Sheffield Teaching Hospitals
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2017-18

INCORPORATING THE ANNUAL QUALITY REPORT

Sheffield Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2017-18

Incorporating the Annual Quality Report

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

Contents

Chairman's Introduction

TONY PEDDER, OBE

I am very pleased to be able to report that 2017/18 has been another year of solid progress for Sheffield Teaching Hospitals NHS Foundation Trust (STH). In the following pages of this Annual Report and Quality Report, you can read much about the work of the Trust over the year and I commend the reports to you.

I have tended to conclude my reports in previous years by referring to our outstanding staff. I want to start this year by highlighting them. They are the vital ingredient which ensures we deliver safe and appropriate care efficiently and within the shortest possible timeframe for our patients. In this report, you can read of many of the initiatives they have developed to do that. I will highlight just two.

The introduction of safety huddles on a number of our wards has led to significant improvements including a reduction in falls. Safety huddles are the coming together of all the ward team at the same time each day to share information and ideas. It also enables all the ward members to be aware of each individual patient's needs or potential issues to look out for. On one ward for example a member of the ward staff came up with the idea of giving patients, at a higher risk of a fall, slip resistant socks similar to those used by children. This simple idea has already had a positive impact.

End of life care has been a particular focus across the Trust during 2017-18 and the development of a new strategy, guidance, care plans and training has been the result of genuine co-production and engagement across staff, patients and carers.

I urge you to read more about these initiatives and also other innovations and developments by our teams, such as point of care patient testing for flu, the Sheffield Safer 10 Principles and the Safer Nursing Care Tool, in the following pages.

As well as further enhancing patient care, all these initiatives ultimately impact on our overall measurable performance and in terms of that performance, I am pleased to report that we have again met the majority of the national standards for waiting times, infection control and other key performance indicators. This includes referral to treatment times and cancer treatment waiting times.

I referred last year to the challenge in meeting the pressure on our emergency department. Once again this year, almost nine out of ten people who attended our Emergency department were seen and either discharged or admitted to hospital within 4 hours and whilst regrettably, this fell short of the national standard, this does reflect a national pressure on the emergency care system.

One of the relevant issues is the ability to safely discharge patients from our wards once they are medically fit and we are pleased that the Care Quality Commission has during the year worked with us and our local partners in carrying out a Local System Review into this issue and the wider care of older people across the health and social care system. We believe this will lead to further improvement possibilities being identified.

Our focus is obviously on ensuring safe, high quality care but we also have to deliver this in the most cost effective and efficient way. We continued to do this in 2017/18 and have met our financial targets. You can read more about this and our financial performance later in this document.

You can also read about our ongoing programme of investment to upgrade and modernise our facilities. This includes the construction of a new £6.7 million eye centre at Northern General Hospital, a £30 million theatre refurbishment project at the Royal Hallamshire Hospital and ward refurbishments at Weston Park hospital as part of a longer term development project for that facility.

We continue to put a lot of focus on research and there are a number of areas highlighted in the attached reports. Sheffield Teaching Hospitals NHS Foundation Trust has always played a significant part in advancing healthcare and has been at the forefront of many medical breakthroughs and innovations throughout the years. Just in the last 12 months these have included the development of the first baby MRI scanner, a ground breaking stem cell treatment which has been proven to reverse disability in some patients with multiple sclerosis and the creation of a device which can help detect the likelihood of a woman having a pre-term birth.

I have referred in previous reports to the greater focus on integration and cross-organisation trends which we are seeing in health and social care. We at Sheffield Teaching Hospitals support that partnership thinking. It is evident in research areas where our partnerships with other care providers, industry and academics are already delivering results. For example, the Trust hosts the Yorkshire and Humber Genomics Medicine Centre which has recruited over 3,000 people to date as part of the UK 100,000 Genome project. Our clinicians have joined forces with technology companies and researchers to test how new technologies can better support patients with long term conditions to manage their health and avoid a crisis which

Chairman's Introduction

TONY PEDDER, OBE

may see them admitted to hospital. This work is being coordinated here in Sheffield through the Perfect Patient Testbed – one of only seven NHS Innovation Testbeds nationally.

We see the challenge of meeting our workforce needs in the future as a really important one and are working in partnership with the City's two universities and others to develop ways of enhancing our workforce both through new entrants and also offering further development opportunities to our existing staff.

In terms of provision of care, the new direction of travel for the NHS nationally has also enabled us to further strengthen our partnerships with other healthcare organisations in Sheffield, South Yorkshire and further afield. This has been underpinned by an announcement in 2017 by Health Secretary Jeremy Hunt that 'Integrated Care Systems' (ICS) would be established. The idea behind these new partnerships of NHS Commissioners and Providers of healthcare is for them to work together across a wider geographical footprint with a common set of goals and vision which supports the planning and delivery of sustainable services now and in the future. We are a partner in the South Yorkshire and Bassetlaw Integrated Care System and our Chief Executive Sir Andrew Cash is also the ICS lead.

As well as this, we also saw the creation of the Sheffield Accountable Care Partnership in 2017 which brings together health and social care organisations in the City to jointly plan and deliver services better tailored to the needs of the Sheffield population.

The story of the NHS is one of evolution and of responding to the changing needs of the people we serve. As we approach the seventieth anniversary of the birth of the National Health Service, which was born with a founding principle of free high quality health care for all, the challenge of a growing and ageing population has never been greater. Over the next few pages I hope you will be pleased to read about so many new ways of working which we have adopted across our hospitals and community health services here in Sheffield in the last year alone.

In concluding my report, I want to come back to the people who make up our organisation. They are the thousands of individuals who work tirelessly, day in and day out across our hospitals and community services to provide the very best care for our patients. None of the achievements outlined in this document would be possible without the skill, dedication and compassion of our outstanding staff.

During 2017 we called upon everyone who works for the Trust to be part of developing our new People Strategy which sets out our vision and plans to ensure Sheffield Teaching Hospitals is a 'brilliant place to work' as well as a brilliant place to receive care. 'Making it Personal' is at the heart of this strategy because we believe that every one of the 17,000 people who make up the Trust have a special part to play in enabling us to continue delivering safe, high quality care and the best possible patient experience. We are now supporting them with a network of "Freedom to Speak up Guardians", so that we ensure the culture at STH remains one of transparency, learning and innovation.

We are also exceptionally fortunate to be supported by over 800 volunteers, incredibly hard working Governors, fantastic charities, committed partners and of course our strong local communities. This year in particular due to the challenges of a difficult winter, their unstinting commitment along with that of our staff has been invaluable and, on behalf of the Board of Directors, I thank them for all their support.

Tony Pedder OBE
Chairman

Performance Report

Performance Report

OVERVIEW OF PERFORMANCE

In the year that the NHS turns 70 years old, there is no doubt that 2018-19 will see the start of a new era in how the NHS delivers care and once again Sheffield Teaching Hospitals will play a pivotal role not only in the continued advancement of treatment but also in health prevention and individuals' wider well-being.

Our performance in 2017/18 has continued to provide the solid foundations on which to build upon as we continue this exciting new journey with the support of everyone who works across the Trust, our partners and of course our patients.

Despite a demanding year, our teams have continued to deliver high quality care and a positive patient experience whilst at the same time exploring opportunities to innovate and develop partnership working across clinical and corporate areas both within the organisation and outside.

Making a Difference

Our overarching priorities in 2017-18 were to:

- 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 PROUD values were developed by our staff:

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

Our drive for continual improvement is embodied within the Trust's Corporate Strategy called 'Making a Difference' which was refreshed in 2017 after consultation with our staff, partners and the public.

The corporate strategy is also supported by a refreshed Quality Strategy and a robust governance framework.

Thanks to the professionalism and dedication of all our 17,000 staff, we are proud to have a reputation for delivering high quality care, effective leadership and innovation in both clinical and non-clinical services. Our current Care Quality Commission rating is evidence of this with a 'Good' rating across all five domains of:

Safe	Caring	Effective	Well led	Responsive	Overall
GOOD	GOOD	GOOD	GOOD	GOOD	GOOD

Many of our services were rated as 'outstanding' which chimes with our excellent results in a number of patient and staff reviews during the year. This included the Care Quality Commission's national inpatient survey in which nine out of ten inpatients said they were treated with respect and dignity during their stay.

A large number of our teams and individual colleagues were shortlisted or indeed won national awards over the last year. This included our Catering Department being awarded Catering Team of the Year and winning the Health Service Journal award for Improving Environmental and Social Sustainability. One of our Chaplains, Sabia Rehman, was presented with the Khadija Award –for 'the most outstanding Muslim woman in South Yorkshire' for her work in the Muslim community.

Our team leading on the 'Okay to Stay' plan project were finalists in the Health Service Journal, Patient Safety Awards and also the Nursing Times Awards. The team are working in collaboration with 21 GP surgeries and Age UK to enable more people to manage their health condition at home and help prevent unnecessary hospital admissions in Sheffield.

Whilst our Sexual Health Team won a top national award for successfully redesigning the city's sexual health services, improving access to those most in need. The team who, introduced citywide 'one stop shops' as part of a remodelling of services scooped the top prize in the community health service redesign category at the 2017

Health Service Journal's Value in Health Awards – one of the most highly coveted awards in the NHS. 99% of patients recently reported that the services they received from Sheffield's Sexual Health Services were good or excellent.

This represents just a small snapshot of the recognition our staff and services have received in 2017/18.

Deliver the best clinical outcomes

We have a strong track record of delivering good clinical outcomes in our hospitals and in the community. Despite this we continually look to adopt best practice and most importantly learn and improve when we do not meet the high standards we have set for ourselves.

There are some important clinical indicators which help us monitor how we are performing in terms of clinical outcomes. Mortality rate is an important clinical indicator, and during 2017-18 our rates were 'as expected' for our type and size of organisation. However we are never complacent and continually review mortality rates including rates at the weekend. We are fortunate to have had the benefit of leading clinicians whose knowledge and work around 'learning from deaths' has been used to inform new National Quality Board (NQB) guidance for NHS providers on how they should learn from the deaths of people in their care.

We carry out thousands of operations successfully every year and because healthcare has a human factor we put in place measures to mitigate the potential for errors. Our safer surgery programme has continued throughout 2017/18 including work to further embed safer surgery checklists. There have also been a number of improvements made as a direct result of suggestions from front line staff working in theatres, surgical specialties and anaesthetics.

On the rare occasions when an error does occur we take it very seriously and investigate the circumstances to determine if any further precautions can be taken. Disappointingly, we did have a very small number of Never Events in 2017- 18 , although we have seen a reduction on the previous year. The four events which happened were reviewed and prompt actions put in place to limit the chance of such incidents recurring.

Rigorous infection prevention and control and clean facilities are fundamental to our care standards and we have a good track record in this area. We work relentlessly to minimise the chances of patients acquiring hospital acquired infections, such as Norovirus and MRSA. Despite caring for over 2 million patients during 2017-18 we had just three cases of MRSA bacteraemia and the number of cases of C.Difficile was 83 against a national target of 87.

During the winter months, flu can pose a real health risk for patients and so during 2017-18 we vaccinated the highest ever number of our staff (76%) so that we limited the risk of spreading the virus. We also offered patients who came in as emergencies the vaccination and our district nurses vaccinated almost all of their patients. Winter 2017/18 was the second year in which we used an innovative flu test. The rapid test takes only 15 minutes, ensuring patients get their result quickly, receive the correct treatment and are cared for in isolation to prevent the spread of the virus. Without rapid testing patients could wait 1-2 days for a flu result to be confirmed. This meant patients received the treatment they needed quicker and they stayed in hospital for a shorter period of time. The quick diagnosis also ensured we protected other patients and staff from getting flu, by putting measures in place to prevent the virus spreading.

During the year, public awareness about Sepsis has grown following an increased focus on this deadly infection by the media. Here at Sheffield Teaching Hospitals our work on all aspects of identifying the signs and symptoms of a 'deteriorating' patient has included significant work on Sepsis and in particular educating and training staff to be aware of the possibility of Sepsis. We have introduced a 'BUFALO' sticker in the Emergency Department to promote timely initiation of the 'Sepsis 6' process for identifying and treating Sepsis. This is an area which has since received national interest and all NHS Trusts are tasked with ensuring their staff are aware of the signs of sepsis. Further developments include the introduction of a track and trigger system which will support early identification of Sepsis.

Another initiative which has had demonstrable results in terms of reducing the number of patient falls and pressure ulcers as well as early detection of a deteriorating patient is the introduction of safety huddles on a number of our wards. Safety huddles are simply the coming together of all ward members (all disciplines and roles not just nursing) for a few minutes at the same time each day. The team use the ward electronic whiteboard to do a quick review of each patient on the ward and share any additional information they may have. For example, if a patient has become a bit unsteady on their feet or are not eating as much as usual. Actions to address any issues are then taken. For example, on one ward staff have introduced traffic light signs on patient's bedhead space to indicate the patient's risk of a fall. This is a clear communication to everyone on the ward. Another idea which came from ward team members was

to test if socks with grips on the bottom would prevent patients who do not wear slippers from slipping or having a fall. The socks have been introduced and already it has contributed to a reduction in the number of falls on the ward.

We consider that good hydration and nutrition is as important as clinical intervention. The Trust's Catering Department, which is responsible for providing 40,000 meals a week to patients, staff and visitors across our five adult hospitals and community sites, has won a string of accolades for introducing a number of changes which have improved the quality and nutritional value of food and increased patient satisfaction. Key changes include: the introduction of new healthier menus in wards and dining areas, which were developed with direct input from patients as well. There has been a significant reduction in waste from food packaging and around 50 staff have been trained to produce freshly prepared food on site. 75% of meals are now produced on site. A network of trained healthy eating and sustainability champions has been created to encouraging staff, patients and visitors to 'rethink, reduce, reuse and recycle' and our relationships with food suppliers has been focused on ensuring ethical, sustainable and environmental sources.

During the year we saw the NHS continue to focus on ensuring all hospitals have safe nurse staffing levels and we continued to use the Safer Nursing Care tool along with other important indicators to ensure appropriate nurse staffing levels are monitored. We are very fortunate to attract high quality nurses and midwives to work for us and during 2017-18 we have recruited almost 350 qualified nurses and midwives and almost 200 Clinical Support Workers since last April into new and existing posts.

Ensuring we provide our patients with safe, high quality care is at the heart of everything we do. To do this, it is important that all staff feel they can raise any concerns they may have about patient safety and to provide support to do this we appointed Freedom to Speak Up (FTSU) Guardians. They will have a key role in helping to raise the profile of how members of staff can raise concerns and will provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. We are also appointing Directorate advocates to support this work.

Provide patient centred services

Equally as important as good clinical outcomes, is ensuring that we treat patients as individuals and meet their needs wherever possible. We aim to ensure all patients receive the right care, in the right place, at the right time.

Our patients tell us that keeping waiting times as short as possible is important to them. With regard to our

overall performance in 2017-18, I am pleased to report that we have met the majority of our national standards for waiting times and other activities. The average waiting time for care at the Trust is 54 days or less and the majority of cancer treatment waiting time standards are met consistently. In terms of meeting the national referral to treatment waiting standards the hard work of our staff has meant we have consistently been one of the best performing Trusts in the UK during 2017/18. The number of patients on an incomplete pathway had gradually decreased throughout the year. Diagnostic test waits remain good but we narrowly missed the national standard of 99% of patients waiting six weeks or less. This was mainly related to the number of trained staff available nationally for some diagnostic tests. We are actively working to resolve this issue. Meeting the standards moving forward and providing patients with safe, appropriate care within the shortest possible timeframe will continue to be a key driver for us in 2018/19.

Whilst we did not consistently achieve the national 95% 4 hour wait time standard, on average we did treat, discharge or admit almost nine out of ten patients who required emergency or urgent care within the required 4 hour timeframe. Despite robust planning, the severe winter pressures experienced by all NHS Trusts brought additional challenges but our community and hospital teams responded magnificently by developing innovative ways of working which supported all our patients who needed care during this time. Despite extraordinary emergency care demands, our teams ensured we continued to meet the national referral to treatment waiting time standard for planned procedures and operations throughout the winter months which was exemplary in the circumstances.

Every winter right across the NHS we hear about the number of patients whose discharge is delayed for one reason or another. In Sheffield it is no different and work is underway by all the main health and social care organisations to do things differently and reduce the number of times when a patient's transfer from hospital to home or the next stage of their support is delayed. During last year we worked with the City Council and Sheffield Clinical Commissioning Group to do an assessment of the reasons why we continue to have large numbers of people in hospital beds facing a delay to their discharge. The results of this assessment focussed our priorities towards three pieces of work.

- Help more people get home, faster (If not home, the next best, most independent, place).

- Increase the capacity in community teams so that we can look after more people more quickly.
- Help more people receive their assessments at home or in Intermediate Care.

One of the key priority areas is how we can get more people who no longer need acute medical care home quicker (or if not home, the next best, independent place for them) and a significant change to the way in which people are assessed for their support needs is already having an impact on reducing the time it takes for someone to be discharged. Most patients who leave hospital are able to return home with little or no support. Others may need help for a short time until they get back to normal, or may need help on a long term basis. Traditionally patients have been assessed for their ongoing care needs whilst in hospital. However it is recognised that this environment is not a true reflection of how a person may be able to function when they are in the familiar surroundings of their own home. Also waiting for the various assessments or indeed decisions about the most appropriate next place of care can mean patients wait longer than they need to in hospital when they no longer need acute care. As well as the potential risks of infection, falls or loss of mobility for the patient, it also means that their hospital bed cannot be used for any other patient who needs acute care. With this in mind the usual discharge process has been redesigned and patients who are ready to move on from acute care no longer wait in hospital. They either go home where appropriate and are met by a team of specialists who assess what short or long term support they need to stay living independently. Or they move to an intermediate care facility where they are assessed for short term rehabilitation or indeed the need for a care or nursing home placement.

The time people stay in hospital is an important factor in their overall recovery and particularly for older patients, we know that the sooner we can return them to their home with support or another appropriate care setting, the quicker their recovery.

Our teams are developing new ways of delivering care to facilitate this and key to this is partnership working across specialties. An example of this is the partnership between staff in the Surgical Assessment Unit and Geriatricians which is enabling elderly patients to return home from hospital more quickly. A lot of elderly patients come in to hospital with a surgical problem, but once they are surgically fit for discharge they end up remaining in hospital because of perceived problems about their ability to cope at home or outside of hospital. By working together, surgical and geriatrician colleagues are quickly identifying these patients so that they get the support in place to enable them to leave hospital sooner. The approach also ensures that hospital beds are not occupied for longer than necessary. The change is part of a wider partnership between General Surgery and Geriatric Medicine, which has seen a reduction in length of stay (by 2.5 days on average) and an increase in the proportion of patients returning to their usual place of residence (up to 92% from 72%).

During 2017/18 we also continued to use our 'Okay to Stay' plans to help patients with long term conditions avoid unnecessary hospital stays or reduce the length of a stay in hospital where appropriate. The simple plan which is developed between patients and community health staff paints a picture for any visiting health professional of how the patient manages at home - who supports them, and what medication they need if unwell. It also helps the patient to recognise deterioration in their condition. The plan is reviewed every three months and the patient retains a printed copy so that it can be shared with health professionals. If a patient calls the Out of Hours service the service is immediately alerted to the patient's plan, they can make a home visit and with the plan, make an informed decision to keep the patient at home. The GP can refer them to the 24-hour Community Nursing Team or Community Intermediate Care Service. We've seen a 40% reduction in hospital admissions for the patients involved in the 'Okay to Stay' plan project. Patients said they felt more confident, supported and more aware of when they needed to go to hospital and when they could stay at home with support, enabling people to better self-manage their own health so that they can remain living independently for as long as possible and avoid a health crisis which results in a hospital admission.

Our role as one of seven NHS Innovation 'Test beds' will help us to take this important work even further by combining the expertise and experience of our health professionals with technology partners and primary care colleagues. Together we will test how technological devices can support patients with long term conditions to better manage their health from home. You can read more about the Perfect Patient Pathway Test bed on page 12.

One of the projects involves some of the City's care homes testing how the integration of new technology combined with partnership working between community health professionals, care homes, hospital teams and GPs can prevent older people from having to go into hospital. The digital care home project being run by the Perfect Patient Testbed is using a range of digital devices, including a blood pressure monitor, pulse check and weigh scales as a package that can help an individual or a carer keep a regular check on their health. The data that is gathered from the devices is sent live to the Single Point of Access community health team at Sheffield Teaching Hospitals who are then able to identify any irregularities in the patients' health data. The team can then follow up any potential concerns by calling the local care home team to offer advice or suggest a further appointment with a health professional if required, and therefore preventing further deterioration of a patient's health. It is hoped this rapid response will help keep care home residents well and reduce hospital admissions by enabling preventative measures to take place earlier.

During the early part of 2018, the Care Quality Commission also carried out a Local System Review into the care of older people which involved all of the health and care organisations across the City. The review focused particularly on the support to enable older patients to be cared for in the right place, at the right time and by the right people. The results of the review

will be shared with the partner organisations in May 2018 and an action plan will be developed to address any areas where improvements are required.

Most of the developments you will read about in this report have come about as a direct result of our staff seeing an opportunity where change would bring a positive benefit for patients, their colleagues or indeed the wider NHS. By giving staff the freedom to make those small changes has seen a growth in the numbers of people now involved in improvement work across the organisation at all levels. This 'bottom up' approach to change has been the focus of our Making it Better programme, which brings together and builds on fantastic improvements made by teams during the "Give it a Go" week, microsystems improvement and Listening into Action (LiA) projects. For example since the launch of LiA there have been 85 schemes covering 26 clinical directorates across all care groups with a total of 8,790 staff being involved. Each scheme has had the commitment and involvement of the Operations Directors, Nurse Directors and Clinical Directors.

Making it Better has 8 Trust wide programmes and hundreds of smaller improvement projects:

1. Seamless Surgery
2. Excellent Emergency Care
3. Outstanding Outpatients
4. Transforming Through Technology
5. Organisational Development
6. Workforce Transformation
7. Commercial, Corporate and Support Services
8. External Partnerships

Some of the ideas and projects originated by staff are:

Learning to Love Lorenzo – This scheme looked at specific processes and functionality of the electronic patient record called Lorenzo. As a result of this scheme the contact assessment form now self populates, ten fewer clicks are needed to complete the process, making it simpler and saving valuable staff time.

Neonatal Unit - Family Matters - Parents worked collaboratively with staff in the Neonatal Unit to increase parents confidence to care for their premature baby with complex needs. A neonatal passport has been created to give parents vital information for the time their child is in the unit and a Family Matters booklet was developed. This work resulted in reduced length of stay for the babies and safer discharges home.

Integration of Front Door Response and Active Recovery - The team reviewed the working relationship of the two areas and identified the potential to make improvements for patients by joining some of the services they cover. Patient's length of stay has been reduced by

one night following the introduction of active recovery intervention in Accident and Emergency. The patient's journey has reduced by two hours as a result of direct electronic referrals.

Wider improvement work has also had staff and patients at the heart of the development and implementation.

An excellent example of this is the work we have focussed on around end of life care. We believe that when someone is at the end of life, caring for them and those important to them is everyone's responsibility and that every member of staff has a key part to play to ensure that the ambitions outlined in the new End of Life Strategy are implemented.

During the year we also introduced a new strategy for Weston Park Hospital to ensure it remains one of the leading cancer centres in the UK. To achieve the exciting new vision of how cancer care, research and support will be provided, a transformation programme is underway. The physical estate at Weston Park is also being transformed with the on-going refurbishment of wards. Wards 3 and 4 have been completed in 2017-18 which has provided a fantastic environment for patients and staff.

Elsewhere across the Trust more than £35 million has been spent improving our facilities during the year.

At the Northern General Hospital, the construction of a new £6.7 million state-of-the art eye centre got underway. The purpose-built unit which will open in April 2018 will provide a 'one stop shop' for specialist eye care for thousands of cataract patients every year. The new facilities and ways of delivering care will enable patients to be assessed, diagnosed and given an appointment for surgery all within one visit to the Centre.

Also at the Northern General Hospital, a £2m purpose-built Frailty Assessment Unit was opened to provide assessment and care for frail older patients. The new unit enables frail older patients to be assessed in an environment which has been designed specifically for their needs. The Unit has ambulatory assessment bays where patients can be assessed from special recliner chairs rather than a bed wherever possible. This is much easier for patients who may be stiff or frail, and also means they can stay in their own clothes which is often more comfortable for them. Other features include a dementia friendly design which is open plan, colour coordinated areas and pictorial signage. The new unit is staffed by an integrated multi-disciplinary team who have received dedicated training to work together in a unique way to provide tailored assessment and treatment. The unit aims to enable patients to return home the same day wherever appropriate and the team work closely with other hospital and community services to ensure patients have any necessary support in place to return home.

Elderly people who live alone are also being given support on their return home from hospital by a charity working in partnership with our teams. Sheffield Churches Council for Community Care (SCCCC) are providing a rapid response service to support older people who may not have family or friends available at the time they are ready to be discharged from hospital. Within an hour of receiving a call from the hospital, a trained volunteer will take the patient home, ensure the heating is switched on, make them a snack and drink and provide emotional support until the arrival of family, friends or a care agency.

The charity can also make referrals to other organisations like the Fire Service or Community Equipment Loan Service, where they believe a patient may be in need of further support.

During the year the Trust also started to re-develop the theatres at the Royal Hallamshire Hospital. The £30m project which will continue over the next few years will mean all 14 theatres on A floor will be re-developed and there will be a new four theatre complex on Q floor. The theatre re-development will be the biggest single investment the Trust has made since the Robert Hadfield building was opened at the Northern General Hospital.

One of our biggest investments in patient care is through our five year 'Transforming Through Technology' programme. Building on the introduction of a new Patient Administration System (PAS) in 2015, we have increased the use of electronic whiteboards linked to the PAS to improve patient flow, handover and observation recording. We have successfully delivered enhancements to tailor the whiteboards to certain areas. For example we have enhanced the Jessop Wing maternity boards to capture observations for mothers and automatically calculate and manage the patient's Modified Early Obstetric Warning Score.

