000	£'000	£'000
Depreciated Historical Cost Basis	52,639	474	4,775	5,625
	52,639	474	4,775	5,625

9.7 Property Valuations

	Land	Buildings excluding dwellings	Dwellings
Net book value of assets covered by valuation method	£'000	£'000	£'000
Modern Equivalent Asset (no Alternative Site)	14,487	341,134	1,325
Modern Equivalent Asset (Alternative Site)	0	0	0
Other Professional Valuations	0	0	0
Total	14,487	341,134	1,325

10 Non-current assets for sale and assets in disposal groups 2013/14

There were no non-current assets for sale and assets in disposal groups in 2013/14 and 2012/13

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 2014 and 31 March 2013).

The Trust owns 45.95% (45.95% 31 March 2013) of the share capital of Epaq, and 9.22% (21.89%, 31 March 2013) of the share capital of Zilico.

12.1. Inventories

	31 March 2014 £'000	31 March 2013 £'000
Drugs	5,583	5,158
Energy	409	414
Other	7,149	7,419
TOTAL	13,141	12,991

12.2 Inventories recognised in expenses

	2013/14 £'000	2012/13 £'000
Inventories recognised in expenses	110,548	95,332
Write down of inventories recognised as an expense	38	123
Total Inventories recognised in expenses	110,586	95,455

13.1. Trade receivables and other receivables

	31 March 2014 Total £'000	31 March 2013 Total £'000
Amounts falling due within one year:		
NHS receivables	18,029	10,685
Other receivables with related parties	4,313	3,758
Provision for impaired receivables	(2,761)	(2,757)
Prepayments	2,432	1,835
Accrued income	8,530	5,258
Interest receivable	21	19
Public Dividend Capital dividend receivable	0	358
VAT receivable	525	789
Other receivables	8,068	7,259
Total due within one year	39,157	27,204
Amounts falling due after more than one year:		
Accrued receivables	0	0
Other receivables	4,889	6,242
Total due after more than one year	4,889	6,242
TOTAL	44,046	33,446

13.2 Provision for impairment of receivables

	2013/14	2012/13
	£'000	£'000
At 1 April	2,757	5,135
Increase in provision	1,364	1,166
Utilised	(222)	(1,538)
Unused amounts reversed	(1,138)	(2,006)
At 31 March	2,761	2,757

13.3 Analysis of impaired receivables

	£'000	£'000
Ageing of impaired receivables		
0-30 days	75	43
30-60 days	379	30
60-90 Days	36	43
90-180 days	216	217
over 180 days	2,055	2,424
Total	2,761	2,757
Ageing of non-impaired receivables past their due date		
0-30 days	7,549	3,563
30-60 days	824	629
60-90 Days	1,344	696
90-180 days	365	255
over 180 days	188	214
Total	10,270	5,357

14. Current asset investments

	2013/14	2012/13
	Total	Total
	£'000	£'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 2014	31 March 2013
	Total	Total
	£'000	£'000
Amounts falling due within one year:		
NHS payables	9,547	8,964
Amounts due to other related parties	6,140	8,191
Trade payables - capital	8,968	9,188
Other trade payables	19,747	16,538
Other payables	7,394	6,716
Accruals	25,947	21,129
Social Security and other taxes	10,502	10,629
Public Dividend Capital payable	89	0
Total current trade and other payables	88,334	81,355

	31 March 2014	31 March 2013
	Total	Total
	£'000	£'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 2014		31 March 2013	
	Total	Number	Total	Number
	£'000		£'000	
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0
- outstanding pension contributions at 31 March	7,049		6,564	

16 Other liabilities

	31 March 2014	31 March 2013
	£'000	£'000
Current		
Deferred Income	14,202	9,995
Total Other Current liabilities	14,202	9,995
Non-current		
Deferred Income	737	1,340
Total Other Non-Current Liabilities	737	1,340

17 Borrowings

	31 March 2014 £'000	31 March 2013 £'000
Current		
Loans from Foundation Trust Financing Facility	1,445	1,445
Obligations under finance leases	410	395
Obligations under Private Finance Initiative contracts	629	605
Total Current Borrowings	2,484	2,445
Non- current		
Loans from Foundation Trust Financing Facility	26,180	27,626
Obligations under finance leases	2,819	3,230
Obligations under Private Finance Initiative contracts	20,114	20,742
Total Non Current Borrowings	49,113	51,598

19.1 Finance Lease Obligations

	31 March 2014 £'000	31 March 2013 £'000
Gross lease liabilities	3,755	4,291
of which liabilities are due		
- not later than one year;	535	535
- later than one year and not later than five years;	2,144	2,143
- later than five years.	1,076	1,613
Finance charges allocated to future periods	(526)	(666)
Net lease liabilities	3,229	3,625
- not later than one year;	410	395
- later than one year and not later than five years;	1,807	1,740
- later than five years.	1,012	1,490