In 2017/18 we also launched a new medication management system 'Electronic Prescribing and Medicines Administration' (EPMA) to replace the paper drug card. We are already seeing a number of improvements to patient safety, and the system also frees up Clinicians' time as they no longer have to rewrite prescription charts for longer staying patients and can access the drug chart from any computer across the Trust at their convenience. Behind the scenes we have also been ensuring our cyber security is as robust as possible.

Whilst we are never complacent, we were pleased that the hard work of our IT teams provided protection from the Wannacry virus that brought many hospitals to a standstill during 2017/18.

As well as using technology to make improvements to the way we work internally, we are also working with our partners to maximise technology links between local NHS Trusts. Following on from the connecting of systems for test results, we are working with the other Trusts across South Yorkshire to build a health information exchange that in the first instance will enable us to provide controlled access to electronic discharge summaries for patients at each of our hospitals so that we are able to provide better joined up care across the region. We are also leading the way in providing electronic referrals of cancer patients between hospitals - giving vital time savings in the referrals process.

We have also used technology to enable us to stop the use of paper letters to Sheffield GPs which has saved up to 1 million sheets of paper per year.

Deliver excellent research, education and innovation

We have a proud history of pioneering medical advances that have now become established NHS treatments, and undertaking high quality research that provides the NHS with the evidence it needs to introduce new treatments and care.

Together with our partners at the University of Sheffield we are leading the way on the development of world-class clinical research in a wide range of disease areas, including cancer, progressive diseases such as dementia, stroke and multiple sclerosis, as well as heart disease and many other lesser known conditions.

Over the past year, we have recruited 14,484 patients to NIHR portfolio trials in comparison to 11,490 in 2016/17, a 26% increase on last year.

A small selection of the research undertaken during the last 12 months is detailed below.

A major research area for the Trust is neurosciences and during 2017/18, in partnership with the University of Sheffield, we opened one of twenty national NIHR

Biomedical Research Centres here in Sheffield. The Centre focuses on translational neuroscience and hosts the development of new, ground-breaking treatments, diagnostics, prevention and care for patients suffering from debilitating diseases such as Dementia, Motor Neurone Disease, Stroke, Multiple Sclerosis, Alzheimer's and Parkinson's disease.

The Trust's leading role in the international effort to examine the long-term benefits of a breakthrough treatment for Multiple Sclerosis known as autologous haematopoietic stem cell transplantation has also received global attention after the publication of the MIST trial results in early 2018. The treatment was the feature of an acclaimed 2016 BBC Panorama programme 'Can You Stop My Multiple Sclerosis?' MIST is the first ever international large scale randomised trial into autologous haematopoietic stem cell transplantation (AHSCT) in relapsing remitting multiple sclerosis and has shown that the treatment stabilised the disease and improves disability in people who had experienced 2 or more relapses in the year before joining the trial.

Cancer patients having their treatment at Weston Park Hospital have had the opportunity to take part in "first-in-human" cancer trials for the first time ever. These breakthrough trials, which test new drugs and treatments are tested in humans for the first time, are a pivotal step in bringing new cancer treatments to the NHS, and have been brought to Weston Park Hospital thanks to its status as a research centre of excellence. One patient to benefit is Amanda Horsman, who suffered with an advanced head and neck cancer. She is one of only 20 in the world to take part in a groundbreaking trial to see if a new drug known as MTL-005 can affect chemotherapy by making cancerous tumour cells more sensitive to radiation therapy.

Professor Jaydip Ray, a consultant ENT surgeon at the Royal Hallamshire Hospital, has become the first surgeon in the north of England and one of only a handful in the world, to successfully implant a fully 'invisible' hearing device into the fine bones of middle ear. The Cochlear CARINA® hearing device – which gives 24/7 hearing and can be recharged through an external charger within 30 minutes – is completely unseen from the outside of the scalp. The device is suitable for those people who have severe hearing loss and who can no longer benefit from conventional hearing aids.

Research comparing the use of traditional technologies in the management of type 1 diabetes with alternative technologies was published by the British Medical Journal. The REPOSE trial, which was led by Professor Simon Heller, Director of Research and Development at the Trust, highlighted that using insulin pumps alone do not significantly improve the quality of people's lives. Instead supporting and educating patients to learn how to manage their diabetes more flexibly so that they could confidently take on tasks such as blood glucose levels, carbohydrate counting and monitoring exercise to improve the quality of their lives was key. The research paper has been named as a 2018 'UK Research Paper of the Year' finalist by the British Medical Journal.

And finally, Professor David Sanders, Consultant Gastroenterologist, has been awarded the prestigious Bengt Ihre Medal from the Swedish Society of Gastroenterology for advancing the understanding of the impact of gluten on lifestyles and health through his landmark research into coeliac disease and non-coeliac disease sensitivity. The international award is one of the most prestigious in Gastroenterology, and has been awarded to UK Gastroenterologists on only three previous occasions in its history.

Perfect Patient Pathway Test Bed

The Perfect Patient Pathway Test Bed, based in Sheffield is one of seven national NHS Testbed programmes. It aims to bring new benefits to patients with multiple long term conditions. This will be achieved through the combination and integration of innovative technologies and pioneering service designs, keeping them well and independent and avoiding unnecessary hospital attendances. The 'Perfect Patient Pathway' Test Bed involves more than 30 partners including the region's NHS, Social Care, Industry, Academic and Voluntary organisations.

The Yorkshire & Humber NHS Genomic Medicine Centre

The Yorkshire & Humber NHS Genomic Medicine Centre, led by Sheffield Teaching Hospitals has now been in operation for just over a year, delivering to the 100k Genomes Project. Comparing the genomes of lots of people will help give a better understanding of diseases, how they develop and which treatments may provide the greatest help to future patients.

Devices for Dignity

The National Institute for Health Research's Devices for Dignity Co-operative, which is hosted by Sheffield Teaching Hospitals was one of 11 organisations across the country to be named by The Secretary of State for Health and Social Care Jeremy Hunt as an NIHR Medtech and In vitro diagnostic Co-operative (MIC). With a key focus on 'Living my life well for longer', the organisation will spend the next five years looking at the challenges that

arise from combinations of long-term conditions in order to develop new and innovative medical technologies that reduce, treat, or improve the management of these restrictions in people of all ages. Working alongside the Children and Young People's MedTech Co-operative, which is hosted by Sheffield Children's NHS Foundation Trust, another key element of research will be the development of technology solutions to help improve children's healthcare.

The National Institute for Health Research's Child Prosthetics Research Collaboration

Led by the NIHR Devices for Dignity MedTech Co-operative, this flagship national organisation aims to rapidly progress innovation in the development of child prosthetic devices by bringing together leading national research centres with capabilities in child prosthetics, key experts from the NHS, industry, and clinical academia and families of children using prostheses. Through its Starworks initiative, the organisation has awarded a total of £423,323 funding to ten groundbreaking projects, including the development of a customisable 3D printed cover that children can clip on over the surface of their existing prosthetic devices and change according to their mood, situation or changing tastes.

The NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRCs)

The NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRCs) is hosted by our Trust. The CLAHRCs are collaborative partnerships between the NHS, public services and Higher Education Institutions, focused on improving patient outcomes through the conduct and application of applied health research and evidence-based implementation. Our vision is to undertake high quality applied research and evidence-based implementation that is responsive to, and in partnership with, our collaborating organisations, patients, carers and the public. The CLAHRC in Yorkshire and Humber delivers national leadership in several areas particularly in engagement with industry and developing capacity in nurses and allied health professionals to deliver high quality applied health services research.

Connected Health Cities

Together with the University of Sheffield the Trust continues to play a key role in the development of the Northern Health Science Alliance (NHSA) which is a partnership established by leading universities, NHS Hospital Trusts and the Academic Health Science Networks (AHSNs) in the north of England to improve the health and wealth of the region. The government also provided £20m to the NHSA to establish a scalable pilot network of 'Connected Health Cities' across the North in which Sheffield will play a key role.

Working in Partnership

We believe the future shape of the NHS will see more integration and partnership working across organisations as set out in the "NHS Five Year Forward View - Next Steps" document published by NHS England in 2017. This has been a feature at Sheffield Teaching Hospitals for some years as exemplified by the integration of community services within our organisation and more recently the stronger interface with GPs and social care colleagues across the city through the Sheffield Accountable Care Partnership .

We know that to design and deliver integrated and joined-up pathways for patients across the range of care modalities and settings requires a different approach to how health care has been delivered traditionally and joint discussion and working with partner providers is essential for success.

This approach is typified by the Working Together Partnership Vanguard which involves seven Acute Trusts in South Yorkshire and North Derbyshire including Sheffield Teaching Hospitals. The aim is to share best practice and improve patient care. We believe that working together on a number of common issues allows all the Trusts to deliver benefits that they would not achieve by working on their own. Working Together is an Acute Care Federation which is enabling more joint decision making and opportunities to realise shared benefits. As we approached the end of 2017/18 the partnership integrated into the South Yorkshire and Bassetlaw Integrated Care System (ICS).

On a system-wide level we are excited by the potential system wide changes we can explore for health and social care as part of the South Yorkshire and Bassetlaw ICS. The ICS will be one of the ways we deliver the shared ambitions outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) at a local level.

The goal is for everyone in South Yorkshire and Bassetlaw to have a great start in life, with support to stay healthy and live longer.

The Integrated Care System has eight priority areas:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective care and diagnostics
- Maternity and children's services
- Cancer
- Non clinical support functions

The South Yorkshire and Bassetlaw ICS includes seven Hospital Trusts, two Care Trusts, five Clinical Commissioning Groups and five Local Authorities as well as 1,200 GPs.

Within the city of Sheffield the six major organisations responsible for providing Sheffield's residents with the care they need have come together to form an accountable care partnership (ACP). This will build on the strong history of joint working in the city and create a more formal arrangement for working together to make decisions, allocate funds, manage performance, and hold each other accountable for delivering results.

It is not a merger or a new organisation, it is an equal partnership, aiming to make it easier for the organisations to work together for the benefit of Sheffield people. In particular, it will support the delivery of 'Shaping Sheffield', the five year plan that has already been developed for improving health and care in the city.

Through Shaping Sheffield more than 60 organisations committed to a single plan for improving health and wellbeing in the city, by reducing health inequalities and focusing on ways to keep people healthy, wherever possible preventing them from becoming unwell.

The new partnership will help the city achieve these aims by removing some of the organisational barriers which can get in the way of progress. The intention is to move towards a fully outcomes-based approach and remove the commissioner-provider split so that all organisations can work as a system to plan and deliver care and services.

The partnership will run in shadow form from April 2018 and be fully operational by April 2019.

Good corporate citizen

Within our region there is much to build on in terms of expertise and leadership in the delivery of healthcare. But we must do even more to tackle health inequalities across the region, which result from deprivation, and lifestyle and behavioural challenges.

We need to deliver a health and care programme that gives everyone a great start in life, and helps them stay healthy and live longer. The quality of our health sector and our strength in public health research can help us tackle these inequalities, supporting innovative practices of collaboration and delivery through the Integrated Care System and ensuring that the region is prepared for the challenges of a changing and ageing population.

As one of the region's largest employers as well as healthcare provider, it is our responsibility to lead in the practice of preventative health care, linking the provision of care more closely to the region's growing exercise and lifestyle opportunities.

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.

With this in mind the Trust is working with Sheffield's two universities, the Sheffield City Region Combined Authority (CA), the Local Enterprise Partnership (LEP) and many public, private and community partners, to implement a vision for the Sheffield City region. There are six programmes in the plan which is called 'A Better Future Together', including one on health and wellbeing.

We want the region to be known for its healthy and active population - a healthy city region.

A key enabler for this is our role in the development of Sheffield's Olympic Legacy Park (OLP) and the park's innovative Advanced Wellbeing Research Centre (AWRC) which is being delivered by Legacy Park Ltd a partnership involving Sheffield City Council, Sheffield Hallam University and our Trust.

Set to become the most advanced research and development centre for physical activity in the world, the AWRC will form the centre piece of the Olympic Legacy Park. It will feature indoor and outdoor facilities for over 50 researchers to carry out world-leading research on physical activity in collaboration with the private sector and based upon the highly successful Advanced

Manufacturing Park in Sheffield. The Advanced Wellbeing Research Centre will undertake research focused upon taking services and products from concept to market, using the intellectual property, products and knowledge developed in the centre to generate both wealth and employment opportunities.

As one of the largest providers of healthcare in the NHS, we see the devastating effects poor health and a lack of exercise causes. We know that physical activity, performed on a regular basis, is associated with significant positive physical and mental health benefits. The result of this sedentary culture is significant negative physical and emotional health with huge clinical, psycho-social, economic and societal consequences.

This burden of chronic disease is felt in no greater measure than in the NHS and that is why Sheffield Teaching Hospitals together with partners from across the city have co-located clinical services alongside physical activity facilities to make it easier for physical activity to become part of usual care. Four Move More centres across the city have now been opened. As well as delivering services such as physiotherapy, weight management and get active programmes, the centres also provide the opportunity to utilise the skills and expertise from our clinicians to develop new services and care pathways that embed physical activity at their core.

In addition to the health and wellbeing agenda for the Region, we have played an active part in supporting employment during the last 12 months. Our work with Sheffield College to develop and expand apprenticeships has been recognised nationally and we continue to support military veterans who are seeking to explore alternative careers within the NHS.

Overview of Going Concern

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. The Trust has a number of policies which reflect social, community, anti-bribery and human rights issues.

Conclusion

I would like to say how very proud I am 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. 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.

The Trust has a number of policies which reflect social, community, anti-bribery and human rights issues.

There is no doubt that 2018/19 promises to be one of our most exciting but challenging years yet but we intend to rise to that challenge and deliver the best possible clinical outcomes, provide a high standard of patient services, employ caring and cared for staff, spend money wisely and deliver excellent research, innovation and teaching.

Sir Andrew Cash OBE
Chief Executive
22 May 2018

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.

The people of **Sheffield** are

moving more

Analysis of Performance

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 over £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 1,079,159 outpatients, 117,310 inpatients, 121,630 day case patients and 149,531 accident and emergency attendances . We have also had 731,569 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 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 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 prevent admissions to hospital wherever possible.

We have around 17,000 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, and neighbouring NHS organisations, the local authority, charitable bodies and GPs.

Our performance

Last year continued to be a challenging one for the NHS with all trusts expected to provide the highest standards of care while achieving demanding efficiency savings.

We treated around 1.23% more inpatients and day cases as well as an additional 0.20% more outpatients. The number of A&E attendances also increased by 1.26%.

Whilst we did not consistently achieve the national 95% 4 hour wait time standard, on average we did treat, discharge or admit almost nine out of ten patients (88.64%) who came to the emergency department within the required 4 hour timeframe.

A Trust wide programme throughout the year has reviewed the emergency care pathways from Emergency Department through to discharge, significantly improving the pathway for patients referred for assessment by their GP, increasing earlier discharge and utilising new eWhiteboards to plan for discharge.

Like most other NHS Trusts last year, meeting the rise in demand for emergency care during the winter months was further exacerbated by an increase in delayed transfers of care for those patients who could not be discharged from hospital, despite being medically fit, because the necessary social or health care was not available. We worked closely with our local health and social care partners to try and manage the position and our community and hospital teams responded magnificently by developing innovative ways of working which supported all our patients who needed care during this time. Despite extraordinary emergency care demands, our teams ensured we continued to meet the national Referral to Treatment waiting time standard which was exemplary in the circumstances.

We are currently working with NHS Sheffield to support their review of 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.

We are confident that this work will have significant benefits for our patients and those who provide their care.

With regard to our overall performance in 2017/18, we have met the majority of the national standards for waiting times. The average waiting time for care at the Trust is eight weeks or less.

ANALYSIS OF PERFORMANCE

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 and have consistently delivered the 92% 'incomplete standard'.

We continue to work with NHS Sheffield on the CASES model to maximise the number of patients who can be managed in primary care by expert GPs.

Last year we also met or exceeded most of the waiting time standards for patients requiring cancer care.

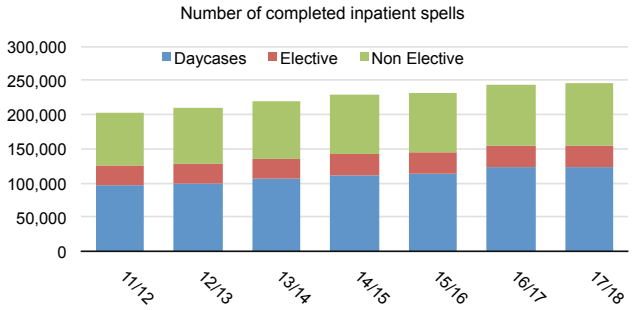
We have also seen some success in reducing the number of non urgent operations which are cancelled on the day of surgery.

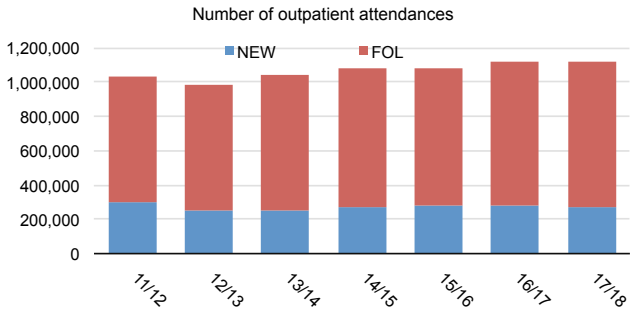
We consider rigorous infection prevention and control and clean facilities to be fundamental to our care standards. We continue to work hard to minimise the chances of patients acquiring hospital acquired infections, such as Norovirus and MRSA. During 2017/18 we had only three cases of MRSA bacteraemia and the number of cases of C.Difficile remained relatively low although slightly higher than the previous year.

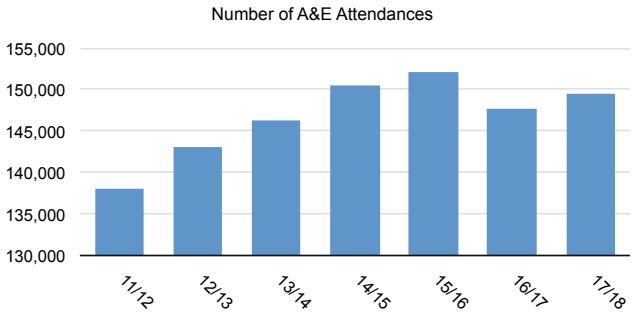
During the winter months, flu can pose a real health risk for patients and so during 2017/18 we vaccinated the highest ever number of our staff (76%) against flu so that we limited the risk of spreading the virus. We also offered patients who came in as emergencies the vaccination and our district nurses vaccinated almost all of their patients.

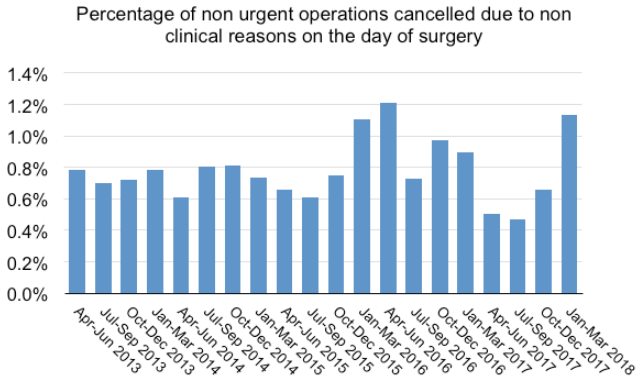
Further information about the principal risks facing the organisation and the processes in place to mitigate the risks can be found in the Annual Governance Statement on pages 59.

For further details of the Trust's performance see the following tables:



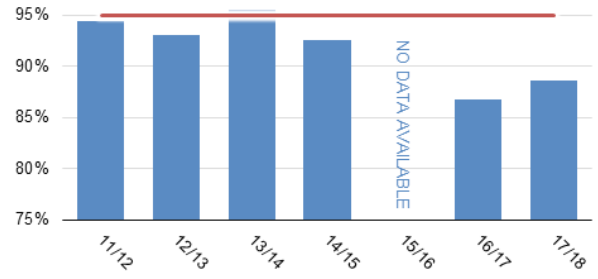




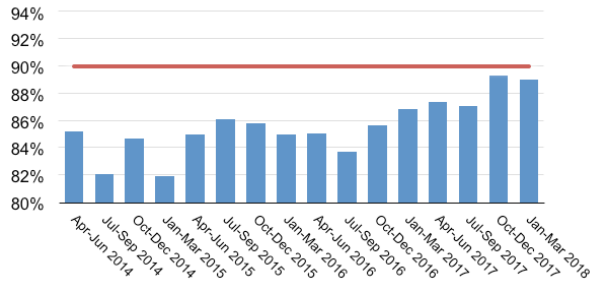


ANALYSIS OF PERFORMANCE

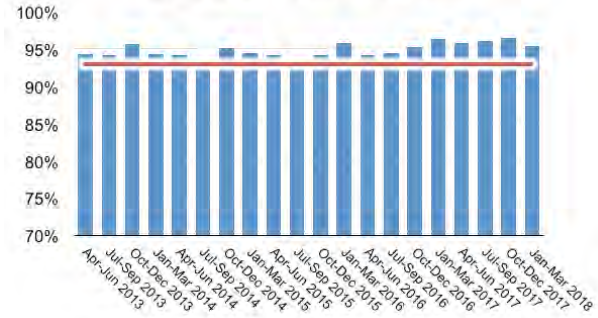
Percentage of patients treated within four hours in A&E



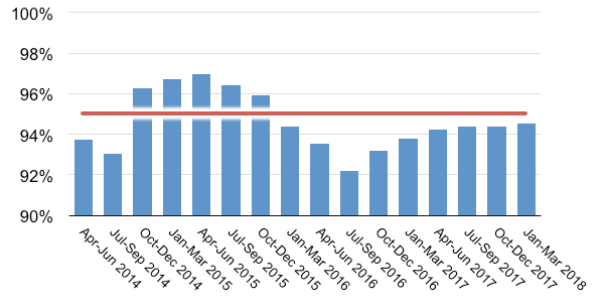
Percentage of patients starting admitted treatment within 18 weeks of referral (English Commissioners only)



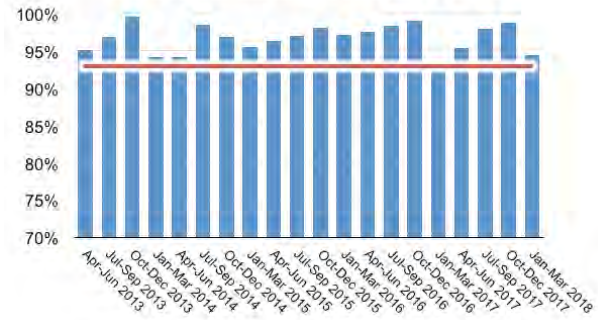
Urgent GP referrals seen within 2 weeks



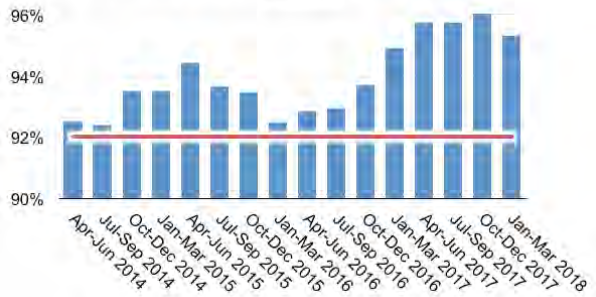
Percentage of patients starting non- admitted treatment within 18 weeks of referral (English Commissioners only)



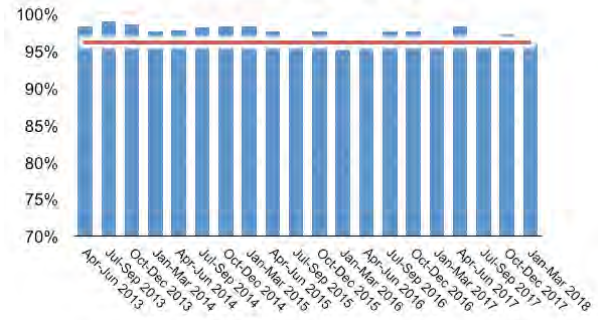
Breast symptomatic referrals seen within 2 weeks



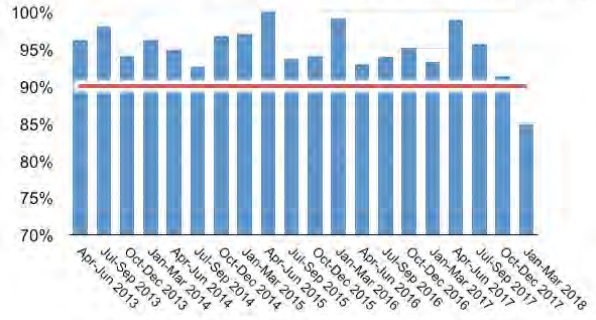
Percentage of patients waiting less than 18 weeks for treatment



First treatment within 31 days

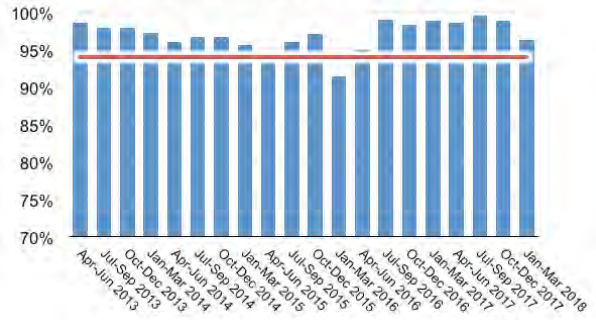


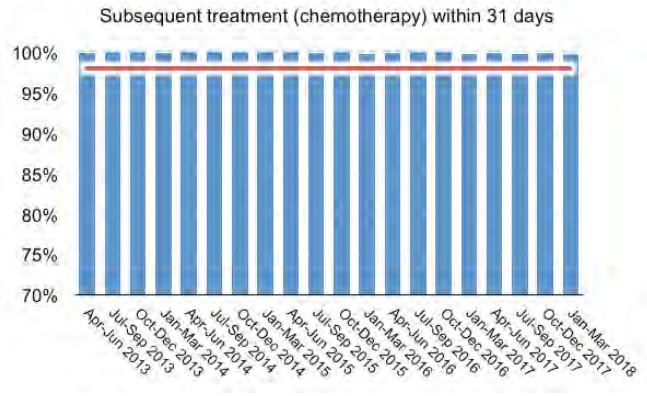
Treatment within 62 days of referral from screening

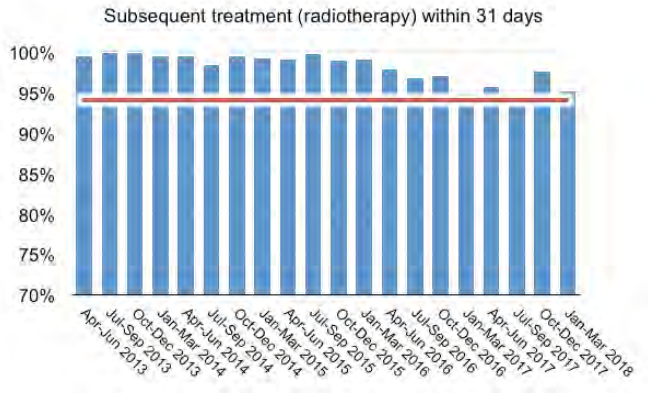


Treatment within 62 days of an urgent GP Referral

Subsequent treatment (surgery) within 31 days







Community performance 2017/18

Service measure	Target	Q1	Q2	Q3	Q4	2017/18
Intermediate Care Community Beds – number of admissions	N/A	291	325	334	316	1266
Intermediate Care Community Beds – Average Stroke Length of Stay	35 days	N/A*	N/A*	N/A*	N/A*	N/A*
Intermediate Care Community Beds – Average Orthomedical Length of Stay	35 days	36	33	35	40	36
Intermediate Care at home – Patients assessed within required timescales	98%	100%	100%	96%	94%	98%
Intermediate Care Number of packages delivered at home	N/A	2,121	2,020	2,140	2,188	8,469
Community Nursing Referrals	9,003	10,303	10,573	11,022	10,425	42,323
Community Nursing Contacts	N/A	179,288	186,809	189,215	176,257	731,569

*Intermediate Care Beds reconfigured at the end of 2016; the stroke beds at Beech Hill were reclassified as general Intermediate care beds so the Trust no longer has dedicated stroke beds

Performance against cancer access targets

Service measure	2015/16	2016/17	2017/18
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			
Urgent GP referral for suspected cancer Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard	83% 85%	79.13% 85%	78.93% 85%
NHS cancer screening service referrals Sheffield Teaching Hospitals NHS Foundation Trust achievement National Standard *Data Source: Open Exeter National Cancer Waiting Times Database*	96.31% 90%	93.79% 90%	91.83% 90%


Tranexamic Acid
500mg/5ml
Solution for Injection
Tranexamic Acid
500mg/5ml

A culture of improvement

In April 2016, the Trust consolidated its approach to improvement through the development of the "Making it Better" programme. The "Making It Better" Programme aims to lift our efforts on improvement and bring together the Trust's transformation work on quality, finance and culture. It also integrates a number of external strategic drivers including the 2016 Carter Report. The development of information and performance management systems, including use of the national Model Hospital metrics, is also a key element of the programme. "Making it Better" comprises eight major clinical and corporate programmes:

- Excellent Emergency Care
- Seamless Surgery
- Outstanding Outpatients
- Transforming through Technology
- Commercial, Corporate and Support Services
- Workforce Programme
- Organisational Development
- External Partnerships

There is increasing evidence that taking an integrated, joined up approach to tackling quality and finance, underpinned by high impact organisational development is how organisations really can develop a high performance, engagement and improvement culture.

As part of this work, we have undertaken a range of projects in 2017/18 including major clinical priorities such as End of Life Care and Sepsis and technology priorities such as electronic medicines system.

The Excellent Emergency Care Programme has developed a new vision for acute assessment, consulting with hundreds of staff and patients. The "Vital Room" has been created for teams across the acute assessment pathway to support and share improvements. The key pieces of work include developing ambulatory care medical pre-referral support to GPs, use of the Glasgow Admission Prediction Score in A&E, Rapid Access Surgical Clinics and creation of the Urology Assessment Unit, improving processes across the three assessment units and creating a single front door assessment process in the Emergency Department.

The Ward Collaborative has been a major project with many wards now demonstrating measured improvements from improved board rounds, to a more standardised environment, to discharge checklists.

The Seamless Surgery Programme was launched in July 2016 and is about creating a patient-focused elective experience through implementing best practice to ensure a smooth patient journey at all stages whilst using resources efficiently. A high impact engagement approach has been taken, using Microsystems and Listening into Action methodology to build widespread engagement. The programme has received national recognition. Early outcomes are encouraging with a reduction in lists cancelled per week and an increase in elective cases per week. Staff have provided feedback that the programme is positively supporting their efforts.

As part of our Outstanding Outpatient Programme we have begun the roll out of an e-check in system across the Trust. This will reduce waiting for patients and help improve patient flow. Capital investment has also been approved for a Patient Booking Hub, which began construction during 2017/18.

The Trust has invested over recent years in an award winning Service Improvement Team which in 2017/18 resulted in a growing body of service improvement work across the Trust. Our nationally acclaimed Microsystems Coaching Academy (MCA) also continues to go from strength to strength. The MCA continues to be cited nationally as good practice of how to build quality improvement capability 'from within' organisations, with references in influential health policy reports. A focus for 2017/18 has been the further development of the Improvement Collaborative methodology, with Collaboratives in Ward Improvement, Outpatients and Weston Park Cancer Hospital. The team also continue to build analytical capability, with increasing skills in using Discrete Event Simulation to help teams model and plan future services. Recent examples of its use include the Acute Assessment Unit reconfiguration, Major Trauma, Stroke and the Emergency Department.

Our Flow Programme, funded by the Health Foundation, develops improvement capability at pathway level.

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. The Friends and Family Test allows us to look in more detail at patient feedback at individual ward and department level where our scores consistently compare well nationally and good response rates are being achieved.

Over 98% of inpatients surveyed as part of the National Inpatient Survey by the Care Quality Commission in 2017 said our wards were clean and over 89% said they were always treated with respect and dignity.

Over 95% of patients surveyed expressed satisfaction with the help they received with pain control.

82% of patients rated their experience as 8 out of 10 or above and 38% rated their experience as 10 out of 10.

Through the Friends and Family Test during 2017/18, over 94% of patients said that they would be 'extremely likely' or 'likely' to recommend our Trust to family and friends.

During 2018 we will be developing a new engagement database which will enable us to consult more widely with patients and the public and, as part of this work we will be focussing specifically on those groups of our community who may be harder to reach or seldom heard. In addition, we will be piloting 'co-production' as a way of working in partnership with patients, their families and carers to redesign and improve more of our services.

During 2017/18 our complaints process has been further strengthened by increasing the number of meetings held with complainants as a way of aiming to resolve complaints.

As the number of complaints meetings has increased, the proportion of re-opened complaints has decreased.

For further information about the work undertaken to ensure we listen and respond to patients' views, complaints and suggestions please see the Quality Report on page 69.

Staff Report

The Trust is privileged to have many skilled and dedicated staff who contribute to the success of our hospital and community services.

This has been particularly evident during the past year when the Trust experienced challenging operational pressures.

Many staff worked over and above their normal duties to ensure that the quality of patient care was maintained. We strive to recruit and retain the best staff and we recognise the importance of positive staff engagement and good leadership to ensure good quality patient care.

Our PROUD values and behaviours continue to underpin the way we lead and deliver through change in the next five years. A focus on staff engagement and involvement ensures we continually learn and change using the ideas and knowledge of our many staff in all roles. You can read more about our progress in this area and other important workforce issues in the Staff Report on pages 47.

Equality and Diversity and Inclusion

We want 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 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. 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.

We have raised the profile of our work to ensure that the diversity of our workforce is understood and celebrated as well as ensuring we have the right systems and mechanisms in place to ensure that everyone who works within the organisation has a positive experience.

We continued to support the Athena Swann programme to actively encourage women who aspire to leadership positions. The programme also recognises work undertaken to address, and not just barriers to progression that affect women. We also had a positive response to the Listening into Action 'Big Conversations' held throughout the year, where colleagues from across the Trust looked at what we do well and what we need to do better to ensure we can meet the needs of our disabled colleagues.

We know BME colleagues are significantly underrepresented in senior management positions and at board level across the NHS and the Trust wishes to address this issue and become an exemplar with regards to race equality. We invited Yvonne Coghill OBE, Director of WRES Implementation team, to work with us to help develop a strategy to take this work forward. We have been talking to staff across the organisation to help shape the development of the strategy with over 100 BME staff attending events and sharing their views on how our organisation can work towards developing a fully inclusive workforce.

It is pleasing to note the improvement in the percentage of BME staff believing the Trust provide equal opportunities in career progression following the work of the WRES QI group who have ensured more BME representation on nursing recruitment panels. The 2017

staff survey results show that at 3.96, staff engagement is higher amongst BME staff compared to the Trust average.

During 2018 we are launching a Reverse Mentoring scheme to help us learn about new ways of being more inclusive and adaptable in our organisation. We also have a member of our Workforce Information team working with Yvonne Coghill, Director of the Workforce Race Equality Programme at NHS England, so we can make more progressive step changes during 2018.

The Trust will continue to develop the diversity and inclusion strategy across all protected characterises and will continue to publish the Trust annual equality report as well as compliance against future nationally agreed standards e.g. Gender pay gap reporting and Disability Equality standard.

Sustainability and Climate Change

The Trust actively encourages our staff to support us with energy efficiency and sustainability issues through initiatives as diverse as recycling and walking to work.

The Trust's predicted gas, electricity and water consumption for the reporting year April 2017 to March 2018 is as follows:-

Gas - 77,085,617 KWh which equates to an 8% reduction when compared against the previous year.

Electricity - 53,952,403 KWh which equates to a 2% reduction when compared against the previous year.

Water -483,289 M^3 which equates to a 5% reduction when compared against the previous year.

These reductions are set against a background of increasing patient activity across the Trust. The overall annual CO2 emissions to atmosphere have seen similar reductions (see tables below). Carbon emissions are an important indicator of the environmental impact an organisation has on the local community.

The carbon footprint generally falls into three categories:-

- Emissions to atmosphere due to the procurement (food, pharmaceuticals, etc.).
- Emissions to atmosphere due to energy consumption, the burning of fossil fuels.
- Emissions to atmosphere due to transport, travel to and from site by staff, patients and visitors, etc.

The Trust has to comply with various statutary environmental Regulations, Act's and national NHS guidelines and is committed to limiting the Trusts impact both in the local and global environment.

The Trust is a member of the European Union Emission Trading Scheme (EU ETS) as a member of this "cap and trade" scheme we are set annual emissions targets by the Environment Agency which are designed to encourage lower consumption. The Trust is achieving these nationally set targets on an annual basis.

The Trust needs to meet the requirements of the Energy Performance of Building Regulations 2012. This requires The Trust to display the operational energy efficiency rating of each building over with a gross internal area of 250M2. This requires an annual energy assessment and the displaying of a Display Energy Certificate (DEC). All the main building across the Trust are rated and achieving a better than typical for their type of construction and use.

The NHS Carbon Reduction Strategy 2015 required the Trust to achieve a 34% reduction in emissions by 2020 when set against a baseline at 1990.

The Climate Change Act 2008 required a reduction of 10% between 2007 and 2015 and 80% reduction by 2050 from the 1990 baseline.

The NHS nationally has achieved an 11% reduction (2007-2015).

The Trust has reduced its emissions relating to energy consumption by 25% between 2007 and 2015 (NB this excludes emissions relating to procurement and travel).

Year	Annual Carbon Dioxide Emissions (tCO_2)	
	Gas	Electricity
2008/09	29,834	36,171
2009/10	27,677	34,712
2010/11	24,660	32,005
2011/12	19,071	30,038
2012/13	20,962	29,061
2013/14	18270	29,220
2014/15	16,754	29,488
2015/16	15,327	29,594
2016/17	15,403	29,949
2017/18	14,335*	29,350*

Trust Consumption Figures for 2017 – 2018*

Utility	Energy Consumption
Water	483,289 M^3
Gas	77,085,617 KWh
Electricity	53,952,403 KWh

* Denotes: Estimations as at February 2018.

The Trust continues to invest in energy saving and carbon reducing schemes, such as the installation of LED lighting which reduces energy consumption, improves lighting levels and reduces maintenance, which is particularly important given the numerous light fittings in use across the Trust estate.

The Trust has commenced a scheme to de-steam the Royal Hallamshire Hospital boiler house and the associated plant and equipment is expected to provide further significant reductions in gas consumption at the Central Campus provide greater controllability and reduce maintenance.

Andrew Cash.

Sir Andrew Cash OBE
Chief Executive
22 May 2018


NHS
DELL

Analysis of Financial Performance

Financial Performance

After a very challenging year, the Trust's financial results for 2017/18 are very satisfactory. The position can be summarised as follows:-

	2017/18 Plan £M	2017/18 Actual £M	Variance £M
Total income	1,057.7	1,077.1	19.4
Expenses excluding depreciation	-1,015.4	-1,026.6	-11.2
Depreciation/ Impairments	-35.3	-45.9	-10.6
Operating surplus	7.0	4.6	-2.4
Public Dividend Capital dividend	-10.0	-10.3	-0.3
Other Financing Costs (net)	-3.0	-2.7	0.3
Deficit for the year	-6.0	-8.4	-2.4

The Trust had a deficit from continuing operations of £8.4m (0.78% of turnover). However, within this position there are exceptional items relating to impairment charges arising from the Estate Revaluation undertaken during the year and additional national Sustainability & Transformation Funding (STF) notified at the end of the year by NHS Improvement (NHSI). Without these items the deficit would have been £1.2m (0.11% of turnover) which would have been an improvement on the plan. The Trust had another very challenging financial year due to the ongoing national financial environment and a range of service, workforce and financial pressures. Significant contingencies and one-off benefits were critical to achieving the outturn position.

The Trust's income position for 2017/18 was as below:-

	£m	% increase over 2016/17
Income from patient services	893.2	2.4
Other operating income	183.9	-1.6
Total Income	1,077.1	1.7

Income growth was modest and almost entirely related to patient services. This was from a combination of increases in volumes; a richer case-mix offsetting losses from new tariffs; and specific cost/case reimbursements. The decrease in other operating income is due to reductions in Education & Training income and recharges to other organisations offset by the receipt of additional STF. Total STF for the year was £27.6m compared to the original plan of £18.6m. The additional funding reflects that the Trust's financial performance was better than the 2017/18 Control Total set by NHSI.

Pay costs rose by 3.2% over 2016/17 levels, partly due to pay awards and the Apprentice Levy. Bank and Agency costs were £6.0m lower. Drugs and clinical supplies and services costs were broadly unchanged. Premises costs increased by 3.5% and the Clinical Negligence Premium increased by 21.9 % reflecting the national increase in costs. The combined depreciation, loan interest and PDC dividend charges reduced by 4.1%. There was a net impairment charge of £17.2m in 2017/18 compared to £6.0m in 2016/17. The latter two items were driven by the Estate Revaluation. This was an interim valuation and was undertaken using the Modern Equivalent Asset alternative single site valuation model.

Efficiency Savings

The Trust again faced a major challenge to deliver the national efficiency requirement and to deliver savings to offset income losses and cost pressures. For 2017/18 the efficiency requirement was again over £20m bringing the cumulative requirement for the last decade or so to over £300m. Virtually all of the 2017/18 plan was delivered. The Trust continued to seek efficiency savings in clinical and back-office areas through its Making it Better Programme; by developing Service Improvement capability and capacity within front-line staff; by supporting Directorates to identify and deliver savings opportunities; and by working with other organisations within the South Yorkshire and Bassetlaw area. This continues to be a critical area with the challenge of delivering efficiency savings from areas under significant service pressure.

Capital Investment

Total capital expenditure for the year was £35.9m and has been analysed below. The focus in 2017/18 was again on investing in the Trust's medical equipment and supporting physical infrastructure whilst promoting new service developments and modernising theatres in order to improve the service to patients across the Trust.

	£,000	£,000
Medical Equipment	**8,945**	
Equipment Replacement Programmes (e.g. Ultrasounds)		3,386
NGH & RHH Plain Film Room Equipment		1,201
CT Scanner Replacements (x2)		1,021
NGH MRI Replacement Scanner		905
Replacement MRI Scanner (1.5T)		748
Replacement Catheter Lab		571
RHH Fluoroscopy Replacement Rooms (x2)		534
Other		579
Information Technology	**859**	
Infrastructure		812
Telephony Platform		462
E-Prescribing		133
VAT Recovery On Prior Year IT investment		-731
Other		183
Service Development	**10,783**	
Northern General Eye Centre		4,197
NGH Frailty Unit		2,146
CCDH Laboratory Refurbishment		993
RHH Minor Operations Suite		788
RHH C Floor Radiology Refurbishment		648
Stroke Rehabilitation – Beech Hill		557
Other		1,454
Infrastructure	**15,299**	
RHH Q Floor Theatres		8,414
WPH Ward Refurbishment		2,147
RHH A Floor Theatres		1,074
RHH Main Lifts		671
RHH Service Block Redevelopment		657
JHW Lifts		527
Other		1,809
Total Expenditure	**35,886**	

Total capital income available to the Trust for the year was £48.5m. This can be analysed as follows:-

	£000
Internally Generated Resources	47,448
National Capital Allocations	69
Other Donations/External Income	1,013
Total Income	**48,530**

Overall, therefore, there was a £12.6m underspend on the Capital Programme due to slippage on schemes, particularly around the Eye Centre, Estates Infrastructure and IT Plans; and general programme under-commitment due to operational and access constraints. These resources are carried forward and will be used to complete the planned investments in due course.

Cash Flow and Balance Sheet

The Trust's net assets employed at 31 March 2018 were £413.4m compared with £426.1m at the previous year-end. The value of Land, Buildings and Equipment at 31 March 2018 was £425.8m. The reduction in 2017/18 reflects the Estate Revaluation referred to above. Outstanding "borrowings" relating to Foundation Trust Financing Facility loans, a PFI contract and a Finance Lease totalled £41.4m at the year-end.

Cash balances increased to £74.9m at 31 March 2018 (£68.3m at 31 March 2017) and net current assets at 31 March 2018 reduced marginally to £26.4m (from £27.5m at 31 March 2017). This reflects the 2017/18 position, Capital Programme underspend and an increase in the level of Payables. There remain significant resources committed to capital schemes and Research projects in future years. The Trust has a requirement as a Foundation Trust to have a sound working capital position in order to provide a degree of financial security and ensure the continuity of patient services. NHSI assesses Trust financial positions through its Use of Resources Risk Rating. This operates on a scale of one to four, where one represents very high low and four represents very high risk. Based on the outturn results, the Trust's risk rating for 2017/18 was one.

Conclusion

Overall 2017/18 was generally another very challenging financial year for NHS acute providers given the on-going national focus on recovering from the major level of deficit in 2015/16. In this context the Trust's 2017/18 financial results are satisfactory with stability maintained and a significant gain from additional Sustainability and Transformation Fund. However, the underlying position remains very difficult as demands on services have continued to grow, the available workforce has been restricted and funding has been constrained for several years. The Trust's 2017/18 position relied heavily on the Sustainability and Transformation Fund and various one-off benefits. Whilst the Trust remains committed to delivering high quality services and to achieving efficiency savings to address financial pressures and to protect and invest in services, it will continue to face many challenges if it is to remain financially, clinically and operationally sustainable. Without changes to the national funding settlement for the NHS and social care in the very near future the Trust's ability to address these challenges is extremely uncertain.

Sir Andrew Cash OBE
Chief Executive
22 May 2018

Accountability Report

Accountability Report

DIRECTORS' REPORT

Board of Directors

The Board of Directors is made up of the Chairman, seven Non-Executive Directors and six Executive Directors . During the year we have strengthened the executive team by appointing a seventh Executive Director to lead the strategy and planning functions and have created the role of Deputy Chief Executive. 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. Annette Laban, Non-Executive Director, was appointed as Senior Independent Director on 1st July 2015.

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 Assistant Chief Executive to Governors following Board of Directors meetings
- Joint meetings between the Board of Directors and Council of Governors on significant issues, when required.
- Active involvement of Governors in key decision making groups such as the Quality Report Steering Group and the successor group the Quality Board

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 are maintained by the Assistant Chief Executive and published on the Trust's website. Plans are underway to publish a wider Register containing Declarations of Interests from any member of staff. The Trust also holds Registers of Interest for staff.

The Chairman has the following other significant commitments: He holds directorships in Metalysis Ltd and EEF Ltd. He is the Pro-Chancellor and Chair of the Council of the University of Sheffield, Chairman of Albion Steel Ltd and Chair of Trustees for South Yorkshire Chaplaincy and Listening Service.

Audit Committee

The Audit Committee is appointed by the Board of Directors and consists of four Non-Executive Directors. Other Non-Executives, who are Chairs of other Board Committees, have a standing invitation to the Audit Committee. The Director of Finance, the Assistant Chief Executive, the Head of Internal Audit and a senior representative of the Trust's External Auditors (Mazars) normally attend the meetings.

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 financial, non-financial and 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 information it requires from staff to fulfil its functions.

In 2017-18 the Committee considered the following matters:

Statutory Financial Statements and Annual Report

- Statutory Financial Statements and Annual Report and Accounts 2016/17 (including the Quality Report) received and approved by the Committee prior to being submitted to the Board of Directors for final approval (May 2017).
- Internal Audit Annual Report including the Head of Internal Audit Opinion received and noted. His report

Board of Directors membership and attendance

Name	Position	Attendance (actual / possible)
Tony Buckham	Non-Executive Director	11/11
Sandi Carman	Assistant Chief Executive*	10/11
Andrew Cash	Chief Executive	9/11
Hilary Chapman	Chief Nurse	11/11
Anne Gibbs	Director of Strategy and Planning (from 1 February 2018)	2/2
Mark Gwilliam	Director of Human Resources and Staff Development	9/11
Candace Imison	Non-Executive Director	9/11
Annette Laban	Non-Executive Director and Deputy Chair	10/11
Kirsten Major	Deputy Chief Executive	11/11
Dawn Moore	Non-Executive Director	8/11
Chris Newman	Non Executive Director (from 1 November 2017)	5/5
John O'Kane	Non-Executive Director	9/11
Tony Pedder	Chairman	11/11
Julie Phelan	Communications and Marketing Director*	11/11
Neil Priestley	Director of Finance	11/11
Pam Shaw	Non-Executive Director (until 31 October 2017)	5/6
Martin Temple	Non-Executive Director	8/11
David Throssell	Medical Director	11/11

* The Assistant Chief Executive and the Communications and Marketing Director also attend all Board of Directors meetings. Following agreement with the Chief Executive, the Assistant Chief Executive and Communications and Marketing Director are now considered Senior Managers for the purposes of the Annual Report.

found significant assurance on the Trust's system of internal controls (May 2017).

- External Audit Annual Governance Report (ISA 260) including the Letter of Representation and Audit Opinion received and noted (May 2017). The report was subsequently presented to the Council of Governors (September 2017).
- External Audit External Assurance Report on the 2016/17 Quality Report received and noted (May 2017). The report was subsequently presented to the Council of Governors (September 2017).
- Accounting Policies for completion of 2017/18 Financial Statements paper, including the appropriate accounting treatment for Charitable Funds, received and approved (January 2018).
- Process and timetable for approval of 2017/18 Financial Statements and Annual Report paper received and approved (January, 2018).
- Going Concern concept (verbal update given in January 2018 and a paper in March 2018). The Committee agreed that the 2017/18 Annual Accounts be prepared on a "going concern basis".

Counter Fraud Services

- Local Counter Fraud Services progress reports were received and noted (all meetings except May 2017);
- The Committee received and approved the Draft 2017/18 Fraud, Bribery and Corruption Risk Assessment and Work Plan (July 2017 and March 2018 respectively).

- The Committee received the 2017/18 Annual Counter Fraud Report (May 2017)

Reports Received

- Losses and Compensations Report received and noted (May 2017).
- Risk Management Annual Report was received and noted (July 2017).
- Single Tender Waiver Reports received and noted (all meetings except May 2017).
- Registers of Gifts reports received and noted (all meetings except May, July 2017).
- Register of Hospitality reports received and noted (all meetings except May 2017
- The Committee received and noted declarations of interests declared by staff in (July 2017, October 2017 and March 2018)
- Insurance Arrangements Annual Report 2017/18 received and noted (January 2018).

Internal Audit

- Internal Audit Progress Reports received and noted (all meetings except May 2017).
- The Audit Committee received and approved the risk-based Internal Audit Plan for 2018/19 (January and March 2018)
- The Committee at a private meeting discussed the Draft Membership Agreement produced by the Consortium (Internal Audit)

External Audit

- External Audit Progress Reports received and noted (all meetings except May 2017).
- 2017/18 External Audit/Internal Audit Protocol for Liaison received and noted (October 2017)
- The Committee received and approved the risk-based 2017/18 Audit Strategy Memorandum (Audit Plan) received and approved (January 2018).

Assurance

- A review of Internal Audit Service received was undertaken and outcome reported to a private meeting of the Committee (July 2017).
- Audit Committee 2016/17 Annual Report and 2017/18 Work Plan and Terms of Reference received and approved (May 2017).
- The Audit Committee received an update on Data Quality – Baseline Assessment Audit (March 2018)

Risks

- Integrated Risk and Assurance Report (IRAR) – discussed at all meetings except May 2017 and March 2018
- The Committee received a separate report on the Delivery of Planned Maintenance and Refurbishment of Wards (October 2017)
- The Committee noted that Chairs of Board Committees were to be invited to a meeting of the Audit Committee to discuss the risks on the IRAR that their respective Committee had oversight of. (January 2018).
- The Committee received an update from the Chair of the Human Resources and Organisational Development Committee (HR&ODC) on the risks that the HR&ODC had oversight of. (March 2018).