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

	31 March 2014 £'000	31 March 2013 £'000
Gross PFI liabilities	38,883	40,803
of which liabilities are due		
- not later than one year;	1,907	1,920
- later than one year and not later than five years;	7,175	7,334
- later than five years.	29,801	31,549
Finance charges allocated to future periods	(18,140)	(19,456)
Net PFI liabilities	20,743	21,347
- not later than one year;	629	605
- later than one year and not later than five years;	2,444	2,448
- later than five years.	17,670	18,294

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

	2013/14 £'000	2012/13 £'000
Building Maintenance	315	305
Insurance	146	141
Other management services	101	98
Depreciation	385	399
	947	943

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	£15,237k
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 2014 Hadfield Block £'000	31 March 2013 Hadfield Block £'000
Within one year	3,356	3,276
2nd to 5th years (inclusive)	14,283	13,946
Later than 5 years	83,407	87,180

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 2014	31 March 2013	31 March 2014	31 March 2013
	£'000	£'000	£'000	£'000
Pensions relating to other staff	179	178	2,224	2,165
Legal claims	1,444	1,331	0	0
Agenda For Change	34	31	0	0
Equal pay claims	31	31	0	0
Redundancy	1,236	1,582	0	0
Other	412	136	0	0
Total	3,336	3,289	2,224	2,165

	Pensions relating to other staff	Legal claims	Agenda For Change	Equal Pay Claims	Redundancy	Other	31 March 2014 Total	31 March 2013 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
At start of period	2,343	1,331	31	31	1,582	136	5,454	4,566
Change in discount rate	95	0	0	0	0	0	95	90
Arising during the year	97	1,271	8	0	1,236	377	2,989	4,012
Utilised during the year	(176)	(792)	0	0	(1,137)	(101)	(2,206)	(2,826)
Reversed unused	(14)	(366)	(5)	0	(445)	0	(830)	(452)
Unwinding of discount	58	0	0	0	0	0	58	64
At 31 March 2014	2,403	1,444	34	31	1,236	412	5,560	5,454

Expected timing of cashflows

Within one year	179	1,444	34	31	1,236	412	3,336	3,289
Between one and five years	688	0	0	0	0	0	688	671
After five years	1,536	0	0	0	0	0	1,536	1,494

Pensions relating to other staff represents liability relating to staff retiring before April 95 (£588k) and Injury Benefit Liabilities (£1,815k).

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 £495k.

- A number of other legal cases, not being handled by the NHSLA, are also recorded under this heading. These total £269k.

- Provisions for certain other potential claims in total amount to £680k.

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 that the Trust may incur as a result of a potential decision to dispose of a Gamma Knife (£373k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (£39k)

£91,540,383 is included in the provisions of the NHS Litigation Authority at 31/03/2014 in respect of clinical negligence liabilities of the Trust (31/3/2013 £80,457,476).

21. Revaluation Reserve

	Total Revaluation Reserve £'000	Revaluation Reserve - intangibles £'000	Revaluation Reserve - property, plant and equipment £'000
Revaluation reserve at 1 April 2013	31,765	0	31,765
Transfer by absorption	1,339	0	1,339
Impairments	(316)	0	(316)
Revaluations	2,184	0	2,184
Transfers to other reserves	(2,275)	0	(2,275)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2014	32,697	0	32,697
Revaluation reserve at 1 April 2012	27,733	0	27,733
Impairments	0	0	0
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

22 Cash and cash equivalents

	31 March 2014 £'000	31 March 2013 £'000
At 1 April	71,089	65,133
Net change in year	5,125	5,956
At 31 March	76,214	71,089
Analysed as		
Cash at commercial banks and in hand	256	216
Cash at Government Banking Service	75,958	70,873
Bank overdraft	0	0
Cash and cash equivalents as in SoFP	76,214	71,089
Third party assets held by the NHS Foundation Trust	31 March 2014 £'000	31 March 2013 £'000
Monies held on behalf of patients	4	8

23. Capital Commitments

Commitments under capital expenditure contracts at the Balance Sheet Date were £3.3m (31 March 2013, £8.0m). The major components of these commitments are as follows:

Property, Plant & Equipment	
31 March 2014	
Scheme	Amount £'000
Medical Equipment	1149
Catering Infrastructure - D Floor Servery	912
RHH Ward Refurbishment Programme - Ward P2	796
Microbiology Car Park	263
Chesterman Lifts	138
Upgrade Tower and Central Stairways	64
Other	22
Total	3,344

24. Events after the reporting period

There are no events after the reporting period to highlight.