Other Work

- The Committee received updates on the Code of Business Conduct including Declaration of Interests, Gifts, Hospitality and Sponsorship Policy (July 2017, October 2017, January 2018, March 2018
- The Committee noted that the Trust had agreed to purchase an electronic system to support the launch of the Code of Business Conduct including Declarations of Interests, Gifts, Hospitality and Sponsorship Policy (October 2017)
- The Committee received an update on the Review of Standing Financial Instructions and Scheme of Delegations (July and October 2017)
- The Committee received a verbal update on the Asset Valuation Approach (2017/18 Interim Year) (January and March 2018)

External Audit Process and Appointment:

- A Review of External Audit Services received by the Trust was undertaken and discussed (July 2017). The review concluded that the Trust was receiving a satisfactory service and recommended the re-appointment of Mazar's for the 2017/18 financial year to the Council of Governors at the September 2017 meeting.
- The Council of Governors approved the recommendation for the re-appointment of external auditors for 2017/18 (September 2017).
- A tender for external audit services was completed in summer 2016 and the contract runs for the financial years 2016/17, 2017/18 and 2018/19. The value of the statutory external audit service is £54k pa.
- An Internal and External Audit Relationship paper including a joint working protocol between Internal and External Audit was received and noted in October 2017.

Provision of Non-audit services by the External Auditor:

- The provision of non-audit services by the external auditor relates solely to the assurance report on the Trust's Quality report for the financial year. The value of this service is £9k pa.

The disclosure set out in the NHS Foundation Trust Code of Governance

Sheffield Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principle of the UK Corporate Governance Code issues in 2012.

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-Executive Directors. Following an extensive review of the Trust's constitution in 2014/15, 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 by the Board of Directors and the Council of Governors.

Council of Governors

Our Governors continue to play an important part in the work of the Trust. 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 Foundation Trust Members and members of the public, appointing the Chair and other Non-Executive Directors and setting their remuneration.

The Council of Governors receives the Trust's Annual Report and Accounts and the Auditor's report and has input into the Trust's Annual Plan and the Quality Report. The Council must approve any significant transactions, mergers and acquisitions and any changes to the Trust's constitution. The patient, public and staff Governors on the Council of Governors are elected from and by the Foundation Trust Membership to serve for three years. Elections for Governors took place in June 2017.

Formal meetings of the Council of Governors are held four times a year.

The Trust's Executive Directors attend Council meetings facilitating the sharing of information and specialist knowledge with Governors. The Chair of the Trust chairs the Council of Governors meetings and the Non-Executive Directors are invited to attend. In addition to attending the Council meetings Governors also contribute to a number of Trust committees, Workstreams and specific projects.

Our membership

We have 28,321 Members: 3,842 patient Members, 8,526 public Members and 15,953 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 to observe at meetings of the Board of Directors and the Council of Governors. They are also receiving invitations to events such as health lectures and talks.

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

- Patient: anyone aged 12 years or over who has been a patient of the Trust
- Public: residents of Sheffield aged 12 years or over
- Public Outside Sheffield: residents of England or Wales, outside of Sheffield, aged 12 years or over
- Staff: employees contracted to work for the Trust for a least one year

We are keen to hear Members' views. Members wishing to get in touch or anyone wanting to know more about Membership should contact:

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

Telephone: 0114 2714322

Email: jane.pellegrina@sth.nhs.uk

More details about the Governors can be found on the Trust website

www.sth.nhs.uk/about-us/council-of-governors/whos-who

Council of Governors membership and attendance

	Elected/Re-elected from	Attendance (actual / possible)
Patient Governors		
Barbara Bell	1 July 2017	3/3
Jennifer Booth	1 July 2016	5/5
Dorothy Hallatt (to 30-6-17)	1 July 2014	0/2
Steve Jones	1 July 2017	3/3
Kath Parker	1 July 2012	5/5
Harold Sharpe	1 Dec 2016	4/5
Graham Thompson (to 30-6-17)	1 July 2014	2/2
Michael Warner (to 9-2-18)	1 July 2015	4/5
Nev Wheeler	1 July 2016	4/5
Public Governors		
Mick Ashman	1 July 2016	3/5
Jo Bishop (to 30-6-17)	1 July 2014	0/2
Wendy Bradley	1 July 2017	2/3
George Clark (to 30-6-17)	1 July 2014	2/2
Michelle Cook	1 July 2017	0/3
Sally Craig	1 July 2014	4/5
Peter Hewkin	1 July 2016	5/5
Martin Hodgson	1 July 2016	5/5
Joyce Justice	1 July 2015	3/5
Jacquie Kirk (to 9-10-17.)	1 July 2014	3/3
Ian Merriman	1 July 2015	5/5
Lewis Noble	1 July 2015	3/5
Spencer Pitfield	1 July 2015	1/5
Sue Taylor	1 July 2016	5/5
Enid Wadsworth	1 July 2017	2/3
John Warner (to 30-6-17)	1 July 2014	2/2
Staff Governors		
Dylan Caffell (Admin, Management & Clerical)	1 July 2015	5/5
Catherine Hemingway (Community Services)	1 March 2015	5/5
Irene Mabbott (Nurses & Midwives)	1 July 2015	5/5
Cressida Ridge (Ancillary, Works & Maintenance)	1 July 2017	3/3
Karen Smith (AHPs, Scientists & Technicians)	1 July 2017	3/3
John West (Doctors & Dentists)	1 July 2015	4/5
Appointed Governors	**Appointed**	
Paul Corcoran (Sheffield College)	1-9-15 – 1-11-17	1/2
Amanda Forrest (SCCG)	21-4-15	3/5
Tim Furness (VAS)	1-2-18	0/1
Luc de Witte (UoS)	1-11-17	2/2
Adam Hurst (SCC)	1-11-17	0/1
Sarah Williamson (VAS)	1-12-16 to 31-1-18	0/4

Nomination and Remuneration Committee of the Council of Governors

The Nominations and Remuneration Committee of the Council of Governors makes recommendations to the Council on the appointment and remuneration of the Chair and other Non-Executive Directors and considers and contributes to the appraisal of the Chair and Non-Executive Directors. Over the year, the Committee met four times. The Council of Governors approved the Committees' recommendation to re-appoint Annette Laban and Martin Temple for a second term of office as Non-Executive Directors. The Council of Governors also approved the Committees' recommendation to appoint Professor Chris Newman as a Non-Executive Director.

Annual Members' Meeting

On 21 September 2017 Members attended our 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 Annual Members' Meeting 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 Meeting was followed by lunch and an opportunity to talk to Governors and an opportunity for Members to join themed sessions focused on innovative Trust work, including Perfect Patient Testbed; Dementia Matters and Life in a Trauma Centre. There was also an opportunity for Members to visit a marketplace of stalls showcasing research studies and new initiatives.

Nominations and Remuneration Committee of the Council of Governors Membership and Atttendance

Name	Designation	Attendance (actual / possible)
Paul Corcoran	Appointed Governor	0/3
Sally Craig	Public Governor	3/4
Amanda Forrest	Appointed Governor	2/3
Cath Hemingway	Staff Governor	4/4
Martin Hodgson (Vice-Chair)	Public Governor	3/4
Jacquie Kirk	Public Governor	1/1
Irene Mabbott	Staff Governor	3/4
Kath Parker	Patient Governor	4/4
Tony Pedder (Chair)	Trust Chair	4/4
Harold Sharpe	Patient Governor	1/1

Board of Directors 2017-18

Non-Executive Directors

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.

Tony Buckham

Tony brings a wealth of experience from his time working within complex global organisations. He has provided strategic support to the HSBC Group Management Board Directors, with particular expertise within IT and Corporate Real Estate for over ten years. He has led divisions of up to 7000 staff with particular focus on people development to enable global transformational change. He has also made a significant contribution to mentoring and coaching programmes.

Candace Imison

Candace Imison is the Director of Policy at the Nuffield Trust. She joined the Nuffield Trust in 2014 with a remit to develop a work programme on new models of care, including technology and workforce. Candace was previously Deputy Director of Policy at The King's Fund, where she researched and published on a wide range of topics, including future health care trends, service reconfiguration, workforce planning, polyclinics, community health services and referral management. Candace has extensive senior management experience in the NHS, including at board level for providers and commissioners. She was also a Director of Strategy for a large acute trust and Director of Commissioning for a large health authority. Candace worked on strategy and policy at the Department of Health between 2000 and 2006, including the Wanless Review, the White Paper "Our Health, Our Care, Our Say" and "Keeping the NHS Local", setting out policy for the reconfiguration of hospital services. Candace holds a Master's degree in health economics and health policy from the University of Birmingham and a degree in natural sciences from the University of Cambridge.

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.

Dawn Moore

Dawn has more than 20 years of HR experience, with over 11 years at director level. She has experience in fields including manufacturing, construction, social housing, fast moving consumer goods and retail. Dawn is Director of HR for Morgan Sindall Construction & Infrastructure, and has previously held other Executive HR director level roles in several large organisations including Tarmac, Northern Foods and Vesuvius plc. She has been a Sheffield resident for over 22 years.

John O'Kane

John joined the Board in October 2014. He is an experienced Finance Director, with experience of managing change in a number of companies. He has worked as Group Finance Director at Redhall Group, Jarvis, Ecobat Technologies, Peterhouse Group and Kelda Group.

Professor Dame Pamela J Shaw
(to 31 October 2017)

Professor Dame Pamela Shaw is a clinician Scientist in Neurology and formerly a Wellcome Senior Clinical Fellow. Supported by long-term programme funding from the Wellcome Trust, she has since 1991 led a major multidisciplinary programme of research investigating genetic, molecular and neurochemical factors underlying neurodegenerative disorders of the human motor system. Professor Shaw is a member of multiple national and international committees, and brings with her a wealth of clinical and research expertise.

Professor Chris Newman
(from 1 November 2017)

Chris joined the Board in November 2017. He is Dean of the Medical School, Professor of Clinical Cardiology and Honorary Consultant Cardiologist at the Trust. He also directs the National Institute of Health Research Sheffield Clinical Research Facility, a joint facility between the Trust and the University of Sheffield.

Martin Temple CBE

Martin is currently the Chair of the Health and Safety Executive and is also on the Board of The Great Exhibition of the North. Martin has served on the boards of a wide range of companies around the world. He was Chairman of the Design Council, on the Council of the University of Warwick as well as the Chair of the Warwick Business School Advisory Board. He has also been Vice President of Avesta-Sheffield AB, Director-General of EEF and also Chairman of EEF from 2008 until 2016. Martin has been a Non-Executive Director and Chairman of The 600 Group PLC. He has also acted as an independent Chairman for several Government Reviews for previous Governments. He has extensive experience covering senior roles in production, marketing, operations and strategy in an international context.

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. He is the Vice Chair of the NHS Confederation and Chair of the NHS Employers Policy Board. Andrew has been Chief Executive of Sheffield Teaching Hospitals NHS Foundation Trust since its inception in July 2004. Prior to that he was the first Chief Executive of the newly merged Sheffield Teaching Hospitals, which came into effect in April 2001.

Chief Nurse

Professor Dame 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 Institute of Healthcare Research (NIHR) Advisory Board, was until recently, a Non-Executive Director of the National Skills Academy (Health), is a member of the Clinical Advisory Forum at NHS Improvement and is a visiting Professor within the Faculty of Health and Wellbeing at Sheffield Hallam University.

Hilary was awarded a CBE for services to nursing in 2012 New Year's Honours and an Honorary Doctorate of Medicine by the University of Sheffield Medical School in 2015. She served as Deputy Lieutenant for the County of South Yorkshire and was appointed Dame Commander of the Order of the British Empire for services to nursing in the New Year's Honours List 2018.

Director of Human Resources and Staff Development

Mark Gwilliam

Mark is currently Director of Human Resources and Staff Development. He took up his original post as Director of Human Resources and Organisational Development in May 2009 and brings with him a wealth of experience. He was previously an Associate Director of Human Resources at Central Manchester University Hospitals NHS Foundation Trust where he worked for three years. Mark joined the NHS in 2004 through the Gateway to Leadership Programme and was assigned on placement at Sheffield Teaching Hospitals NHS Foundation Trust. Prior to this he worked in the fast moving consumer goods sector in numerous operational management and human resource management roles.

Deputy Chief Executive

Kirsten Major

Kirsten joined the Trust in February 2011 as Director of Strategy and Planning. Prior to this Kirsten was 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 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 Planning

Anne Gibbs

(from 1 February 2018)

Anne was appointed in post in February 2018, prior to this she worked for NHS Improvement in a joint role with Greater Manchester Health and Social Care Partnership. Previously, she has worked for a number of Trusts in London and Birmingham.

Other Senior Managers who attend the Board

Communications and Marketing Director

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.

Assistant Chief Executive

Sandi Carman

Sandi has over 20 years' experience working in NHS acute, community, and commissioning organisations and is passionate about ensuring the delivery of high quality care. Sandi's career started in Occupational Therapy at the Northern General Hospital and she has since gained a wealth of experience in operational and managerial roles. Sandi is a Non-Executive Director for South Yorkshire Housing Association and a Joint Independent Audit Committee Member for the South Yorkshire Police and Crime Commissioner. Sandi holds a master's degree in health care practice and has achieved the NHS Leadership Academy Award in Executive Healthcare Leadership.

Andrew Cash.

Sir Andrew Cash OBE
Chief Executive
22 May 2018

Annual Statement on Remuneration

The remuneration of Executive Directors and Senior Managers (spot salaried) is determined by the Nominations and Remunerations Committee of the Board of Directors. In detailing the information below the expanded definition for Senior Managers as contained within the Annual Reporting Manual has been applied i.e. those who influence the decisions of the Trust as a whole rather than the decisions of individual directorates or sections within the Trust. Such persons will include advisory and Non-Executive Board members. In November 2014, the Chief Executive confirmed that Senior Managers would include the Assistant Chief Executive and the Communications and Marketing Director as well as the Executive and Non-Executive Directors, and this continues to be the case.

During 2014/15 the Committee received a report which had been commissioned from Hay during 2013/14. This report provided the Committee with an analysis of comparable roles across other Trusts. In determining the salaries of Senior Managers for 2017/18 the Committee took account of the national decision to award a consolidated pay award to both medical and non-medical staff who are on national terms and conditions, such as Agenda for Change. The Committee decided to mirror this approach in its decision to award a 1% consolidated increase in pay to Executive Directors and Senior Managers (spot salaried). The Committee also took the opportunity to consider and confirm that it was appropriate that all Executive Directors of the Trust received salaries in excess of £150,000, this being the benchmark set by Government for public sector salaries determined by Government requiring the approval of the Chief Secretary to the Treasury.

Tony Pedder OBE
Chairman of Nominations and Remuneration Committee
May 2018

Senior Manager Remuneration Policy

The remuneration of Executive Directors and Senior Managers (spot salaried) is determined by the Nominations and Remunerations Committee of the Board of Directors. The role of the Committee is:

- To decide upon and review the terms and conditions of office of the Trust's Executive Directors in accordance with all relevant Trust policies, including:
  - Salary, including any performance-related pay or bonus;
  - Provision for other benefits, including pensions and cars;
  - Allowances.
- To monitor and evaluate the performance of individual Executive Directors.
- To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective .
- To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.
- To determine arrangements for annual salary review for all staff on Trust contracts.

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. Whilst the Trust does not operate a system of performance related pay, the performance of Senior Managers is reviewed annually in line with the Trust's appraisal policy.

During 2017/18 the Committee took account of the national decision to award a consolidated pay award to both medical and non-medical staff. This approach was mirrored in its decision to award a consolidated award to Senior Managers (spot salaried) and those Executive Directors not receiving a pay uplift as set out earlier.

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is determined by the Nomination and Remuneration Committee of the Council of Governors. The components of the remuneration policy for Non-Executive Directors (NEDs) are as follows:

Component	Narrative
Pay	In order to attract and retain able NEDs, regular comparisons with remuneration levels across the FT sector generally and the Shelford Group, in particular, are made.
Pension-related benefits	NEDs are not employees and therefore not eligible for pension benefits.
Performance-related pay	NEDs do not receive performance related pay.

Remuneration of Executive Directors and Senior Managers

The remuneration of Executive Directors and Senior Managers (spot salaried) is determined by the Nomination and Remuneration Committee of the Board of Directors. This is a formally appointed committee of the Board. 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 of the Board, who also acts as Chairman of the Committee. The Chief Executive, Director of Finance and Director of Human Resources are all invited to attend the Committee (except where matters relating to their own salaries are under discussion). The Committee is supported by the Assistant Chief Executive, in the capacity as Trust Secretary, to ensure that an appropriate record of proceedings is kept.

All Executive Directors are subject to individual performance reviews. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to 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 and the Chairman operated a similar review process with NEDs.

Duration of Contracts

All Executive Directors have a substantive contract of employment. The Trust is required to give Executive Directors 12 months' notice if they wish to terminate their contract. Other Senior Managers have a substantive contract of employment with a three month notice period. These termination arrangements do not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the individual where necessary.

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).

Membership of the Nomination and Remuneration Committee of the Board of Directors and Attendance Record

Below are details of the members of the Board of Directors' Nomination and Remuneration Committee and their attendance record. The Committee met on four occasions in 2017/18.

Name	Comment	Attendance
Tony Buckham		4/4
Candace Imison		4/4
Annette Laban		3/4
Dawn Moore		4/4
Professor Chris Newman	From 1 November 2017	2/2
John O'Kane		3/4
Tony Pedder (Chairman)		4/4
Professor Dame Pam Shaw	To 31 October 2017	1/2
Martin Temple		3/4

Expenses for Executive and Non-Executive Directors and Governors

Expenses for Executive and Non-Executive Directors and Governors are reimbursed on a receipts 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 2017/18 are detailed in the table below:

	2017/18	2016/17
Executive and Non-Executive Directors		
Number who claimed expenses during the year	9	8
Number of Executives / Non Executives who held office during the year	16	15
Amount claimed in total	£11,500.34	£13,521.83
Governors		
Number who claimed expenses during the Year	11	10
Number of Governors who held office during year	37	35
Amount claimed in total	£6,564.93	£3,391.28

Single Total Remuneration for Senior Managers*

	Single Total Remuneration - 2017/18			Single Total Remuneration - 2016/17		
Name and Title	Salary (Bands of £5k)	Increase in Pension Related benefits in Year (Bands of £2.5k)	Single Total Remuneration (Bands of £5k)	Salary (Bands of £5k)	Increase in Pension Related benefits in Year (Bands of £2.5k)	Single Total Remuneration (Bands of £5k)
Mr A Buckham Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Ms S Carman Assistant Chief Executive (from 1 Sept 2016)	100 - 105	57.5 - 60.0	155 - 160	55 - 60	75.0 - 77.5	130 - 135
Sir A J Cash OBE Chief Executive	245 - 250	-	245 - 250	250 - 255	-	250 - 255
Professor Dame H Chapman, CBE Chief Nurse	180 - 185	42.5 - 45.0	225 - 230	175 - 180	42.5 - 45.0	220 - 225
Ms A Gibbs Director of Strategy and Planning (from 1 February 2018)	20 - 25	55.0 - 57.5	80 - 85	-	-	-
Mr M Gwilliam Director of Human Resources and Staff Development	150 - 155	27.5 - 30.0	180 - 185	150 - 155	25.0 - 27.5	175 - 180
Ms C Imison Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Ms A Laban Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Ms K Major Deputy Chief Executive	165 - 170	52.5 - 55.0	220 - 225	165 - 170	52.5 - 55.0	220 - 225
Ms D Moore Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Professor C M H Newman Non-Executive Director (from 1 November 2017)	5 - 10	-	5 - 10	-	-	-
Mr J O'Kane Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Mr A Pedder Chairman	55 - 60	-	55 - 60	55 - 60	-	55 - 60
Mrs J Phelan Director of Communications and Marketing	105 - 110	35.0 - 37.5	140 - 145	105 - 110	32.5 - 35.0	140 - 145
Mr N Priestley Director of Finance	180 - 185	-	180 - 185	175 - 180	40.0 - 42.5	220 - 225
Mr N Riley Assistant Chief Executive (to 31 August 2016)	-	-	-	50 - 55	10.0 - 12.5	60 - 65
Professor Dame P Shaw Non Executive Director (from 1 May 2016 to 31 October 2017)	5 - 10	-	5 - 10	10 - 15	-	10 - 15
Mr M J Temple Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Dr D Throssell Medical Director	160 - 165	37.5 - 40.0	200 - 205	160 - 165	50.0 - 52.5	210 - 215
Professor A P Weetman Non-Executive Director (to 30 April 2016)	-		-	0 - 5	-	0 - 5

No remuneration is paid to any Director by way of any taxable expense payments nor by any form of performance related pay or bonuses.

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:

Increase = ((20 x PE) + LSE) - ((20 x PB) + 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).

Total Pension Benefits*

	Real increase in pension at pension age (£'000)	Real increase in pension lump sum at pension age (£'000)	Total Accrued pension at pension age @ 31.3.2018 (£'000)	Lump sum at pension age related to accrued pension at 31 March 2018(£'000)	CETV @ 31.3.17 (£'000)	Real Change in CETV (£'000)	CETV @ 31.3.18 (£'000)	Employer Contribution to Stakeholder Benefits (£,000)
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	(£'000)	(£'000)	(£'000)	(£'000)
Ms S Carman Assistant Chief Executive (from 1 Sept 2016)	2.5-5	2.5-5	30-35	80-85	452	70	526	-
Sir A J Cash OBE Chief Executive								
Professor Dame H Chapman, CBE Chief Nurse	0-2.5	5-7.5	85-90	260-265	1,599	139	1,754	-
Ms A Gibbs Director of Strategy and Planning (from 1 February 2018)	0-2.5	0-2.5	35-40	85-90	461	6	504	-
Mr M Gwilliam Director of Human Resources	0-2.5	5-7.5	25-30	80-85	490	53	548	-
Ms K Major Deputy Chief Executive	2.5-5	0-2.5	45-50	115-120	688	53	748	-
Mrs J Phelan Director of Communications and Marketing	0-2.5	0-2.5	30-35	85-90	530	56	591	-
Mr N Priestley Director of Finance					1,547		N/a	
Dr D Throssell Medical Director	0-2.5	5-7.5	60-65	190-195	1,265	113	1,391	-

*This information has been subject to Audit

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 Statement of Financial Position 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.

For members of the 1995 pension scheme, the total accrued pension and related lump sum figure at 31/3/18 comprises an annual pension amount and a lump sum equivalent to three times that annual pension. No lump sum accrues to members of the 2015 pension scheme.

Fair Pay Multiple Statements

	2017/18	2016/17	2015/16
Highest paid Director Total Remuneration (midpoint banded remuneration in multiples of £5k)	£247.5k	£252.5K	£242.5K
Median Total Remuneration	£24,733	£24,175	£25,053
Ratio	10.01	10.44	9.68

*This information has been subject to Audit

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 2017/18 and 2016/17. The multiple, although higher this year, remains comparable with Trusts of a similar size and complexity and evidences consistency in determining the CEO's remuneration in 2017/18 compared to how remuneration is determined for all members of staff.

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 2017/18 was £248k compared to £250k in 2016/17. This was 10.01 times the median remuneration of the workforce, which was £24,733. The figures are shown in tabular format above.

Sir Andrew Cash OBE

Chief Executive

22 May 2018


NHS

Employ caring and cared for staff

The dedication, ongoing commitment and skill of our employees are what makes our hospitals and community services successful and we continue to appreciate the hard work that they do. We place a high priority on the health and wellbeing of our staff.

Our PROUD values and behaviours will continue to underpin the way we lead and deliver our services 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 us to work compassionately and efficiently to deliver our services.

Our 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

These values are increasingly being incorporated into the recruitment process for all staff and are used for all newly qualified staff nurses, clinical support workers and apprentices. The Trust uses a Performance, Values and Behaviour based appraisal process to further embed the PROUD values and to provide staff with quality well-structured appraisals.

We have continued using the PROUD values to recruit in the assessment centre process and having seen the benefits of this are now rolling it out to all staff. To enable us to do this we have purchased a system that enables us to screen all candidates on application to ensure we have staff with the right caring compassionate values working across the organisation.

We recognise the importance of positive staff engagement to ensure good quality patient care so we were pleased to be shortlisted for the HSJ Staff Engagement Award in November 2017 in recognition of our work in this area.

During 2017 we began to consult with staff and patients about our People Strategy and the Board of Directors approved this at the start of 2018.

In recognition that organisational development is a significant area of work for the Trust and that it is key to the transformation agenda, a new Organisational Development Director post has been established. The Organisational Development function brings together equality, diversity and inclusion activities, the Microsystems Coaching Academy and Service Improvement teams with the Listening into Action (LiA), Leadership and Development teams and workforce redesign. The aim of this new function is to provide a planned, systematic approach to improving organisational effectiveness – one that aligns strategy, people and processes.

Staff engagement and wellbeing

During 2017 the implementation of the Trust Staff Engagement Strategy and the Trust Health and Wellbeing Strategy have provided a particular focus on improving staff involvement, motivation and wellbeing for all staff. We continue to look at new ways of supporting our staff and this year, with the help of the chaplaincy department, we have introduced more mindfulness sessions for staff and managers together with health and wellbeing training for line managers which were well received. We have provided more personal resilience sessions for teams of staff and over 2,500 staff have accessed the Headspace Mindfulness and Meditation app. The introduction of health checks for staff over 40 years of age as well as our continued referrals to staff physiotherapy and our new Employee Psychological Services demonstrates our commitment to caring for our staff.

This year a staff benefits and wellbeing site on the Trust intranet has been further developed to provide staff with easy access to information on staff engagement, rewards and benefits and health and wellbeing initiatives.

The Trust has an in-house Occupational Health Service which, in addition to providing a comprehensive service

for STH, provides services across all NHS employers in Sheffield and to a number of other private and public sector organisations in the city, and provides consultant occupational physician input to other NHS services in South Yorkshire. The service is accredited under the Safe, Effective, Quality Occupational Health Services scheme which is run by the Royal College of Physicians.

Our Directorate staff engagement plans had a particular focus on actions to improve staff motivation through increased recognition and appreciation of staff at departmental level eg local recognition schemes, usage of 'Give a little thanks' our electronic recognition system as well as via our Thank You Awards and improving staff involvement through our Microsystems academy systems coaching, Give it a Go weeks and the ongoing Listening into Action programme.

Staff involvement

The Trust participated in the staff Friends and Family Test in quarter 1, 2 and 4, as well as undertaking a full census staff survey in quarter 3. Engagement events have been held across the Trust during 2017/18, particularly in clinical areas to discuss the findings of the staff Friends and Family Test results. These events have resulted in staff making suggestions, leading to improvements for both staff and patients. It is pleasing to note that the Trust is now recognised as a centre of good practice in its approach, and use of the staff Friends and Family Test data. The Trust was asked to write a case study to share practice across the NHS which was published by NHS Employers 'Staff Engagement for Quality Improvement.

The Trust Executive and Non Executive Directors continue to spend time in clinical and non-clinical departments regularly as part of our "Back to the Floor" programme. This gives the opportunity to meet with staff and listen to their feedback. The Chairman also meets regularly with the Staff Governors to seek feedback and the Board of Directors meet staff and recognise their efforts.

NHS staff survey

This year a full census staff survey was undertaken with over 7,250 responses received with the vast majority of staff completing the survey online.

The Trust staff engagement score for 2017 increased to 3.83 which means the Trust is above average in comparison to other combined acute and community trusts.

It is encouraging to note that 81% of our staff would recommend the Trust to family and friends for treatment, this is well above the NHS average for combined acute and community trusts of 69%. Additionally 68% of our staff would recommend the Trust as a place to work, this again is above the NHS average for combined acute and community trusts of 59%.

Response rate

2016		2017	
Trust	National Average	Trust	National Average
44%	40%	44%	43%

Top five ranking scores

Key Finding	2016		2017		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF26 % staff experiencing harassment, bullying or abuse from staff in the last 12 months	20	23	20	24	same as 2016
KF6 % of staff reporting good communication between senior management and staff	39	32	39	33	same as 2016
KF20 % of staff experiencing discrimination at work in the last 12 months	9	10	8	10	improvement
KF1 staff recommendation of the organisation as a place to work or receive treatment	3.91	3.71	3.92	3.75	improvement
KF16 % staff working extra unpaid hours	68	71	66	71	improvement

N.B Please note in 2017 Sheffield Teaching Hospital NHS Foundation Trust was benchmarked in the Combined Acute & Community Group as in previous years.

Bottom five ranking scores

Key Finding	2016		2017		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF27 % staff/colleagues reporting the most recent experience of harassment bullying or abuse	45	45	43	47	deterioration
KF24 % staff/colleagues reporting the most recent experience of violence	63	67	62	67	improvement
KF7 % staff able to contribute towards improvements at work	67	71	68	70	improvement
KF4 staff motivation at work	3.86	3.94	3.87	3.91	improvement
KF15 % staff satisfied with the opportunities for flexible working	51	51	51	51	same as 2016

Biggest Improvements since 2016

Key Finding	Trust 2016	National Combined Acute & Community Average	Trust 2017	National Combined Acute & Community Average
KF16 % staff working extra hours	68	71	66	71
KF9 Effective team working	3.71	3.78	3.74	3.74
KF14 staff satisfaction with resourcing and support	3.35	3.28	3.39	3.27
KF19 Organisation and management interest in action on health and wellbeing	3.65	3.61	3.68	3.63
KF32 Effective use of patient/service user feedback	3.51	3.65	3.70	3.68

NB There were no statistically significant deteriorations in any of the 32 key findings year.

The Trust has a Staff Engagement Lead and a Staff Engagement Coordinator who work with Directorates to promote the sharing of good practice in both staff engagement and wellbeing across the Trust. As well as discussions about staff Friends and Family Test (FFT) results we hold a variety of events to encourage staff involvement and promote the sharing of good practice such as departmental timeouts, the Sharing of Good Practice Festival, Leadership forums, Give it a Go, LIA Pass it on events and the Microsystems Academy Expo to name a few.

We are looking at different ways to motivate and reward our staff during 2018 with the introduction of more local recognition schemes and increased staff benefits as well as introducing new communication methods to ensure more staff are aware of them. We are also looking at what more we can do to support staff and will be ntroducing Schwartz rounds, a learning and sharing technique.

An overall Trust staff engagement action plan has been drawn up to address the areas for improvement that is further supported by individual Directorate staff engagement action plans. These also address the Staff Friends and Family Test findings.

Undertaking a full census staff survey enables a staff engagement score to be calculated for every Directorate so these together with the action plans and Directorate staff Friends and Family Test scores are monitored via the Trust Executive Group / directorate performance review process and the Staff Engagement Executive.

Friends and Family Test - Staff who would recommend the Trust (from Staff Survey)	2015/16	2016/17	2017/18
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.			
National average: Combined acute & community trusts	81%	69%	68%
Highest performing Trust score: (Combined acute & community trusts)			91%
Lowest performing trust score: (Combined acute & community trusts)			48%

The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor.

Work Race Equality Standard (WRES) Key Finding		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	21%	26%	20%
	BME	21%	27%	21%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19%	23%	19%
	BME	24%	29%	23%
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	73%	90%
	BME	75%	74%	71%
Q17b In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	5%
	BME	13%	15%	15%

The Trust has established a diversity post which will focus on workforce matters. The Trust continues to have a LiA scheme focusing on diversity and inclusion focusing on both staff with a disability and Black and Minority Ethnic (BME). It is pleasing to note the improvement in the percentage of BME staff believing the Trust provide equal opportunities in career progression following the work of the WRES QI group who have ensured more BME representation on nursing recruitment panels. The 2017 staff survey results show that at 3.96, staff engagement is higher amongst BME staff compared to the Trust average.

We are launching a Reverse Mentoring Scheme to help us learn about new ways of being more inclusive and adaptable in our organisation. We have a member of our Workforce Information Team working with Yvonne Coghill, Director of the Workforce race equality programme at NHS England, so we can make more progressive step changes during 2018.

Workforce Race Equality Standard

During 2017/18 the Trust has dedicated time to reviewing its position against the nationally agreed WRES and associated action plan.

Improvements have been made in the majority or metrics, but we recognise there is still more work to do.

In particular we have focused on recruitment systems for clinical support workers and clerical officers and established a Black and Minority Ethnic (BME) network.

In relation to gender we have continued to pilot the Athena Swann programme to actively support women who aspire to leadership positions and will be establishing an Equality, Diversity and inclusion team.

In relation to disabilities the Trust has achieved Disability Confident Employer, which demonstrates our commitment to supporting disabled candidates and employees.

The Trust is also committed to supporting the whole armed forces community. The Trust has developed a strong working relationship with its local reserve forces unit. The Trust is also participating in the "Step into Health" national programme supporting ex armed forces staff into NHS careers.

During 2017/18 staff costs were commensurate and proportionate with additional patient activity undertaken and the 1% rise in pay, however agency costs have decreased from the previous year as there has been significant focus on this area. There were no Exit packages in 2017/18 compared with 1 exit package in 2016/17 in the pay band £10-25k. This related to compulsory redundancy at a cost of £14k.

Staff Sickness Absence	2017/18	2016/17	2015/16	2014/15	2013/14
Days lost (long term)	131,686	144,902	132,674	134,152	129,062
Days lost (short term)	78,272	88,347	87,003	66,097	89,279
Total days lost	209,958	233,249	219,678	200,249	218,341
Average working days lost	11.25	12.87	12.4	15.4	16.9
Total staff employed in period (headcount)	18, 660	18,121	17,698	17,026	16,664
Total staff employed in period with no absence (headcount)	6,871	6,385	6,199	6,461	5,591
Percentage staff with no sick leave	36.82%	35.2%	35%	37.9%	33.6%

Employee Expenses*

	2017/18 Total	Permanent	Other	2016/17 Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	515,055	501,707	13,348	496,785	483,802	12,983
Social Security Costs	45,199	45,199	0	43,309	43,309	0
Apprentice Levy	2,429	2,429	0	0	0	
Employer contributions to NHSPA	59,438	59,438	0	56,515	56,515	0
Other pension costs	103	103	0	63	63	0
Agency / contract staff	11,016	0	11,016	17,136	0	17,136
Total	**633,240**	**608,876**	**24,364**	**613,808**	**583,689**	**30,119**

The Apprenticeship Levy became chargeable from 1 April 2017.

The above figure of £633,240k is net of the amount of £548k (2016/17 £1,792k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1).

In 17/18 the capitalised salary recharge value includes retrospective VAT recovery on contractor charges. The VAT recovery position was concluded with HMRC in April 2017.

Average number of persons employed (Contracted Whole Time Equivalent basis)*

	2017/18 Total Number	Permanent Number	Other Number	2016/17 Total Number	Permanent Number	Other Number
Medical and dental	1,704	1,657	47	1,671	1,613	58
Administration and estates	2,970	2,945	25	2,910	2,783	127
Healthcare assistants and other support staff	1,844	1,626	218	1,690	1,588	102
Nursing, midwifery and health visiting staff	5,747	5,635	112	5,790	5,532	258
Scientific, therapeutic and technical staff	2,511	2,491	20	2,474	2,452	23
Healthcare Science Staff	158	158	0	148	148	0
Total	**14,934**	**14,512**	**422**	**14,683**	**14,116**	**567**

*This information has been subject to audit.

Employee benefits

There were no employee benefits in 2017/18.

Off Payroll engagements

The Trust has identified three off-payroll engagements remunerated at more than £245 per day which have existed for between one and two years as at 31 March 2018. In addition, a further three engagements have been identified which have arisen during 2017/18. Of these new engagements, all were assessed as within the scope of IR35, with one being engaged directly by the Trust. In all cases, assurances / relevant actions have been taken to ensure the appropriate declaration of income tax and national insurance are made to HMRC.

A total of 18 individuals have been deemed 'board members and/or senior officials with significant financial responsibility' during 2017/18, all of which were on-payroll engagements.

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018	3
of which	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one year and two years at time of reporting	3
No. that have existed for between two year and three years at time of reporting	0
No. that have existed for between three year and four years at time of reporting	0
No. that have existed for between for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months.

Number of new engagements, or those that reach six months in duration, between 1 April 2017 and 31 March 2018	3
of which	
Number assessed as within the scope of IR35	3
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contacted to trust) and are on the trust's payroll	1
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For all off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	18

Leading for Success

Providing opportunities for our staff to develop and flourish is a key priority for the Trust and throughout 2017/18 we continued to build on internal and external training programmes already in place as well as innovating new leadership programmes.

The Institute of Leadership and Management programme continued to be provided during 2017, numbers for each cohort have increased from 25 to 30 per cohort to meet the increasing demand. In total we have had 60 participants through two cohorts of this programme.

A new format for the Effective Management Series has been developed to offer a management development pathway for aspiring and new managers into the organisation. This offers a selection of sessions that begin with Introductory, Intermediate and on to Advanced that can be selected as pure development, as part of an induction, or as ongoing development for existing managers. This is organised as a step-in step-off programme to encourage all managers across the organisation to attend sessions that are relevant or of interest to them.

We are working across the region to develop a Coaching Database which will act as a central resource for coaches to connect and build upon coaching relationships. The "Manager as Coach" programme and this is embedded within current Leadership and Management Development programmes as well as being developed as a standalone offer to foster a coaching conversation approach for managers.

Insights Discovery

We continue to make use of the Insights Discovery Tool during programmes such as ILM, Leading for Success and increasingly with teams across the Trust, in order to enhance engagement and team effectiveness.

Making it Better

Every day, colleagues from across the Trust are making little changes or sparking ideas which make a real difference to patients, each other and indeed in many cases become exemplars which the rest of the NHS adopt. This 'bottom up' approach to change has been the focus of our "Making it Better" programme, which brings together and builds on fantastic improvements made by teams during the "Give it a Go" week, microsystems improvement, Listening into Action or other projects and programmes. For example since the launch of LiA there have been 85 schemes covering 26 clinical directorates across all care groups with a total of 8790 staff being involved. Each scheme has had the commitment and involvement of the Operations Directors, Nurse Directors and Clinical Directors.

Making it Better has eight Trust wide programmes and hundreds of smaller improvement projects:

1. Seamless surgery
2. Excellent emergency care
3. Outstanding Outpatients
4. Transforming Through Technology
5. Organisational Development
6. Workforce Transformation
7. Commercial, corporate and support services
8. External partnerships

Staff Health & Safety

The Trust is committed to protecting the health, safety and welfare of staff, patients, visitors and others. We have in place robust health and safety management systems to ensure that risks to health and safety are identified, evaluated and controlled to minimise harm and loss.

During 2018 a Trust-wide audit of the health and safety management system has begun. The audit will identify examples of good practice to share, as well as highlighting any gaps or areas for improvement. The benefits of this exercise include:

- providing an organisation-wide view of current Trust occupational health and safety management systems and processes and how effective and helpful these are in practice;
- providing a baseline assessment and identifying priority areas or issues where improvement is needed;
- informing the development of a Trust Occupational Health and Safety Strategy which will be supported by an annual work plan.

A report of occupational health and safety performance is produced annually and presented to the Healthcare Governance Committee.

A new Occupational Safety and Risk Committee has been established and membership includes Staff Side representatives along with key Trust staff. The Committee will oversee the audit.

Incident management

Staff are encouraged to report all incidents including those which have the potential to cause harm. The benefits of this approach are to raise awareness of issues and ensure a thorough investigation to prevent incidents re-occurring or escalating to become more severe incidents and injuries. Incidents are monitored and actioned at a local level via formal governance structures within each clinical and corporate directorate. At organisational level, incidents are reported to the Occupational Safety and Risk Committee and the Healthcare Governance Committee. The graph below shows the number of incidents reported over the last three years by staff group:

Total number of incidents by Work Group	2015/2016	2016/2017	2017/2018
Accident/ incident involving contractor	52	51	44
Accident/ incident affecting member of public	185	211	284
Accident/ incident involving student	105	87	48
Accident/ incident involving member of staff	1699	1824	1978

Sir Andrew Cash OBE

Chief Executive

22 May 2018

Sharps Safety

The Health and Safety Executive (HSE) visited to assess the Trust's compliance with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 as part of HSE's Management and prevention of sharps injuries; Inspection of NHS Organisations. The Northern General Hospital was included in the inspection programme and the visit took place on the 17th November 2015. The inspectors gave verbal feedback at the end of the visit which was followed up in writing with recommendations for further action by the 1st February 2016. The implementation programme has now been completed the HSE have been informed and no further action is expected.

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.

Consultation Processes

The Trust has a Trust-wide Partnership Forum where management and union representatives meet to discuss Trust-wide workforce issues. During 2017/18 the membership of the operational Partnership Forum was reviewed to ensure that the Trust could respond to matters raised by union colleagues in a timely manner. The Trust operates an engagement approach to organisational change to ensure that staff are involved at an early stage in matters that will affect them. Formal consultation would take place to ensure the Trust meets its legal obligations.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework has applied from Quarter 3 of 2016-17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Regulatory Ratings

	NHS Improvement - Segmentation
2017/18	
Q3	2
Q4	2

This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS Trusts and NHS Foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

The Finance and Use of Resources theme is based on the scoring of five areas consisting of 34 measures from '1' to '4' where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that Finance and Use of Resources is only one of five themes feeding into Single Oversight Framework, the segmentation of the Trust disclosed above, might not be the same as the overall Finance score here.

REGULATORY RATINGS

		2016/17 SCORE		2017/18 SCORE			
Area	**Metric**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Financial sustainability	Capital service capacity	1	1	2	2	1	1
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E Margin	2	1	4	3	2	2
Financial controls	Distance from Financial plan	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1
Overall Score		1	1	3	2	1	1

Sir Andrew Cash OBE

Chief Executive

22 May 2018

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Sheffield Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting 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 the NHS Foundation Trust Accounting Officer Memorandum.

Sir Andrew Cash OBE
Chief Executive

22 May 2018

Annual Governance Statement 2017-18

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 on-going 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 2018 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 the Trust developing and maintaining the robust systems of internal control required to manage risks associated with the achievement of organisational objectives and compliance with its licence, constitution, 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 and Performance Committee
- Human Resources and Organisational Development Committee.

The committees of the Board are chaired by Non-Executive Directors 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 Senior Managers who attend the Board 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, Operations Directors, Nurse Directors 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 department of Patient and Healthcare Governance provides additional support guidance and expert advice to staff on risk management. Incidents, inquests, complaints, 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 Incident (SI) 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 SI Group review and classify serious incidents to determine which must be reported to the appropriate Clinical Commissioning Group as a SI and which may not meet the commissioners' SI criteria but are deemed serious enough to be similarly investigated and managed. The SI 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 SI 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 (SRMB) (now superseded by the Occupational Safety and Risk Committee and the Patient Safety and Risk Committee – see below for details) receive a monthly verbal update on SIs and a six monthly written report. A Trust policy which formalises the systems and processes for managing SIs ensures a standard approach is followed.

From February 2018 two new committees, the Occupational Safety and Risk Committee and the Patient Safety and Risk Committee, have replaced the SRMB. These two new committees will continue the work of the SRMB, but will have an increased focus on sharing learning including learning from serious incidents within the Trust and from best practice nationally. In addition, the Occupational Safety and Risk Committee will provide oversight of a Trust-wide audit of occupational safety which is to be undertaken during 2018. The outcomes from the audit will form the basis of a three-year Trust Occupational Safety Strategy.

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. Participation in national audits is reported in the Trust's Quality Report.

Underpinned by a comprehensive policy, the Trust has an 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 quarterly progress report of outstanding action plans to the Healthcare Governance Committee.

National survey results are routinely reported, as required, to TEG, the Healthcare Governance Committee, Finance and Performance Committee, Human Resources and Organisational Development Committee or 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 TEG, the relevant Board Committees and the Board of Directors.

The risk and control framework

The Healthcare Governance Committee, which is a Board Committee, provides oversight of quality issues. The Committee has a structured annual workplan which is based around the core quality themes of effectiveness, experience and safety. The Committee receives relevant reports in relation to quality performance and Care Quality Commission (CQC) compliance including reports from key committees such as the Occupational Safety and Risk Committee, Patient Safety Committee and Risk, and Clinical Effectiveness Committee.

The Trust's updated Quality Strategy was agreed during 2017. The strategy sets out a new structure and process for selecting and overseeing the implementation of annual quality improvement priorities. This new process includes the large-scale involvement of both patients and Trust staff in the selection of quality priorities. Implementation of the strategy will be overseen by a new Quality Board whose membership includes senior Trust staff along with Trust governors, Healthwatch Sheffield and voluntary and community sector representation. The Quality Board, which reports to the Healthcare Governance Committee, will also oversee production of the annual Quality Report.

With support from The Health Foundation the Trust continues to work with partners across Sheffield and beyond in the delivery of its Microsystem Coaching Academy (MCA). The MCA trained coaches use evidence based, structured improvement process to support frontline teams to understand their systems and then identify and make improvements using a series of Plan-Do-Study-Act cycles. The Trust is also being supported by the Health Foundation to set up a Flow Coaching Academy (FCA) which enables improvements to be made at the care pathway level.

This frontline and pathway improvement approach is brought together with strategic improvement through

the Trust's Making it Better (MiB) transformation and improvement programme which was launched in the first quarter of 2016/17. The MiB programme aims to support the Trust to deliver its overall strategy and, in particular, lift our efforts on improvement and transformation to help secure improved quality and sustainable finances in a challenging context. The programme is made up of eight programmes, each with executive leadership and a programme team reporting to TEG. The programmes are Organisational Development (OD); Transformation Through Technology; External Partnerships; Outstanding Outpatients; Excellent Emergency Care; Seamless Surgery; Workforce Transformation; and Commercial, Corporate and Support Services.

In recognition that Organisational Development is a significant area of work for STH and that it is key to the transformation agenda, a new Organisational Development Director post has been established. The Organisational Development function brings together equality, diversity and inclusion activities, the MCA and Service Improvement teams with the Listening into Action (LiA), Leadership and Development teams and workforce redesign. The aim of this new function is to provide a planned, systematic approach to improving organisational effectiveness – one that aligns strategy, people and processes.

The Trust employs a wide range of methods to capture feedback from patients, their families and carers including comment cards, national and local surveys, website feedback, complaints and the Friends and Family Test. Results and actions following feedback are reported in the quarterly Complaints and Feedback reports to the Trust Executive Group, the Healthcare Governance Committee and the Board of Directors.

During 2018 the Trust will be establishing a new engagement database which will enable the Trust to consult widely with patients and the public and, as part of this work; we will be focussing specifically on those groups of our community who may be harder to reach or seldom heard. In addition, we will be piloting 'co-production' as a way of working in partnership with patients, their families and carers to redesign and improve services.

A Trust-wide review of action planning to improve services has commenced. Outputs from the review will include a generic action plan template and an agreed action planning process based on nationally recognised best practice. The new template and process will mean that assessing the robustness of action plans and auditing the implementation of actions are an integral part of the action planning process.

The complaints process has been further strengthened during 2017/18. Work has included:

- Increasing the number of meetings held with complainants as a way of aiming to resolve complaints. As the number of complaints meetings has increased, the proportion of re-opened complaints has decreased from 11.5% during the quarter July-September 2016 to 6.1% during the quarter July-September 2017.
- Complaints training for all staff have continued and have been extremely positively evaluated. The training focuses on welcoming and acting on feedback, responding to issues 'on-the-spot', undertaking resolution-focused investigations and producing high quality, evidence based responses. Up to January 2018, over 700 staff have attended the training with 98% stating that they would be 'extremely likely' or 'likely' to recommend the training.

The Trust was inspected by the CQC in December 2015. In response, the Trust has had a programme of work in place to address each of the regulated action 'Must do' requirements. This also includes a number of 'Should do' requirements, which are integrated into the Trust's monitoring and assurance process. Work has continued on these priority areas during 2017-18 including work on urgent care pathways, end of life care, medicines management, nurse staffing and foetal heart monitoring recording.

The Trust has a Risk Management Policy which is approved by the Board of Directors. It was reviewed during 2016/17 and it 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 and clarifies accountability arrangements along with individual and collective responsibilities for risk management at all levels across the organisation. It also provides guidance for staff to help identify, assess, score, 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 risk 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. At a corporate level, the Board of Directors receives risk reports and other risk information

to consider its risk appetite. The Board of Directors acknowledge risk appetite and risk tolerance needs to be high on the agenda and should be core to the Trust's consideration of the risk management approach. To this end the Audit Committee, on behalf of the Board, are reviewing the development and implementation of a risk appetite statement as part of the committee's objectives for 2018/19 and will present its findings to the Board of Directors for consideration and approval.

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 Trust has, however, identified that staff in key roles require additional training on risk management. The Head of Patient and Healthcare Governance will be developing a programme to address this in 2018.

Risk management is firmly embedded into the activity of the organisation and operational responsibility is delegated to individual directorate 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.

New risks logged on the Trust's Risk Register and existing risks that are scheduled for review by the risk owner in the previous month, are considered and validated by the Risk Validation Group (RVG). RVG is a sub-committee of the Patient Safety and Risk Committee which in turn reports to the Healthcare Governance Committee. The RVG receives and reviews new risks and provides a monthly report to the Trust Executive Group summarising the risks it has considered and highlighting those risks that it assesses as warranting detailed consideration and potential action by TEG.

During 2017, an internal audit of the Trust's operational risk management processes and structures was undertaken and provided 'Significant Assurances' of risk management activities and controls. However, within that report four medium risks were identified. These related to the governance infrastructure below the Healthcare Governance Committee, job specific training around risk management, review dates on the risk register and management information reports. A plan is in place to address these issues in 2018.

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 the Blood Transfusion Committee, Infection Prevention and Control Committee, Information Governance Committee, Medical Device Management Group, Medicines Safety Committee and Radiation Safety Steering Group.

During 2017, the format for the Trust's serious incident investigation reports was reviewed and a new format, which puts the patient and their family or carers at the centre of the incident process, has been developed and is being piloted. In addition, during 2018, work is being undertaken to ensure that human factors considerations and approaches are built into the incident management process from beginning to end.

In line with the revised way of Board working introduced in February 2015, the Audit Committee has assumed a more focused role in providing assurance about risk management to the Board. The Assurance Framework and the Top Risk report were combined into the Integrated Risk and Assurance Report (IRAR) in January 2016. The IRAR identifies the Trust's principal objectives and the high level risks that threaten their achievement along with key controls and sources of assurance. 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 IRAR by the Executive Lead. The IRAR is considered four times a year by the Audit Committee on behalf of the Board of Directors, and relevant issues are escalated to the Board. Each of the risks is owned by an Executive Director and has oversight by a Board Committee. 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 principal and strategic risks reported on the IRAR at quarter 4 are as follows:

Failure to maintain and improve the quality of care including:

- Risks related to nursing and midwifery staffing;
- Health care associated infections;
- Medicines management;
- Care of patients with mental health needs in an acute setting;
- Under delivery of planned maintenance and refurbishment of the wards;
- IT stabilisation; and
- Asbestos management.

Failure to deliver and maintain operational performance including:

- Care of patients in an inappropriate setting; and
- Gaps and duplication in service delivery (South Yorkshire healthcare).

Failure to sustain an engaged and effective workforce including:

- Recruitment difficulties;
- Compliance with New Deal for medical staff; and
- Increased rates of sickness absence.

Failure to secure financial balance and organisational sustainability including:

- Failure to maintain financial balance in present and future years.

In April 2015 an Integrated Performance Report (IPR) was developed and implemented. The IPR is reported on a monthly basis to the Trust Executive Group, the Finance and Performance Committee and the Board of Directors. It is organised around the Trust's five strategic aims and includes an executive summary of aspects of performance identified by the relevant Executive Directors as requiring the attention of the Board; a RAG-rated dashboard of performance against national and local indicators including monthly, year-to-date and trend analysis (and data quality ratings); in-depth exception reports on aspects of performance where a target is not met, including a summary of key issues and actions to improve performance; a RAG-rated directorate performance dashboard; and a deep-dive analysis of performance on an agreed specific topic of interest to the Board.

The IPR has subsumed a number of separate performance reports that were previously reported to the Board. The Board is assured of the quality of data included in the IPR via a number of sources including routine scrutiny of component data sources by Committees of the Board, through internal data quality assurance systems and by the work of internal and external audit.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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 provides clear guidance on the requirement to understand the impact of changes to existing or the establishment of new process on groups with protected characteristics through the Equality Impact analysis policy.

The guidance outlines the requirement for an objective and measured assessment to be completed and recorded prior to process and policies being progressed. For example all Human Resource related polices must declare this assessment prior to consultation and approval.

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

The Trust is fully aware of its responsibilities relating to Carbon Reduction and the Climate Change Act. The Trust has a corporate risk assessment relating to the current position and has well developed plans relating to emergency preparedness and also to meeting the civil contingency requirements. The contents of the UKCP09 weather projections has been reviewed, a risk assessment has been carried out in relation to the flood risk and the Trust has a heat wave plan as part of emergency preparedness.