25. Contingencies

	2013/14 £'000	2012/13 £'000
Gross value	(266)	(260)
Amounts recoverable	0	0
Net contingent liability	<u>(266)</u>	<u>(260)</u>

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 94 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:

	2013/14		2012/13	
	Income	Expenditure	Income	Expenditure
	£'000	£'000	£'000	£'000
Sheffield PCT			399,090	3,984
Bassetlaw PCT			7,572	
Derby County PCT			27,588	
Barnsley PCT			200,583	
Rotherham PCT			24,005	
Doncaster PCT			15,331	
Leicestershire County and Rutland PCT			38,381	
Yorkshire and The Humber Strategic Health Authority			65,927	
NHS Sheffield CCG	361,205	175		
NHS Bassetlaw CCG	6,193			
NHS North Derbyshire CCG	19,106			
NHS Barnsley CCG	23,879			
NHS Rotherham CCG	20,550			
NHS Doncaster CCG	12,009			
NHS Hardwick CCG	3,365			
NHS Wakefield CCG	1,687			
NHS England	318,908	1,005		
Health Education England	64,410			
Community Health Partnerships		1,204		
NHS Litigation Authority		11,048		13,433
National Blood Authority		6,249		6,339
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	7,266	7428	6,969	7,551
Sheffield Health and Social Care NHS Foundation Trust	1,792	3764	1,548	3,303
Sheffield Children's NHS Foundation Trust	7,756	3758	7,548	4,202
Barnsley Hospital NHS Foundation Trust	5,282	1940	5,210	2,001
Chesterfield Royal NHS Foundation Trust	3,544	2438	3,323	2,368
The Rotherham NHS Foundation Trust	4,599	1740	4,530	1,952

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 £44,046k at 31 March 2014, (£33,446k at 31 March 2013, note 13.1) £26,559k (£15,943k at 31 March 2013) 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. £2,748k was receivable from the University of Sheffield at 31 March 2014, (31 March 2013, £2,915k) in respect of clinical and estates support services provided.

During the year the Trust purchased healthcare from Thornbury Private Hospital in the sum of £2,416k (2012/13 £2,886k.)

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 £3,669k (2012/2013 £8,848k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Payables falling due within one year of £88,334k (31 March 2013, £81,355k, note 15.1) include £9,547k owing to NHS bodies (31 March 2013, £8,964k). This sum includes monies owing to other NHS Trusts and Foundation Trusts for clinical support services received.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely.

These governors represent the views of the staff and of the organizations with and for whom they work.

This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in the year from this Charity amounted to £1.0m (2012/13, £1.1m). 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 £'000	Assets at fair value through the SoCI* £'000	Held to maturity £'000	Available -for-sale £'000	Total £'000
Trade and other receivables excluding non financial assets	36,317				36,317
Cash and cash equivalents at bank and in hand (at 31 March 2014)	76,214				76,214
Total at 31 March 2014	112,531	-	-	-	112,531
Trade and other receivables excluding non financial assets	16,143				16,143
Cash and cash equivalents at bank and in hand	71,089				71,089
Total at 31 March 2013	87,232	-	-	-	87,232

* SoCI - Statement of Comprehensive Income on page 118

27.2 Financial liabilities by category

	Other financial liabilities £'000	Liabilities at fair value through the SoCI* £'000	Total £'000
Liabilities as per Statement of Financial Position			
Borrowings excluding Finance lease and PFI liabilities	27,625		27,625
Finance lease obligations	3,229		3,229
Obligations under Private Finance Initiative contracts	20,743		20,743
Trade and other payables excluding non financial assets	63,783		63,783
Provisions under contract	2,476		2,476
Total at 31 March 2014	117,856	0	117,856
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
Trade and other payables excluding non financial assets	64,010		64,010
Provisions under contract	2,926		2,926
Total at 31 March 2013	120,979	0	120,979

* SoCI - Statement of Comprehensive Income on page 118

27.3 Fair values of financial assets at 31 March 2014

	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 2014

	Book Value £'000	Fair value £'000
Provisions under contract	0	0
Loans	0	0
Total	0	0

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 21 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 in this area. 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 fixed.

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 Clinical Commissioning Groups, or the Department of Health, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

28. Third Party Assets

The Trust held £3,764 (31 March 2013, £7,645) at bank and in hand at 31 March 2014, which related to monies held 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

Losses	2013-14		2012-13	
	Number	Value £'000	Number	Value £'000
Cash Losses	3	0	7	1
Fruitless payments and constructive losses	0	0	1	45
Bad debts and claims abandoned	211	215	1331	1316
Stores losses (including damage to buildings and property)	18	38	12	133
	232	253	1351	1495
Special Payments				
Extra-contractual payments	1	13	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	3	98	1	5
Special severance payments	0	0	0	0
Ex -gratia payments	94	18	57	10
	98	129	58	15

No individual items exceeding £250,000 were incurred in either year.

These losses are reported on an accruals basis.

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, and to pay a dividend based on this rate to HM Treasury. The rate of 3.5% is applied to the Trust's net relevant assets, which are abated by the value of donated assets and average daily cash balances held with the Government Banking Service. This resulted in a dividend of £9,643k (2012/13 £9,926k).

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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