The Trust continues to make good progress in reducing carbon emissions relating to energy and water consumption, travel, transport, waste management and catering. The Trust is confident it will achieve the 2020 carbon reduction target as this relates to direct energy usage.

Whilst the Trust does not have a Board approved Sustainable Development Management Plan (SDMP), the risks around not having a plan have been acknowledged and controls have been established to mitigate these risks, including an annual report to the Trust's Healthcare Governance Committee which outlines the current status relating to sustainable development at the Trust.

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 cost pressures and 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. These areas remain particularly challenging given the current NHS financial environment. Financial plans are considered during their development and then approved by the Board, supported by its Finance and Performance Committee. The production of an annual Operational Plan, reflecting all aspects of the Trust's operations, is led by the Business Planning Team and is submitted to NHS Improvement. The financial element of the plan generates a Use of Resources risk rating. The plan generally 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 Trust formulates its Corporate Strategy on the basis of its understanding of the NHS environment and key influences.

The in-year use of resources is monitored by the Board and its committee's 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.

Monthly/Quarterly monitoring returns are submitted to NHS Improvement from which a Use of Resources financial risk rating is again derived. The Trust's performance management processes are crucial in the 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; through looking to work with other organisations (locally and nationally); and through developing capability and capacity to deliver the required change. The Trust's Service Improvement function drives this work via the Making It Better Programme 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, including use of the national Model Hospital metrics, is 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.

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 NHS Improvement's risk ratings and the CQC'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.

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.

Information governance

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. 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 has reviewed 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 on-going 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 data sticks are issued to staff. The introduction of port control and an approved list of removable storage media is planned to be introduced as part of the actions to protect the Trust IT systems from malware and cyber-attack.

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.

During 2017/18, there were no serious data security incidents, classified as Levels 1 and 2 in the Information Governance Serious Incidents Requiring Investigation (SIRI) tool.

In 2016/17 a new Data Quality Steering Group was established to ensure a continued focus on this important area. This group has continued to function effectively in 2017/18.

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. NHS Improvement (in exercise of the powers conferred on 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 Board oversees the design, production, publication and review of the report. The Board is accountable to the Healthcare Governance Committee and membership includes managers, clinicians, representatives from Healthwatch Sheffield and Trust governors. The Board has reviewed progress made against the quality priorities that were agreed for 2017/18 and has identified 13 new priorities for 2018/19. 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 Trust's Council of Governors and were 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 review the Quality Report and 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.

The Trust has strong governance in the management and oversight of elective waiting time data. The Elective care working group meets on a monthly basis to review performance, service themes and data validation. A performance report, supported by operational reports, details activities underway to ensure that elective waiting time data is accurate. Assurance is provided to the Waiting Times Performance Overview Group which also meets monthly. This group is chaired a Non-Executive Director and supported by the Deputy Chief Executive.

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 who 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 of Directors, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Integrated Risk and Assurance Report (IRAR) provide me with evidence that, the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed. The Integrated Risk and Assurance Report is seen four times a year by the Audit Committee, other Board Committees are designated as the oversight committee for the risks relevant to their terms of reference. The Trust Executive Group and the Board also receive the IRAR.

The work of the Audit Committee in 2017/18 is described in more detail in the Annual Report. The committee provides the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. It receives reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements.

The Audit Committee Chair has recent and relevant financial experience which supports expert and rigorous challenge on financial reports received by the committee, an understanding of NHS Improvement's Risk Ratings and sound accounting policies and practices.

Internal Audit work to a risk based audit plan, agreed by the Audit Committee, and covering risk management, governance and internal control processes, both financial and non-financial, across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. A report is produced at the conclusion of each audit and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to, and followed up with, the responsible Executive Directors. The results of audit work are reported to the Audit Committee which plays a central role in performance managing the action plans to address the recommendations from audits. Internal audit reports are also made available to the external auditors, who may make use of them when planning their own work. In addition to the planned programme of work, internal audit provide advice and assistance to senior management on control issues and other matters of concern. The 2017/18 Internal Audit Plan covered a total of 26 audits, of these 17 assurance reports have been issued. Of these reports 10 have given significant assurance, two reports were issued with limited assurance (Estates Maintenance and Policy Management Framework), two reports were issued with a split significant / limited assurance (Compliance with Legislation and General Data Protection Regulations) and three reports were issued with no audit opinion. All actions from internal audit reports are logged and progress monitored by the Audit Committee.

Internal Audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews. Based on the work undertaken, including a review of the Board's risk and assurance arrangements the Head of Internal Audit Opinion concluded that significant assurance could be given that there is a generally sound system of internal

control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. The Internal Audit team also provides a counter-fraud service to the Trust.

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 external assurance audit undertaken by our External Auditors, as part of the process of producing the Quality Report, will report to the Board and to the Council of Governors and provides 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 and specifically their Annual Governance Report;
- Quarterly Risk Ratings and Segmentation by NHS Improvement;
- On-going compliance with CQC's Fundamental Standards for all regulated activities across all its locations, as part of the registration process, CQC reports on its visits and inspections;
- 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 Serious Incidents;
- User feedback such as monitoring of patient experience, complaints and claims;
- Other external Visits, Inspections and Accreditations;
- Council of Governors reports; and
- Clinical Audit reports.

Conclusion

No significant internal control issues have been identified.

Sir Andrew Cash OBE
Chief Executive
22 May 2018

NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

QUALITY REPORT
2017-18

1.1 Statement on Quality from the Chief Executive

This Quality Report outlines some of those areas where we have already had good success thanks to the innovation, dedication and skills of our teams. It also sets out our priorities for 2018-19 along with areas where we need to continue to improve.

Ensuring our patients have good clinical outcomes and a positive experience are two of the five main aims of the Trust and to achieve this we strive to do all we can to treat and care for people in a high quality, safe environment which protects them from avoidable harm.

Our drive for continual improvement is embodied within the Trust's Corporate Strategy 'Making a Difference' which is supported by a Quality Strategy and Governance Framework. The Quality Strategy describes a new approach to the compilation, monitoring and performance management of Quality Objectives, and places a new Quality Board at the centre of these processes.

These are our five 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 PROUD values underpin these aims:

- Patient first - Ensure that the people we serve are at the heart of all we do
- Respectful - Be kind, respectful to everyone and value diversity
- Ownership - Celebrate our successes, learn continuously and ensure we improve
- Unity - Work in partnership and value the roles of others
- Deliver - Be efficient, effective and accountable for our actions

We also have robust processes in place across the Trust from Board to ward level to ensure we continually monitor clinical safety indicators and take action where issues are flagged. Our management structure is purposely heavily clinician led and this informs and drives decision making and retains our focus on delivering safe high quality care.

Our mortality rates and infection prevention metrics continue to be good. In the last two years we have also seen a continued reduction in the number of falls and pressure ulcers as a result of Trust wide initiatives such as 'React to Red' and safety huddles.

A number of innovations and developments by our teams, such as point of care patient testing for flu, the Sheffield Safer 10 Principles and the Safer Nursing Care Tool have also been shared wider across the NHS as good practice.

End of life care has been a particular focus across the Trust during 2017-18 and the development of a new strategy, guidance, care plans and training has been the result of genuine co-production and engagement across staff, patients and carers. We promote the culture that care of the dying is everyone's responsibility, and are providing the skills and tools to enable our staff to consistently and compassionately undertake this.

Personalised, responsive and timely care is also important to those patients who are being referred for care which is why we have continued to sustain a strong performance against the 18 week referral to treatment time standards with our national performance in the top quartile over the last two years. We have delivered this through a strong focus on systems, processes, governance and the implementation of national best practice.

Across a number of elective care pathways, service improvement work has continued to identify and remove unnecessary delays and improve efficiency of care. One particularly successful area has been across the Seamless Surgery programme which aims to create best practice and truly patient centred experience of elective surgery where the referral to recovery process for every patient is seamless.

As well as timeliness and efficiency of care, ensuring services take account of the particular needs and choices of different people is integral to our service improvement work. We are caring for an increasing number of patients with one or more long term conditions and in particular a significant number of people living with dementia. Dementia training is high on the agenda across our organisation for all levels of staff. Many wards have been upgraded using the design principles from the Kings Fund 'Enhancing the Healing Environment' guidance.

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

We have also signed up to 'Johns Campaign' offering carers passports for use outside of visiting hours and extended visiting hours to encourage relatives and carers to be involved in assessment and care planning.

Privacy and dignity of patients is inherent in everything we do and the importance we place on this was demonstrated in January 2018 when we refused to relax our zero tolerance stance on mixed sex accommodation despite the national standard being relaxed due to Winter pressures.

We also ensure that patient privacy and dignity and compassion and kindness are fundamental considerations in all developments including capital schemes, changes to practice, efficiency programmes, infection prevention and control considerations, training and education. It was therefore pleasing to note that in the most recent NHS national inpatient survey nine out of ten inpatients said they were treated with respect and dignity during their stay.

We have invested heavily in new facilities with the emphasis on design and care pathways which meet the personal needs of the patients being care for. For example at Weston Park we have embarked on an exciting multi million pound ward transformation programme which will include more single rooms for privacy and a dementia friendly environment.

A new Frailty Unit at the Northern General Hospital is enabling frail older patients to be assessed in an environment which has been designed specifically for their needs. The Unit has ambulatory assessment bays with recliner chairs rather than beds. This is easier for patients who are frail as they can stay in their own clothes. Other features include a dementia friendly design. The new unit is staffed by an integrated multi-disciplinary team who have received dedicated training to work together in a unique way to provide tailored assessment and treatment. The unit aims to enable patients to return home the same day wherever appropriate.

The last two years have seen some fantastic partnership work between health, social care and voluntary teams to make real differences to the lives of people living with physical or mental illnesses in our city. It is the beginning of a journey which has already started to prevent older people or those individuals living with long term conditions having to be admitted to hospital.

When patients no longer need our care we assist them to experience a smooth and timely discharge or transfer to the next stage of their care. Like many other trusts across the country this has been a more challenging area of improvement. However it has also presented the opportunity to build strong multi- agency working, integrated models of care and a new discharge assessment process which puts the individual needs of the patient at the centre of the process. The 'Why not Home, why not today' initiative focuses on expediting discharges and removing inpatient days which add no value.

A commitment to adopt and work with shared and trusted data has been fundamental to the early success of new ways of working across the transfer of care pathways. We are at the start of this journey but good progress was made during 2017 with a significant reduction in delayed transfers of care. There have been further challenges over the winter period which continue to be addressed by all the partners with a particular emphasis on the underlying causes.

On a system-wide level we are excited by the potential changes we can explore for health and social care as part of the South Yorkshire and Bassetlaw Integrated Care System (ICS). This new approach will outline how health and care services are planned by place or location, rather than around individual Trusts and care providers. The Sheffield Place Based Plan will be one of the ways we deliver the shared ambitions outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) at a local level.

Within the plan there are eight priority areas:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective care and diagnostics
- Maternity and children's services
- Cancer
- Non clinical support functions

Over the next few years we look forward to this increased collaboration fostering further quality improvements for our patients.

Further information about this and other developments during 2017-18 can also be found in the Annual Report and on our website: www.sth.nhs.uk/news.

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Of course none of these improvements are possible without the support of all 17,000 individuals who work for the Trust and our amazing volunteers and charities whose dedication and commitment is a source of great strength for our organisation.

It was exceptionally pleasing that national and local survey results during 2017-18 consistently showed that the majority of our patients and staff would recommend the Trust as a place to receive care and to work and indeed we were rated as above average in many of the key domains. Our staff also won a number of quality and safety awards throughout the year and the Friends and Family Test for patients and staff gives a valuable insight into where our future focus needs to be.

During the last 12 months we have continued to encourage more of our staff to be actively engaged and involved in decisions, setting the future direction of the organisation and innovations. We are committed to continuing this important work during 2018-19 because we believe our staff are key to the delivery of excellent patient care.

We feel it is very important that we value everyone who works in the organisation and the efforts they go to every day to make a difference to our patients.

I am confident that by fostering our culture of learning and continual improvement we will provide our patients with the safe, high quality care and experience they deserve.

The following pages give further detail about our progress against previous objectives and outline our key priorities for the coming year. To the best of my knowledge the information contained in this quality report is accurate.

Sir Andrew Cash OBE
Chief Executive

22 May 2018

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 2017-18

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.

A new Quality Board oversees the production of the Quality Report. The membership includes Trust managers, clinicians, governors, and representatives from Healthwatch Sheffield and the local Voluntary and Community Sector. The remit of the Quality Board is to agree the content of the Quality Report along with the Trust's quality improvement priorities whilst ensuring it meets the regulatory standards set out by the Department of Health and NHS Improvement.

As a Trust, we have considered carefully which quality improvement priorities we should adopt for 2018-19. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with Trust governors and with representatives from NHS Sheffield Clinical Commissioning Group (CCG), Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2016-17 Report. The proposed quality improvement priorities for 2018-19 were agreed by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 26 February 2018 The final draft of the Quality Report was sent to external partner organisations for comments in April 2018 in readiness for the publishing deadline of the 31 May 2018.

Dr David Throssell
Medical Director

2.0 Priorities for Improvement

This section describes progress against the three priorities for improvement during 2017-18 and provides an update on progress in relation to improvement priorities from previous years. In addition, priorities for 2018-19 are outlined, along with an explanation of the process for their selection.

2.1 Priorities for improvement 2017-18

Priority

To further improve the safety and quality of care provided to our patients through initiatives such as the Patient Safety Zone and Safety Huddles.

Background

To build on the Trust's focus on patient safety within inpatient areas, a structured process to improve the transfer of time-critical patient information, Safety Huddles, continued to be implemented throughout the Trust to aid communication. Safety Huddles were initiated in healthcare by the Yorkshire and Humber Academic Health Sciences Network Improvement Academy. From initial testing in three pilot sites (Leeds, Scarborough and Barnsley), The Health Foundation funded a three year programme to roll out Safety Huddles on a wider scale across the region in a programme called 'Huddle Up for Safer Healthcare'.

Objective

To continue to roll out Safety Huddles, a meeting focused on reducing the risk of patient harm. The use of Safety Huddles is an opportunity to improve multidisciplinary team working, communication, and proactively managing risks to avoid incidents. Aim to have 30% of all inpatient areas using Safety Huddles by March 2018. Alongside this continue to roll out and embed the Patient Safety Zone across the Trust.

Achievements against objective

At the end of March 2018, a total of 29/75 (38.6%) inpatient teams had introduced Safety Huddles. A further 25 inpatient teams have expressed an interest in starting Safety Huddles in 2018.

In addition to inpatient areas, Portering Services held their first huddle on 27 February and invited Infection Control to discuss personal protective equipment. The Radiology Team at the Northern General site started huddles during summer 2017 and have seen a reduction in the number of reported incidents. There has also been interest from Charles Clifford Dental Hospital who aim to implement changes to prevent sharps injuries.

Many of these teams have achieved a stepped reduction in the number of patient falls since introducing Safety Huddles and are having longer periods of time between new pressure ulcers. All of these successes have been shared on Twitter and Facebook and staff engagement in safety is increasing.

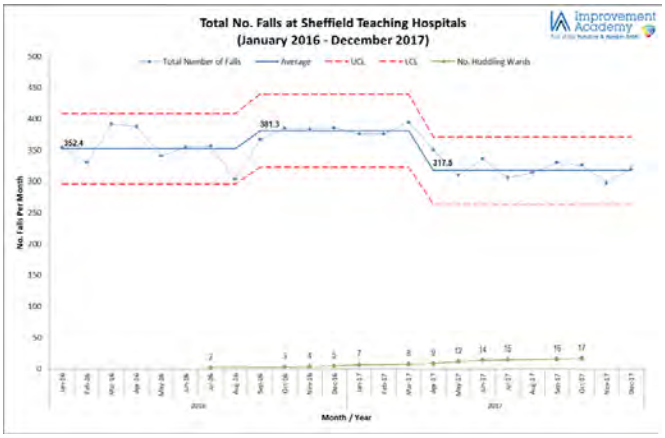
Over the last two years (January 2016 – December 2017), the number of falls across the Trust has reduced from 352.4 per month to 317.5 per month, an overall reduction of 10%. This means that a total of 315 falls were avoided (Chart one). NHS Improvement has calculated the cost of a fall (based on 'no/low harm') at £2,600. Based on the assumption that all 315 avoided falls were 'no/low harm', the cost saving to the Trust to date is around £819,000. The cost saving may be significantly higher however, as during this time period, 26% of falls in the Trust were categorised as 'moderate harm or above'. As at January 2018 when this analysis was completed, a total of 17 inpatient areas were focusing on reducing falls. As this number increases, we would expect the number of falls to continue decreasing.

Most areas have undertaken a Teamwork and Safety Climate Survey and these will be completed again to identify any improvements in teamwork and safety culture since the commencement of Safety Huddles.

The NHS Improvement 90 day Falls Improvement Collaborative recognised the work within the Trust as 'The Initiative that is most easily transferred between organisations'. The development of this intervention is also being shared with other external partners including providers of intermediate care beds, with an aim of reducing readmissions.

Work is ongoing to increase the number of Safety Huddles across the Trust, with a trial to be developed for virtual huddles to be introduced in the community setting.

Chart One



This work is now becoming embedded into practice. To support this Safety Huddle Coaches are now established in Medicines and Pharmacy Services (MAPS) and in South Yorkshire Regional Services (SYRS).

Work is underway within Hearing Services to embed the Patient Safety Zone (PSZ). The PSZ is now embedded in all areas that have received Physiological Services accreditation across the Trust. These are:

- Neurophysiology
- Gastrointestinal Physiology
- Audiological Science

On ward areas, the principles of the PSZ are being incorporated into structured processes for effective ward rounds. This includes staff introducing themselves and confirming the patient's identity. This approach continues to be piloted in two areas as part of the 10 Safer Sheffield Principles.

Priority

To further improve End of Life Care

Background

There has been a significant change in the way end of life care is delivered in hospitals. Nationally this has included the removal of the Liverpool Care Pathway (2014) and locally the Sheffield End of Life Care Pathway, in line with Department of Health policy following the Neuberger Review (More Care, Less Pathway).

Local guidance focusing on looking after patients who may die in the next few hours or days of life was implemented in October 2015 and subsequently evaluated through a notes audit across three wards. The purpose of the audit was to assess the impact of the new guidance on documentation around the Five Priorities of Care for end of life care for Trust patients. The evaluation examined documentation pre and post guidance implementation.

Although the audit did show a small number of improvements, it was concluded that overall there were no significant changes after the guidance was introduced.

Following the CQC inspection in December 2015, the Trust received 'Requires Improvement' for End of Life Care at the Royal Hallamshire, Northern General and Weston Park Hospitals. End of Life Care in the Community received a rating of 'Good'.

The following actions were identified for the Trust by CQC:

- The Trust must ensure there is a clear strategy for end of life care, which is implemented and monitored.
- The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The Trust must ensure that DNACPR records are fully completed.
- The Trust should develop a system for monitoring whether patients died in their preferred place of care.
- The Trust should monitor preferred place of care for patients at the end of life.

Objectives

To develop an implementation plan, with staff, to operationalise the End of Life Care Strategy across the Trust. To have the implementation plan rolled out by March 2019.

Achievements against objectives

During March and April 2017 staff were consulted on the End of Life Care Strategy and from this an implementation plan for how this strategy would be operationalised in the Trust was developed. The clinical leads are now leading on the roll out of the implementation plan supported by the End of Life Care Project Working Group. The key objective was to implement all five work streams of the implementation plan. The five workstreams are;

- Develop a Care Planning Toolkit
- Guidance Review
- Develop an Intranet Site
- Review of Education and Training
- Electronic systems

The following progress has been made across the five workstreams.

The core nursing care plan in Lorenzo (with section 12 for End of Life Care) continues to be rolled out across the Trust, the plan includes recording of preferred place of care and death. The use of section 12 of this plan is being monitored by the project team. Accompanying support and information to encourage its use has been developed in conjunction with nursing staff. Roll out commenced in June 2017 and is planned to complete at the end of August 2018.

The guidance review has concluded and new 'guidance for the care of the person who may be in the last hours to days of life' was launched in December 2017. The new 'Individualised Care Plan for the last days of life' has been developed and approved. This is currently being piloted on three wards and will then be rolled out across the Trust once an evaluation has taken place and any changes from the pilot have been made.

The new End of Life Care intranet page is currently being developed and will be launched in early 2018. This will act as a central hub for staff to access all relevant End of Life Care information. An End of Life Care education and training subgroup has been set up to review and move forward with aspects of education and training to support the implementation of these new resources.

An end of life care survey was run for 12 months from May 2016 in order to seek feedback from bereaved family and carers in relation to the care of their loved one during the last days and hours of their life. The results of the survey have been reviewed and key themes for improvement have been established.

The key themes are:

- care received.
- the environment.
- communication.
- pain control.

There were also many positive comments in these areas as well.

These results and themes will be used as a baseline against which we can compare the results of future surveys to identify if improvements have been made

Work to improve End of Life Care will continue during 2018-19. Details of the objective for 2018-19 can be found on page 89.

Priority

Introduce Electronic Care Planning across the Trust to improve the quality of care planning.

Background

In 2015-16 it was identified by Nurse Directors and the CQC that care planning across the Trust does not always fully reflect the individual needs of patients. To improve this, an extensive scoping and consultation exercise was undertaken to develop a way forward for care planning in the Trust. Feedback from the consultation overwhelmingly pointed towards a return to a well-established nursing model of care planning. This is aimed to improve individual care plans, sharing of information and interaction with patients/carers.

An electronic version of this model has been built in the Trust electronic patient record, Lorenzo and debated at various forums for approval. This was then piloted on three wards for a six-week period from the week commencing 31 October 2016, on wards E1/2, RHH and Firth 9, NGH.

The Department of Health defines care planning as:

"…a process which offers people active involvement in deciding, agreeing and owning how their condition will be managed. It is underpinned by the principles of patient-centeredness and partnership working. It is an on-going process of two-way communication, negotiation and joint decision-making in which both the person and the health care professionals make an equal contribution to the consultation."

The intended outcomes of the care planning pilot were:

- To have fully individualised care plans for patients.
- To improve the quality of documentation.
- To enable evaluation of the care to be done at the bedside in collaboration with the patients (using laptops on wheels).
- To facilitate contemporaneous documentation using laptops on wheels.

Following agreement with the Chief Nurse and Nurse Directors, the model was approved to roll out Trust-wide.

Objective

To roll out previously agreed e-care planning model using Lorenzo as a platform to all 72 wards at STH. Providing bespoke e-care plans as required for different specialities.

Achievements against objective

E-care planning is currently rolled out to 47 wards. The project is scheduled to finish at the end August 2018.

Initially there were some concerns regarding hardware and connectivity, however these have been resolved through partnership working with key IT colleagues.

Staff views and feedback have been used throughout the development process for example; the format of the care plan has changed in response to staff feedback. It now appears as a "one pager" scrollable document which has reduced the amount of clicks required to evaluate the care plan. A "Lorenzo extension" has been introduced, this enables staff to see the entire evaluated care plan at a single click of a button from Lorenzo.

The project has developed numerous bespoke care plans for different specialties, including cardio-thoracic, PVDU,

lines and access devices, diabetes, delirium, vascular, advanced respiratory care, post-operative surgery, drug and alcohol abuse.

Throughout the project a number of incidental achievements have been achieved, including the standardisation of the content and completion of the discharge checklist.

The care plan now prompts staff to ask for the passports for patients with Learning Disability passports, which meets the requirements of the accessible information standard about communication needs of patients. It has also provided the opportunity for several specialities to review any existing care plans and bring them up to date with current requirements. As a result, any paper care plans have been transposed into Lorenzo.

Work is currently underway with the Nurse Directors on amendments to the Nursing Contact Assessment admission documentation to mandate certain fields such as Next of Kin. The Deputy Nurse Directors and Tissue Viability colleagues are working to undertake a Trust-wide review of pressure ulcer documentation in line with NHS Improvement requirements.

The project is on track to be completed by June 2018. Progress of this project will continue to be monitored by the Nursing Executive Group.

2.2 Update On Progress Against Previous Priorities For Improvement

Priority

To improve how complaints are managed and learned from.

There have been key changes in the management and structure of the Patient Partnership Department during the past year. The Complaints and Patient Services teams now sit managerially within the Patient and Healthcare Governance Department and within the Medical Director Directorate, providing the opportunity to more closely align complaints, incidents and inquests/claims. A new Complaints Manager was appointed in January 2018.

A number of further quality initiatives have been implemented over the past 12 months as follows:

Medicine and Pharmacy Services (MAPS) and Acute and Emergency Medicine (AEM) transferred the coordination of complaints to the central complaints team during 2017-18. This has been a positive move, with response times to complaints improving significantly as a result.

The revised tiered response time targets continue to provide a framework and benchmark, with the target remaining as responding to 85% complaints within the agreed timescale. The performance this year (April 2017 to February 2018) was 93%, achieving the target (85%) for the third consecutive year.

The Concerns and Complaints Policy was reviewed and updated in late 2017. This will be supported by easy to follow flow charts summarising the complaints process, which will be produced during 2018.

The complainant satisfaction survey continues to be undertaken with surveys being sent to complainants, by either post or email, three weeks after the response to their complaint.

Between April and December 2017, 177 complainants responded to the survey, a response rate of 24%. The highest scoring area was in relation to how easy the responses were to understand. The lowest scoring area was in relation to complainants having confidence that improvements had been made as a result of their complaint. Work is underway to address this issue through improving the robustness of action plans Trust-wide, including within complaints.

In addition to the survey, a sample of complainants who chose to provide their contact details through the survey are interviewed either by telephone or face to face. Additionally, the associated complaint files are audited against the outcome of the survey, with interviews and audits then being analysed and compared. There will be a review of the complainant satisfaction survey during 2018 in order to ensure robust and meaningful information is obtained.

A comprehensive programme of complaints training has been running since September 2015. The training is underpinned by an ethos of welcoming and acting on feedback. During 2017-18, 45 training sessions have been held, attended by 670 staff across three different sessions, Complaints are Like Medicine, Investigation Skills and Getting it Write. 526 staff provided evaluations of the training, with over 98% stating that they would be extremely likely or likely to recommend the training.

The programme is planned to undergo a review in 2018. The Patient Experience Committee will continue to oversee the programme of work.

Priority

To improve staff engagement by using the tools and principles of Listening into Action (LIA).

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Background

LIA was introduced in the Trust in the Autumn of 2014 as way of introducing changes that will make a positive impact for patients and for staff through high engagement strategies.

Since the launch there have been 85 schemes delivered by 52 teams. In 2017 we had 43 schemes in eight clinical directorates, five schemes with Trust-wide reach and six corporate schemes. 20 LIA schemes were focussed directly on improving patient experience, 23 of which focussed on improvements for patients through high engagement practices. Some of these were comprehensive programmes of work spanning a minimum of 12 months and a wider Organisational Development approach and therefore feature in more than one phase. The schemes progressed in 2017 are detailed in table one.

Table One

Phase 4	
Frontline	
Developing a Protected Clinical Assessment Area for Vascular Ambulatory Care	Improving Patient Choice for Pain Management for Minor Procedures in Obstetrics & Gynaecology
Creating a Safe, Efficient and Timely Cardiac Surgery Pathway & Positive Patient Experience	Patient Safety Zone – Developing Safer Medicines Management in Critical Care
Introducing a Pelvic Pain Pathway in Obstetrics & Gynaecology	Improving Patient Experience and Reducing Waiting Time Prior to Induction of Labour
Collaboration Between Front Door Response Team & Active Recovery to Support Winter Pressures	Review of Working Practices to Allow More Time for Patient Care Over a 7 Day Week in Therapy Services
Review of Clinical Operations & Discharge Process	
Enabling Our People	
Reducing the Backlog in Clinical Coding at Month End	Diversity: Networking for disabled and BME staff
Improving Staff Engagement in Informatics	Staff Engagement: Improving the Junior Doctor Experience
Improving ENT Medical Engagement	Improving Staff Engagement in Vascular Services
Shared Care Planning in Spinal Injuries	Improving Health & Wellbeing in Operating Services, Critical Care & Anaesthesia
Improving Team Working in Charles Clifford Dental Hospital	Improving Team Working in Laboratory Medicine
Perfecting Physiotherapy Placements for Physiotherapy Students and Clinical Educators	

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Phase 5	
Frontline	
Reconciling the Needs of Patients, Relatives and Staff in Critical Care	Introducing Family Centred Care in Neonatology
Improving the Pathway for Women Having Planned Caesarean Sections	Improving the Continuity of Care for Women Antenatally and Postnatally
Improving Patient Preparation for Oesophageal and Gastric Surgery	Development of a Therapy Instructor Role in Medicine
Implementation of Virtual Yearly Follow Up of Primary Hip Replacements	Improving Patient Choice for Pain Management for Minor Procedures in Obstetrics & Gynaecology
Collaboration Between Front Door Response Team & Active Recovery to Support Winter Pressures	
Enabling Our People	
Improving Staff Engagement in Operating Services, Critical Care & Anaesthesia	Improving Staff Engagement in Informatics
Improving the Junior Doctor Experience	Improving Staff Experience and Use of Lorenzo Across STH
Improving Health & Wellbeing in Operating Services, Critical Care & Anaesthesia	Improving Communication in Charles Clifford Dental Hospital
Perfecting Physiotherapy Placements for Physiotherapy Students and Clinical Educators	Embedding Governance into Day-to-Day Culture of Obstetrics, Gynaecology and Neonatology
Reducing the Backlog in Clinical Coding at Month End	
Phase 6	
Frontline	
Reconciling the Needs of Patients, Relatives and Staff in Critical Care	Improving the Process of Discharge from Transitional Care in the Neonatal Unit
Delivering an Effective Handover for the Labour Ward Multi-disciplinary Team	Improving Attendance Rate at Charles Clifford Dental Hospital
Optimising Nutritional Status Following Hip Trauma Surgery on Vickers 4	Implementation of Virtual Yearly Follow Up of Primary Hip Replacements
Optimising Surgical Listing through a Visual Medium in Orthopaedics	
Enabling Our People	
Improving Staff Morale in ENT	Improving Staff Engagement in Informatics
Improving the Junior Doctor Experience	Improving Staff Experience with and Use of Lorenzo Across STH
Improving Staff Engagement in EPRS	

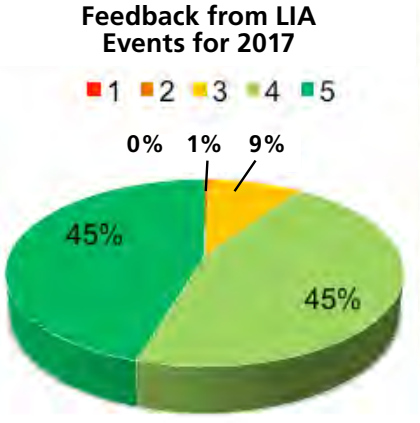
Measuring the difference

We can measure the impact of LIA in the following ways:

Outcomes: Each scheme develops targets and desired outcomes at the start and these are revisited at the end. Examples of outcomes includes:

- The Front Door Response Team & Active Recovery team have proven by a trial in A&E of Active Recovery intervention that there is a need for the service within A&E. This trial showed that the patient's length of stay can be reduced by one night with this support. As a result the team are looking for funding to secure this service on a permanent basis.
- The protocol for starving elective C-section patients has been revised as a result of an audit, which will mean that patients are able to drink freely prior to surgery rather than the lengthy time of starvation that was the case previously (often more than 12 hours).
- A re-audit has shown that Sheffield is meeting the national requirements, with an average of a woman seeing a maximum of two members of staff antenatally and three postnatally.
- Informatics Directorate have developed, with staff, a comprehensive staff experience plan and are implementing this. Staff involvement is now embedded in how the leadership team manage day to day business and changes that are planned have staff experience weaved in throughout.
- LIA was used to engage all staff in South Yorkshire Regional Services on Lorenzo and identify how we could make improvements could be made that would benefit patients and improve staff experience and usage. Changes have been made to the system, bespoke training provided and computers have been changed where needed to improve the speed.

Chart 2



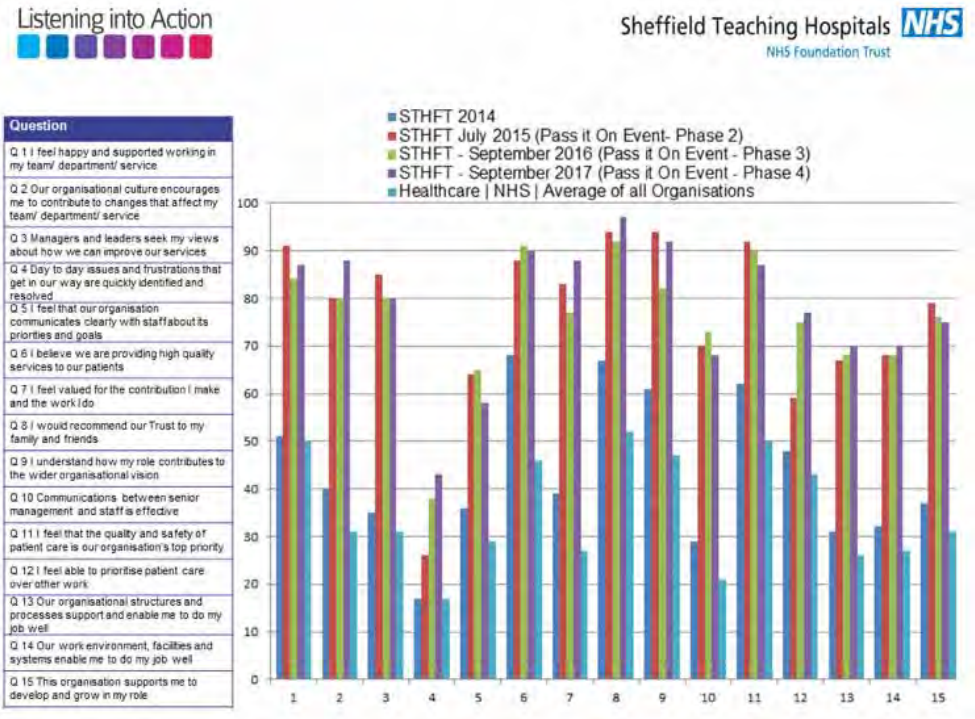
At every event staff are asked to provide feedback on how motivated the session has made them feel in connection with the LiA. Chart two shows accumulated data from teams who attended the launch, Compass Check and Pass It On Events since LIA's introduction. A total of 366 respondents, with 1,006 responses replied to the following three questions:

- How would you rate today's events?
- How do you feel that today has been a good use of your time?
- Do you feel that the LIA way will help us to improve patient care and how we work together?

The impact of LIA is also being measured by a Pulse Check. This consists of 15 questions focussing on how staff feel they are engaged and supported to do their job, which link to the key areas of the staff survey. It is simple and quick to complete and administer. To date 478 people have completed a Pulse Check. Results in chart three show the scores benchmarked against the average score for all other trusts that have adopted LIA. The Trust has better results than any other organisation. This shows overwhelmingly that people who get involved in LIA feel better led, more involved, motivated and positive about their work and the Trust.

Work has already started on increasing the evaluation of scheme outcomes with the aim of taking these into other areas as appropriate.

Chart 3



2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Priority

In July 2014 the Trust committed to a three year 'Sign up to Safety' campaign. The Trust's overall aim was to further improve the reliability and responsiveness of care given to patients, which in turn aims to achieve a 50% reduction in harm.

Progress against the five goals which underpin the campaign is outlined below:

Cultural change that ensures that patient safety will be embedded within all aspects of clinical care.

The Trust has introduced bespoke training packages in Human Factors, providing staff with the skills to undertake simulation exercises and to improve the investigation of and learning from serious incidents. During 2017-18 there have been two training days including a bespoke session for Executive Directors and senior colleagues.

Training has also been ongoing to promote Human Factors awareness across the Trust with information being provided through nurse education, F1 'away days', Acute Care of the Medical Emergency course and presentations at medical governance meetings to enable all staff to understand the implications of Human Factors for practice.

Improved recognition and timely management of deteriorating patients leading to improved care.

An audit of patients' pre-cardiac arrest SHEWS was undertaken. This provides assurance that the Management of the Deteriorating Patient Policy is being adhered to. The audit ensures that where any learning is identified this is discussed with local governance teams and reviewed through local governance processes. The Trust has also developed a plan for the introduction of a Track and Trigger system which will provide early alerts when patients start to deteriorate. This is an objective for 2018-19. Details can be found on page 97.

Improved recognition and timely management of patients presenting with, or developing, Red Flag Sepsis and Acute Kidney Injury (AKI).

Care bundles for Red Flag Sepsis and AKI have continued to be rolled out and developed throughout 2017-18 and a joint education package for newly qualified nurses has been developed which links the management of sepsis, AKI and the deteriorating patient into one teaching session. The sepsis tool has been implemented in all areas and 80 champions have been trained to undertake the train the trainers role.

The AKI team have been continuing with delivering education across the Trust and have been piloting a revised fluid balance chart prior to evaluation and launch across the Trust. A small number of wards have also been trialling the use of weighing scales to accurately measure fluid output for incontinent patients.

Sepsis and AKI are now standalone objectives for 2018-19. Details of the sepsis objective can be found on page 96. Details of the AKI objective can be found on page 98

Absolute reduction in the cardiac arrest rate

The Trust continues to maintain a reduction in the cardiac arrest rate. Audits following every cardiac arrest have provided the Trust with quality data, which is submitted to the National Cardiac Arrest Database . Following a review of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms further work has commenced and is being evaluated into the use of a treatment options form to be used alongside the DNACPR form. The purpose of this form is to establish the most appropriate care for the patient and to ensure that plans are fully communicated to the patient, their family or carer, and other staff.

Improved communication in the introduction of structured processes to improve the transfer of patient information.

This was embedded into the 2017-18 objective to further improve the safety and quality of care provided to our patients through initiatives such as the Safety Huddles. Details can be found on page 74.

Priority

To ensure 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.

A recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry report and the government's formal response 'Hard Truths' specified that every hospital patient should have the name of their consultant and the nurse responsible for their care displayed above their beds.

In July 2015, the Trust introduced a mix of tent boards and wall mounted boards at patients' bedside which captures each patient's named nurse and consultant. The type of board used was dependent on the different locations and patients' needs. Between October and December 2016 a Trust wide evaluation of the use of the boards commenced. A total of 140 staff and 140 patients took part in the evaluation. The results showed that the majority of staff and patients across the Trust were completing the tent boards. The Nurse Executive Group have determined that the tent boards/whiteboards at the back of beds should continue to be used as an aide to good communication practice and identification of the consultant and nurse responsible for care.

Following the evaluation, education packs have been produced and circulated to educators through the Nurse Directors. These, along with posters, have been used to re-launch/promote the use of the tent boards within their care groups. The evaluation found that there were issues with the availability of pens to complete the tent boards. In order to improve this, the order codes for pens have been re-circulated. Ward Managers now ensure that pens are on regular order and are readily available.

All the actions following the evaluation have been completed and will be monitored going forward. As such, this will now be routine practice and will no longer be reported in the Quality Report.

Priority

To review mortality rates at the weekend and to focus improvement activity where necessary.

The Trust has continued to review mortality by day of the week during 2017-18. Findings show that our Hospital Standardised Mortality Ratio for all admissions (and for non-elective admissions only) for each day of the week, including Saturdays and Sundays, is 'as expected' when compared to the national average.

The Trust continues to be involved in the national High-Intensity Specialist-Led Acute Care (HiSLAC) project. This HiSLAC project is a three year rolling programme and the Trust has an active role in the research with the Principle Investigator residing within the Medical Director's office. The initial output from this work has yet to be published but it suggests that there is no material effect on mortality from differential staffing by consultants at the weekends.

To ensure, as a Trust, we learn from all deaths we have been implementing the National Quality Board guidance on Learning from Deaths during 2017-18, full details can be found on page 108.

Priority

Cancelled Operations

On day cancellations of elective surgical procedures can create problems for patients and staff. When an avoidable cancellation occurs, this can often lead to delays to patient treatment, and extensive re-work for administrative and clinical staff to prepare the patient for surgery again.

The on-day cancellation rate for elective surgery has reduced during 2017-18 to around 5.7%, from over 6% in the past two years, which is a significant improvement and represents a full year reduction of around 300 avoidable on-day cancellations. This improvement has resulted from coordinated and targeted efforts in multiple directorates, through the Seamless Surgery Improvement Programme, to identify and address the root causes of on day cancellations.

Examples of work that has taken place to enable this improvement are as follows:

- An expansion of reminder calls for patients at four days prior to surgery to ensure they are fit, ready, willing and able to attend as planned.
- Improved planning and scheduling processes in directorates to ensure appropriate equipment and staffing can be planned well in advance to reduce potential on day problems.
- Development and implementation of a Standard Operating Procedure for elective scheduling, to enable better communication with patients and clinical teams, reducing the chances of list and patient cancellations .
- Rigorous implementation of a Policy for Management of On-Day Cancellations, which when followed, ensures all steps are taken to avoid an on day cancellation.
- Introduction of new guidelines for high blood pressure in Ophthalmology, meaning patients who may previously have been cancelled on the day are now having their procedure as planned.

During 2017-18 the main reasons for patients being cancelled on the day of surgery have been as follows:

- Patient unfit – For example patients arriving with an infection, or having results of standard tests outside of the expected ranges (e .g . high blood pressure) .
- Patient did not attend - The patient did not arrive for the scheduled procedure.
- Operation not required - Symptoms that have improved or disappeared or the patient may have changed their mind about having the surgery.
- Lack of theatre time - Previous patients on the list taking longer than expected; changes to the order of a list resulting in (or as a result of) delays .

These reasons account for around 70% of all on-day cancellations so work continues to be undertaken to address these challenges to ensure that elective operations go ahead as planned wherever possible. The Seamless Surgery Programme is about creating a best practice elective pathway where the referral to recovery process is right first time and work is taking place in all surgical directorates to address the principles of seamless surgery. As we move into 2018-19 work will continue to focus on reducing the on-day cancellation rate further and this will be overseen by the Seamless Surgery Board,

chaired by the Medical Director. Examples of additional planned improvements to help a further reduction in cancellations are as follows:

- Text message reminders to patients seven days prior to elective surgery reminding of the date, time, location and the cost to the NHS of not attending for surgery.
- Further improvements to advance theatre list planning in all specialties.
- Full adherence to the Management of On-Day Cancellations Policy in all cases.
- Standardisation and spread of the weekly root cause analysis at directorate level.
- Collate the outcomes from the directorate analysis centrally, to support organisational learning and improved processes.

The challenge of reducing the volume of on-day cancellations is critical to providing the best elective surgical pathway, so the focus will continue to remain on this during the next year. This work will be overseen by the Seamless Surgery Board and will no longer be reported in the Quality Report.

Priority

Pressure Ulcer Prevention

Monthly survey data for the period	2015-16 Oct 15-Mar 16	2016-17 Oct 16-Mar 17	2017-18 Oct 17-Mar 18
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.81%	1 .57%	1.78%
Proportion with pressure ulcers prior to receiving care from the Trust (Inherited)	5.03%	4.38%	4.39%
Overall proportion	6.84%	5 .94%	6.17%

As shown in table two the overall proportion of pressure ulcers has increased to 6.17% during 2017-18. Previously, work reporting on pressure ulcers has been focused on using the data obtained through the Safety Thermometer. The Safety Thermometer data are collected on a single day in the month and then validated prior to uploading to the national system. For 2018-19 onwards STHFT plan to use actual numbers of reported pressure ulcers by grade in order to more accurately reflect the pressure ulcer numbers being reported. These data will be reported via the nursing and midwifery quality dashboard. An ambitious plan for improvement has been set for 2018/19.

During 2017 the Trust Executive Group (TEG) formally approved the integration of the acute and community tissue viability teams. Both teams have worked collaboratively over the course of the year and have been proactive in implementing strategies to reduce the incidence of acquired pressure damage through a number of different initiatives. This work has also considered improved outcomes of existing pressure ulcers. It is anticipated the integration of the acute and community tissue viability teams, planned for completion in April 2018, will positively influence the pressure ulcer preventative work further.

Following the community pressure ulcer prevention audit in 2016 several areas of concern were identified and an action plan was developed. The aim of this was increasing the number of risk assessments completed at first visit, increasing the number of risk assessments reviewed, updating and improving the pressure ulcer prevention care plan and increasing the number of patients receiving a Malnutrition Screening Tool (MUST) assessment. All of these actions have now been implemented. A re-audit was undertaken in November/ December 2017, the results are currently being analysed and an improvement plan will be developed if required.

The community are currently engaged in the wound care CQUIN and this has resulted in an audit of the completion of the wound template and use of photography in wound care on SystmOne. Actions arising from this audit have already been implemented and a further audit is planned for March 2018.

Due to the increasing demand for pressure relieving equipment in the community, an audit was undertaken to ensure that clinicians are requesting individual items from the British Red Cross in line with current clinical guidelines. The audit provided the required assurances that requesting is appropriate and changes have been implemented when required.

The Trust was successful in joining the NHS Improvement pressure ulcer collaborative, launched in October 2017.

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

This collaborative focuses on 'Stop the Pressure' initiatives to reduce patient harm in the acute setting. The focus is on using quality improvement methods and knowledge to develop pressure ulcer prevention strategies across the multi professional team. The strategies developed include using a Nightingale style handover (this is a project to improve consistency and standardised approaches to delivery of care), body mapping and bedside education. The number of pressure ulcer free days since starting the initiative is recorded daily on both wards and the final session with NHS Improvement is due to take place in April 2018. So far the results have been promising and the learning from this initiative will be communicated Trust wide at the 2018 Sharing Good Practice Festival.

Across the Trust wards are implementing and embedding Safety Huddles with the support of the Improvement Academy framework, a proportion are focussing on pressure ulcer prevention. The Safety Huddles, led by clinicians and with a multidisciplinary focus, support the team to identify those patients most at risk of developing a pressure ulcer and a plan for prevention.

The Tissue Viability Team have delivered bi-monthly study days for Health Care Assistants and Registered Nurses that focused on pressure ulcer prevention and management, with over 140 staff attending these days since April 2017. The Acute Team also provide teaching sessions on pressure ulcer prevention and management to all new Registered Nurses, Healthcare Assistants undertaking the 'Prepare to Care' course, Medical Students, Apprentices, Therapy Assistants and Operating Department Practitioners. Educational projects have also been developed including 1:1 ward based 'Tissue Viability Champion' training (piloted and evaluated), bed and mattress champion training and a moisture versus pressure damage educational tool used by ward staff.

In community further roll out of the 'React to Red' training programme, which is a pressure ulcer prevention training initiative, has been delivered to community nursing, intermediate care, active recovery, stroke services and therapy mental health services. By October 2017, 578 staff members had accessed and undertaken the React to Red e-learning programme, which is currently being evaluated using a post training and implementation to practice questionnaire.

Following the success of the 'React to Red' implementation in community settings, there are plans to roll out to home care providers in Sheffield community and also across the acute hospital sites. The e-learning package has now been adapted for use in the acute setting. It is hoped that the e-learning package will also be available as a phone application in the near future.

During the past year the Tissue Viability Team has been involved in the Total Bed Management Project. This has incorporated an in-depth review of beds, specialist beds and foam mattresses, to ensure clinical and cost effective products only are included in the tender. Off-loading heel devices have also been trialled. Two city wide joint study days have been held during 2017-18, covering aspects of pressure ulcer prevention. The Trust also held a 'Stop the Pressure' day to coincide with the national programme.

Electronic care records are being rolled out across the acute site. A workshop was held in February 2018 to fully review the current documentation in use and a plan is being developed to ensure that the documentation in use focuses on pressure ulcer prevention. The Tissue Viability Team has worked with the technology team to develop an electronic referral system, so that ward staff can refer appropriate patients into the service. This has improved documentation and communication.

A triage protocol, which is awaiting implementation, has been developed to ensure patients are prioritised effectively. Electronic records for nursing staff relating to wound assessment and care planning for pressure ulcer prevention are being developed. The wound template has been refined to meet the national minimum data set for wound assessment and created so information can be collected electronically to inform practice and allow some consideration of wound healing rates and outcomes.

The Tissue Viability team have also been involved in working with the Nursing and Midwifery Quality Dashboard group and pressure ulcers are a key indicator included in this work. This continues to be a priority for the Trust for 2018-19. Details of the priority for 2018-19 are outlined on page 95.

Priority

Optimise Length of Stay

The Trust has been continuing to develop its arrangements to optimise patient flow and reduce length of stay. The strategic direction for this work is provided by the Excellent Emergency Care workstream, part of the Trust Transformation Programme, 'Making it Better'. Work during 2017-18 has included:

Development of the Sheffield SAFER Flow 10 principles based on national best practice and local learning from wards at STHFT. The underlying principles of this work are informed by the NHS England guidance Safer, Faster, Better: good practice in delivering urgent and emergency care. The aim of these principles is to ensure that all patients have a plan and they receive the care they need

in a timely way. 'Give It A Go Week' this year (June 2017) was all about launching the Sheffield SAFER Flow 10 principles across the Trust and creating a momentum for improvement.

Learning from 'Give It a Go Week' and established improvement work with a number of wards is that the Board Round is the most important phase of good discharge planning. 70% of base wards currently have a daily board round. Service Improvement will be working with directorates and wards teams to help them agree plans to ensure all patients receive a senior review and plan every day on all wards and that these board rounds meet a local gold standard.

The Trust is a partner in the Sheffield Delayed Transfer of Care Programme (why not home, why not today?), aiming to enable more people to leave hospital immediately on the day that they no longer need hospital treatment and enable a greater proportion of people to be able to return safely to their own home. Routes out of hospital have been simplified to three main routes and four wards are involved in piloting these along with earlier discharge planning. A ward metrics dashboard has been created with the Trust's Information Services Department to enable the impact of these changes to be assessed.

2.3 Priorities for Improvement 2018-19

The priorities for improvement 2018-19 have been agreed by the Quality Board in conjunction with patients, clinicians, governors and Healthwatch Sheffield. These were approved by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, in February 2018.

The Quality Board will review quarterly progress reports on all Trust priorities for improvement, providing advice and support where necessary to ensure the project achieves its goals within agreed timescales.

A total of 13 priorities for improvement, these span the domains of patient safety, clinical effectiveness and patient experience. The priorities for improvement 2018-19 are as follows:

Safety:

- Reduce inpatient falls during 2018-19 by 10%.
- Develop a human factors plan which will have practical application and lead to tangible improvements in safety culture.
- Demonstrate a 30% improvement in the early recognition and management of sepsis within the Trust.
- Ensure a Trust wide reduction by 10% of all avoidable patient harm associated with pressure ulcer prevention and management.
- Improve recognition and timely management of deteriorating patients leading to improved care- Implement an electronic system for tracking patients' observations.
- Reduce preventable Acute Kidney Injuries (AKIs) across the Trust (three year plan).

Patient Experience:

- Implement and evaluate at least one major co-production project and develop a plan for embedding this approach more widely.
- Ensure that End of Life Care is individualised and meets the needs of both patients and those who are important to them.
- Ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, and meet the needs of both patients and national good practice guidelines.
- Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard. These people are often those who need our services most but with whom we engage the least.
- Increase the availability of high quality refreshment facilities in outpatients including hot drinks.

Effectiveness:

- Improve the process and quality of consenting with a focus on ensuring patients are provided with individualised information.
- Ensure that the Sheffield Teaching Hospitals Procedure Safety Checklist is embedded into practice, aiming to reduce errors and adverse events, and increase teamwork and communication.

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve consenting

Improvement Goal: Improve the process and quality of consenting with a focus on ensuring patients are provided with individualised information

Quality Domain	Effectiveness
Senior Lead	Associate Medical Director, Safety
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Contact each Care Group to confirm which procedures and treatment require written consent. In addition identify which procedures and treatments requiring written consent are appropriate for delegated consent. • 40% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to develop the combined procedural/ treatment specific patient information leaflet and consent form. • Review existing Trust written consent forms.	• Work with Medical Education to map delegated consent education and training package currently available or identifying any packages that need updating or developing. • 60% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to review and approve the combined procedural/treatment specific patient information leaflet and consent form. • Consult with Trust solicitor and clinicians on proposed revisions to the existing Trust written consent forms.	• Update and develop delegated consent education and training packages. • 80% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to implement the combined procedural/treatment specific patient information leaflet and consent form. • Trust to approve final version the revised Trust written consent forms.	• Re-launch the delegated consent process and education and training packages. • All specialities engaged in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to audit the combined procedural/ treatment specific patient information leaflet and consent form. • Re-launch revised Trust written consent forms.

Outcome Measures

- Increase compliance rates in the consenting process.
- 100% of Clinical Directorates are engaged with the Clinical Effectiveness Unit to develop/implement processes to undertake the Trustwide Consent Audit.
- 100% of pilot sites have embedded the new combined patient information leaflet / procedure specific consent form.

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce errors and adverse events in interventional procedures

Improvement goal: Ensure that the Sheffield Teaching Hospitals Procedure Safety Checklist is embedded into practice aiming to reduce errors and adverse events, and increase teamwork and communication

Quality Domain	Effectiveness
Senior Lead	Associate Medical Director, Safety
Operational Lead	Nurse Director
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Review and update STH Safer Procedure Policy including standardisation of the Procedure Safety Checklist and audit tool. • Develop local induction programme for relevant new starters that participate in defined invasive procedures including competency development. • Upload on PALMS an online learning programme for the WHO Safer Surgery Checklist for all relevant staff to demonstrate an understanding of and compliance with the 5 steps to safer surgery/ procedure according to the World Health Organisation's (WHO) guidelines, procedural checklists and supporting documentation.	• Ratify and issue STH Safer Procedure Policy. • Implement local induction programme for relevant new starters including issue of competency to staff. • Ensure that the PALMS online learning programme is built into job specific training.	• All relevant areas engage in monitoring compliance and effectiveness with the STH Safer Procedure Policy. • Monitor compliance of local induction programme for new starters. • Monitor the compliance of completing the PALMS online learning programme.	• All relevant areas implement local action plans. • Evaluate local induction programme and competency for new starters. • Review and act upon levels of compliance with completing the PALMS online learning programme.

Outcome Measures

- Increase compliance in the procedural safety checklist audit across all areas.
- Reduce the number of errors and adverse events reflected in the incident data on Datix
- Reduce the level of risk associated with the audit outcomes as registered on Datix
- Access PALMS online learning programme to monitor compliance of staff completion of packages

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve working in partnership with our patients, their families and carers towards shared goals.

Improvement Goal: We will build on our experience of co-production, working in partnership with our patients, their families and carers towards shared goals. We will implement and evaluate at least one major co-production project and will develop a plan for embedding this approach more widely. We will use NHS England's recognised 'Always Event' methodology to support co-production work.

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Planning • Identify an oversight committee (PEC) • Select a pilot unit (Spinal Injuries) • Identify staff to be part of the Always Event • Identify possible opportunities for improvement • Create over-arching plan including schedule of meetings and timeline of key actions to ensure project delivery • Establish ground rules to ensure patients are equal partners throughout the process • Plan 'kick start' event involving patients and staff	Co-design • Hold 'kick start' event to help understand what matters most to patients. From this event, identify patients who want to be involved on an ongoing basis. • Convene working group to include patients and staff • Identify priorities for change • Collaborate with staff, patients family members and carers to co-design a meaningful improvement • Develop an Aim Statement • Define how the improvement will address what matters to patients • Ensure the improvement meets the four criteria outlined in the NHS England Always Event tool kit which are: Important, Evidence-based, Measurable, and Affordable and Sustainable	Implementation • Implement improvement • Define measures (key indicators) to demonstrate improvement • Observe and redesign processes as needed, to increase reliability • Create a system to ensure improvement happens for every patient, every time • Ensure systems are sustainable	Evaluate • Use measures and assess progress/ success • Create summary of the Always Event methodology • Measure experience of involvement with the Always Event (patients and staff) • Measure experience following changes to service (patients and staff)

Outcome Measures Year 1

- Completed and evaluated an Always Event in selected areas
- Positive experience following changes made to service (patient and staff)
- Increased patient and staff satisfaction across key indicators
- Positive experience of being involved with the Always Event (patient and staff)

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: To further improve End of Life Care

Improvement goal: To ensure that End of Life Care is individualised and meets the needs of both patients and those who are important to them.

Quality Domain	Patient Experience
Senior Lead	Clinical Leads
Operational Lead	Service Improvement Lead
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Continue roll out of Core Nursing care plan, including Section 12 for End of Life Care, in Lorenzo • Evaluate the pilot of the 'Individualised plan of care for the last days of life' • Introduce E-learning programme for End of Life Care Undertake a review of end of life care-related complaints • Carry out surveys via End of Life Care feedback cards • Continue engagement with the DNACPR Committee regarding respect form and future developments • Disseminate findings of clinical audit report evaluating the completion of the DNACPR form	• Complete roll out of Core Nursing care plan, including Section 12 for End of Life Care, in Lorenzo across the Trust • Develop education and training to support launch of the 'Individualised plan of care for the last days of life' and Section 12 • Continue surveys via End of Life Care feedback cards and evaluate results • Continue engagement with the DNACPR Committee regarding respect form and future developments	• Launch the 'Individualised plan of care for the last days of life' to all staff • Provide Education and training for the 'Individualised plan of care for the last days of life' and section 12 • Monitor use of and evaluate success of Section 12 (including preferred place of care and death) • Continue to develop education and training resources to support 'Individualised plan of care for the last days of life' and section 12 and additional learning as identified by evaluation • Continue engagement with the DNACPR Committee regarding respect form and future developments	• Undertake review of notes and clinicians survey 'how was it for them?' • Amend Section 12 based on evaluation and target further education and training in areas requiring this • Continue to develop education and training resources to support 'Individualised plan of care for the last days of life' and section 12 and additional learning as identified by evaluation • Continue engagement with the DNACPR Committee regarding respect form and future developments • Re-launch full bereavement survey

Outcome Measures

- Suite of education and training and the 'Individualised plan of care for the last days of life' launched to all staff
- Results of complaints review
- Results of the End of Life Care survey feedback card

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve communication with patients

Improvement Goal: To ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, meet the needs of both patients and national good practice guidelines

Quality Domain	Patient Experience
Senior Lead	Performance and Information Director
Operational Lead	Deputy Transformational Lead
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Complete review of current letters held within Lorenzo • Understand the system configuration potential for amendment and presentation of letters • Produce a list of standard letter templates • Undertake a cull of all unused letters, as agreed at the Lorenzo User Group • Produce a sample letter, in a format suitable for post, email and Xerox hybrid mail • Consult patient views on the new format	• Amend sample letter, taking account of patient views • Test new format and content • Amend all outpatient letters to comply with new format and content • Produce a Standard Operating Procedure (SOP) for the use of the new letters, and for any future amendments • Roll out new letters across all services • New outpatient letters in use	• Evaluate impact of new letters – patient views, service views etc. • Begin to review content of in-patient letters • Undertake a cull of all unused I/P letters, as agreed at the Lorenzo User Group • Produce a sample letter, in a format suitable for post, email and Xerox hybrid mail • Consult patient views on the new inpatient letter format	• Amend sample letter, taking account of patient views • Test new format and content • Amend all inpatient letters to comply with new format and content • Produce a SOP for the use of the new letters, and for any future amendments • Roll out new letters across all services • New inpatient letters in use • Undertake patient survey to evaluation the new letters

Outcome Measures

- All new out-patient and in-patient letters changed to new, agreed format
- SOP for the use of the new letters, and for any future amendments, developed and communicated to staff
- Evidence of patient involvement
- Completed evaluation of the new letters

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard. These people are often those who need our services most but with whom we engage the least.

Improvement goals:

Year 1: Establish an engagement network database which provides quick and easy access to large numbers of people and groups, including seldom heard groups.

Year 2: Pilot this new model focussing on one seldom heard group, evaluate the model and publicise for wider use across the Trust.

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Research • Research best practice in engagement with seldom heard groups. • Liaise with Healthwatch Sheffield to understand their programme of work in this area and their engagement database. • Review existing databases of networks including the Sheffield Citizen Portal • Review Trust support groups such as SHOC (cardiac surgery) and epilepsy support group • Liaise with the Foundation Trust Manager to explore increased engagement with Foundation Trust members	Proposal • Consider IT issues/ solutions, maintenance of network database, consent and other Information Governance issues • Prepare options appraisal for engagement model, consult and agree final proposal.	Set up • Build, develop and populate engagement database • Develop Standard Operating Procedure for its use	Pilot • Liaise with relevant organisations such as Healthwatch and Public Health to understand local demographics and priority groups • Analyse Trust patient demographics including DNAs to understand specific groups who are not engaging with the Trust • Agree a pilot of the new model with one topic

Outcome Measures

- Engagement database set up and operational
- Positive feedback from voluntary and community sector, Healthwatch and Foundation Trust members about the model

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve patient experience of outpatient areas

Improvement Goal: Increase the availability of high quality refreshment facilities in outpatients including hot drinks

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Patient Experience Coordinator
Objective timescale	1 year

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
• Survey outpatient areas to understand current patient, family and carer requirements and views • Review the current market for options to offer additional refreshment facilities in outpatient areas	• Select a method for offering refreshment facilities to pilot in two to four outpatient areas across the Trust • Put new refreshment facilities in place in pilot areas	• Undertake a survey within pilot areas to seek patient, family and carer (along with staff) feedback to evaluate the new facility	• If successful embed the new refreshment facilities in the two pilot sites. • Undertake a Trust-wide scoping exercise in relation to the various possible refreshment solutions in different outpatient areas and prepare a proposal for rollout.
Outcome Measures			
• Completed outpatient survey demonstrating an improvement in access to refreshments • Improved patient, family and carer satisfaction with outpatient refreshment facilities			

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce inpatient falls

Improvement goal: Reduce inpatient falls during 2018-19 by 10%

Quality Domain	Patient Experience
Senior Lead	Consultant Geriatricians
Operational Lead	Consultant Geriatrician
Objective timescale	12 months and then ongoing

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Agree changes to current version of falls documentation within Lorenzo • Draw up Trust response to results of Second National Audit of Inpatient Falls (NAIF2) • Pilot changes to improve weekly updating of falls risk for inpatients (in response to first audit of bedrail use). • Increase wards participating in Safety/ Falls Huddles in GSM and MAPS through identification of Safety Huddle coaches to increase engagement and provide on-going support for frontline teams.	• Begin Service Improvement process to improve implementation and recording of actions to address falls risk factors (from NAIF2) • Share Yorkshire evaluation report. Share data for previous two-year period to demonstrate improvements to date.	• Continue Service Improvement process to improve implementation and recording of actions to address falls risk factors (from NAIF2) • Re-audit of bedrail use and updating of falls risk assessment	• Review falls documentation within Lorenzo to ensure they are still appropriate • Review results of actions to improve implementation and actions from NAIF2 • All wards in MAPS and GSM engaged in Safety/ Falls Huddles

Outcome Measures

- Reduce inpatient falls by 10% compared with 2016-17 (Maximum limit of 4000 in 2018-19)
- Reduce inpatient hip fractures by 10% compared with 2016-17 (Maximum limit of 39 in 2018-19)

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Further develop the safety culture across the Trust

Improvement goal: Develop a human factors plan which will have practical application and lead to tangible improvements in safety culture

Quality Domain	Safety
Senior Lead	Head of Patient and Healthcare Governance and Associate Medical Director, Safety
Operational Lead	Patient Safety Manager
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Work with an appointed consultancy to undertake a review of human factors with a focus on action planning from incident investigations • Research trusts who have developed a human factors approach and draw learning from them • Research literature in relation to human factors • Scope the current provision of human factors training within the Trust • Undertake a skills assessment of trainers providing human factors training • Review any previous culture study work undertaken within the Trust • Agree measures of success and impact measures	• Identify any potential areas for immediate gains • Identify priority areas for human factors development and the practical application of human factors principles and techniques • Develop a human factors plan based on recommendations from the review and on learning from literature and from other trusts • Obtain examples of good practice in human factors training from within the Trust and share • Assess capacity to provide human factors training across the Trust • Undertake focussed work with risk/ governance leads to question elements of human factors when undertaking investigations and agreeing action plans • Determine options on how best the Trust can provide human factors expert knowledge (eg buy in, or employ 'expertise)	• Implement any immediate gains/quick wins • Develop a human factors implementation plan with timescales and commence implementation • Undertake baseline safety culture surveys in departments where human factors developments are going to take place • Commence work with departments were no human factors training is currently taking place	• Demonstrate initial changes, including examples of practical changes, as a result of the human factors plan • Human factors to be considered and recorded in all moderate or above incidents

Outcome Measures

- Human factors plan completed with clear, practical applications
- Success/impact measures are agreed and include practical measures

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce overall harm from avoidable pressure ulcers

Improvement Goal: To ensure a Trust wide reduction by 10% of all avoidable patient harm associated with pressure ulcer prevention and management.

Quality Domain	Safety
Senior Lead	Deputy Chief Nurse
Operational Lead	Lead Clinical Nurse Specialist Tissue Viability
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Agree annual work plan for 2018/2019 • Reset goals for pressure ulcer reduction with each ND to be incorporated into the Nursing Quality Dashboard • Change reporting to reflect actual numbers of pressure ulcers and patient harm • Revise Pressure ulcer prevention policy to ensure it is fit for purpose. • Roll out agreed documentation strategy via e care planning when in use. • Develop a plan for implementation of react to red across the home care sector • Review the pilot of combined P1&P2 documentation. • Refocus the tissue viability workload into provision of specialist advice • Complete work relating to NHSI pressure ulcer collaborative and establish plan for organisational spread of learning • Establish Share point site for all educational materials in relation to pressure ulcer prevention and management • Complete the integration of acute and community tissue viability teams, to ensure seamless reviews throughout the health community. • Agree an educational strategy for Pressure ulcer prevention and management • Review Incident reporting processes to embed Root cause analysis tools within the system • Pressure Ulcer Prevention and Management Group (PUPMG) to formalise case study reviews to aid learning	• Review and establish with PUPMG a process for a "learning review" or "check and challenge" of patient harm in relation to hospital acquired pressure ulcers. • Continue educational roll out plan to embed in directorates • Establish a regular method of auditing pressure ulcer prevention and management within the acute directorates (linked to accreditation) • Ensure investigation of pressure ulcers is completed within a timely fashion • Reduce timescales for completion of all root cause analysis (RCAs) from 6 weeks to 28 days. • Establish a process of RCAs including an embedded form in Datix for Grade 2 pressure ulcers trust wide, led by ward sister's charge nurses. • Embed agreed documentation strategy • Establish a plan for implementation of photography in pressure ulcer prevention, management and wound care within STH.	• Launch process of clinical accreditation to include all aspects of pressure ulcer prevention and management • Contribute specialist tissue viability advice to the review of specialist mattresses trust wide. • Ensure that the process for ordering specialist equipment is robust and timely. • In conjunction with the Trust wound group and procurement agree a trust standard formulary for wound management products trust wide • Complete embedding of learning from NHSI pressure ulcer collaborative. • Review goals for pressure ulcer reduction with each ND. • Agree a method with acute and community for ensuring that data collection around trust attributable pressure ulcers is robust to inform future decisions.	• Evaluate e care planning of tissue viability interventions to ensure that new processes are embedded and effective • Evaluate effectiveness of educational strategy • Agree formal work plan priorities for 2019/2020 • Set goals for pressure ulcer reduction with each ND. • Submit proposal to Nurse Executive Group to consider a Zero tolerance approach for 2019/2020. • Complete implementation of react to red across the care home sector

Outcome Measures

- Development of pressure ulcer prevention annual work plan and education strategy
- 10% reduction in all avoidable patient harm associated with pressure ulcer prevention and management.
- Sustained reduction in avoidable harm related to pressure ulcers across STH

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduction in sepsis

Improvement goal: Demonstrate a 30% improvement in the early recognition and management of sepsis within the Trust

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Lead Nurse, Sepsis
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• On-going patient identification and data collection. • Feedback on current screening tool. • Examine an electronic feedback mechanism for the Trust on compliance to screening and care delivery. • Develop multimedia educational tools to maintain resilience	• Promote effective use of current electronic systems within the Trust to identify patients as having sepsis. • Re develop the screening tool to ensure compliance in its use. • Develop a dashboard will need support from the Trust and extract data from current spreadsheets. • Consider mandatory element of sepsis education.	• Expand sharing of data with deteriorating patient and AKI leads. • Re launch new deteriorating patient tool and changes • Develop the dashboard and provide training for wards. • Develop educational material and enter on PALMS	• Ensure data collected demonstrates change. • Continue to examine compliance through data collection. • Continue feedback mechanisms to ward areas. • Maintain registration of education through PALMS.

Outcome Measures

- 90% of identified patients who deteriorate with an infection will have been screened for sepsis and will have received appropriate treatment within one hour.
- An electronic feedback system for wards to monitor compliance with the deteriorating patient and sepsis will have been developed
- 80% of clinical staff will have received education on sepsis and an update to maintain resilience.
- 30% improvement in the early recognition and management of sepsis within the Trust

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improved recognition and timely management of deteriorating patients

Improvement goal: Improved recognition and timely management of deteriorating patients leading to improved care- Implement an electronic system for tracking patients' observations

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Patient Safety Manager
Objective timescale	One year

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
• Convene a project working group with representation from Informatics, Operational Change, Strategy & Planning, Safety, Nursing and Medical • Identify inter-depencies of Trust systems including Mobile Devices • Scope the capabilities of the Lorenzo system	• Commence discussions with Lorenzo developer • Establish a 'first of type' case to facilitate the access to further potential external funding stream • Understand the impact of a Track and Trigger System • Convene a project working group for the implementation of NEWS 2	• Determine the requirements of the system and compare this with the current infrastructure within the Trust • Clarify the role out strategy for NEWS 2 • Roll out the New Vital Signs monitors	• Begin trials of the new system in a selected area • Implement NEWS 2
Outcome Measures			
• Improved recognition of deteriorating patients and timeliness of intervention			

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Achieve an absolute reduction in the prevalence of preventable Acute Kidney Injury (AKI) in the Trust

Improvement Goal: Three year plan set as a reduction in preventable acute kidney injuries (AKIs) across the Trust

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Three years

Work plan

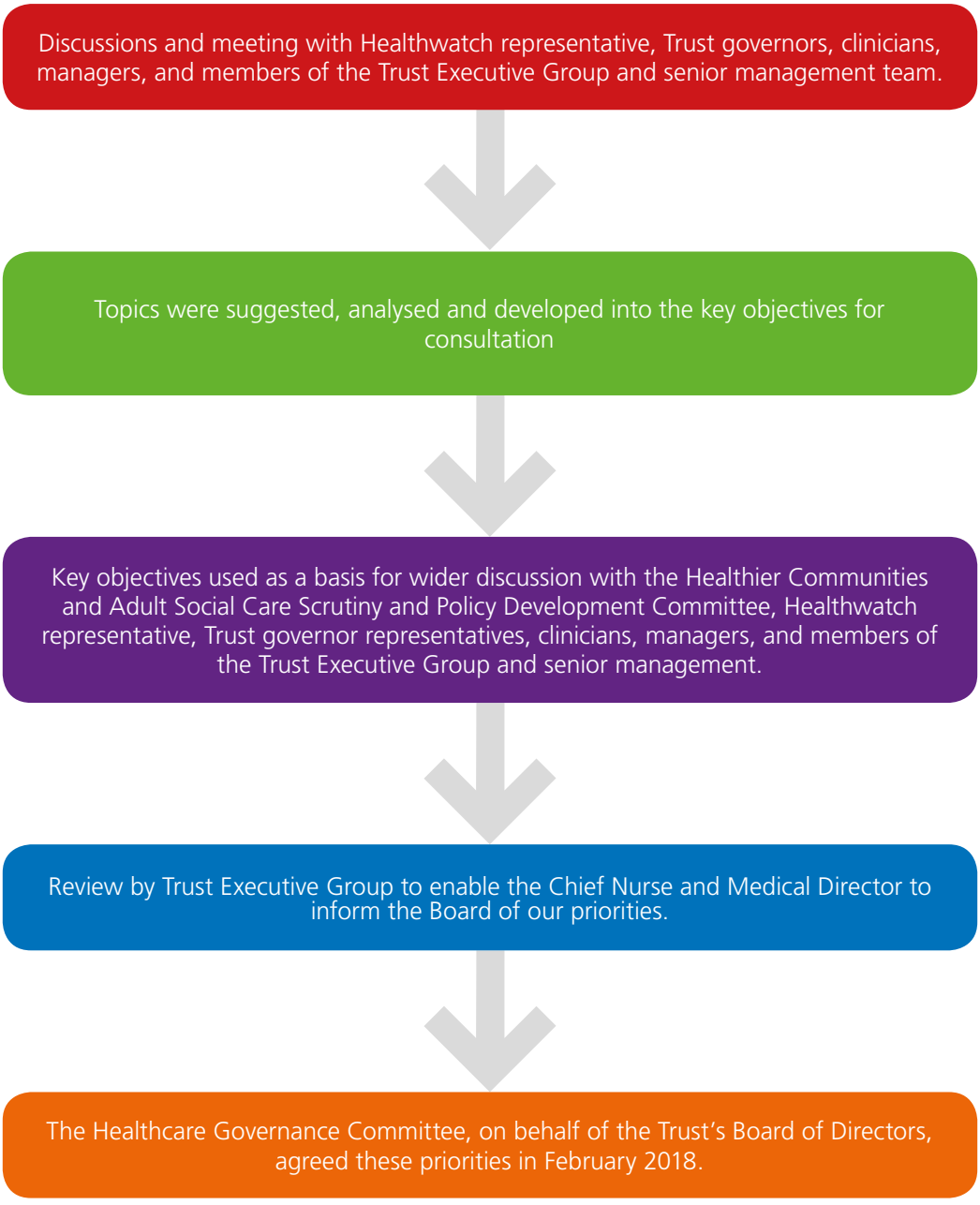
This objective spans the lifetime of the Quality Strategy. In 2018-2019 a reliable baseline measure of the prevalence of preventable AKI will be defined which will provide a springboard for improvement targets to be set. This will involve review of patients referred to the renal physicians with AKI followed by a retrospective case note review on the management of these patients. It will also include the determination of the number of elective patients flagged as being at risk of developing AKI and those who then go on to develop AKI during their inpatient stay.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Plan and register a project with the Trust Clinical Effectiveness Unit to obtain a baseline of preventable AKI. • Pull together a steering group to oversee the project. • Create and pilot a data collection tool. Pilot to the tool on renal referrals for AKI.	• Data collection for project - Undertake retrospective case note review on the management of patients referred to renal physicians with AKI, to include; • Retrospective case note review of management prior to referral • Auditing of whether management was in line with Acute Kidney Injury Policy • Assessment of current staff engagement with AKI care bundle checklist, extrapolating if this improves compliance with AKI policy treatment protocols	• Identify ward/wards with highest referral rate for quality improvement project (QIP) • Identify junior Dr/nurse on selected wards for QIP data collection • Design QIP. • Carry out two quality improvement cycles to identify which improvements are most effective	• Implementation and monitoring of change • QIP to continue and complete. • Action planning for year two, including setting improvement targets.

Outcome Measures

- Established baseline of the prevalence of preventable AKI.
- Completed quality improvement project
- Plan, included improvement targets, for 2019-20.

2.5 HOW DID WE CHOOSE THESE PRIORITIES?



2.6 Statements of assurance from the Board

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

a) Services Provided
b) Clinical Audit
c) Clinical research
d) Commissioning for Quality Improvement (CQUIN) Framework
e) Care Quality Commission
f) Data Quality
g) Learning from Deaths
h) Patient Safety Alerts
i) Staff Engagement
j) Annual Patient Surveys
k) Complaints
l) Friends and Family Test
m)Mixed Sex Accommodation
n) Coroners Regulation 28 (Prevention of Future Death) Reports
o) Never Events
p) Duty of Candour
q) Safeguarding Adults
r) Seven Day Service

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

a. Services Provided

During 2017-18, the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 50 relevant health services. The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 50 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2017-18.

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

b. Clinical Audit

During 2017-18, 58 national clinical audits and four national confidential enquiries covered relevant health services that Sheffield Teaching Hospital NHS Foundation Trust provides.

During that period Sheffield Teaching Hospital NHS Foundation Trust participated in 100% of 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 Hospital NHS Foundation Trust was eligible to participate in during 2017-18 are documented in table three.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2017-18, 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.

Table Three

Audits and Confidential Enquires	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Case Mix Programme (CMP)	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Major Trauma Audit	Yes	100%*
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):		
Heart Failure	Yes	100%
Young People's Mental Health	Yes	100%
Chronic Neurodisability	Yes	93%
National Emergency Laparotomy Audit (NELA)	Yes	46%* See supporting statement
National Joint Registry (NJR)	Yes	82.6%*
National Neurosurgery Audit Programme	Yes	100%
National Ophthalmology Audit	Yes	100%
Nephrectomy audit	Yes	92%
Percutaneous Nephrolithotomy (PCNL)	Yes	100%
Cystectomy Audit	Yes	100%
National Bariatric Surgery (NBSR)	Yes	100%
Female Stress Urinary Incontinence Audit	Yes	100%*
Urethroplasty Audit	Yes	100%*
Radical Prostatectomy Audit	Yes	76%
Fracture Neck of Femur	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme:		
Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	100%
Blood and Transplant		
Bowel Cancer (NBOCAP)	Yes	90*
Head and Neck Cancer Audit HANA	Yes	100%*
National Lung Cancer Audit (NLCA)	Yes	100%*
National Prostate Cancer Audit	Yes	91%*
Oesophago-gastric Cancer (NAOGC)	Yes	70%* See supporting statement
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Audits and Confidential Enquires	Participation N/A = Not applicable	% Cases Submitted
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%*
Adult Cardiac Surgery	Yes	100%*
Cardiac Rhythm Management (CRM)	Yes	100%*
Congenital Heart Disease (CHD)	Yes	100%*
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%*
National Cardiac Arrest Audit (NCAA)	Yes	94%
National Heart Failure Audit	Yes	82%*
National Vascular Registry:		
National Carotid Interventions Audit	Yes	98%
Abdominal Aortic Aneurysm (AAA)	Yes	81%
Peripheral Vascular Surgery – Lower limb angioplasty/stenting	Yes	55%
Peripheral Vascular Surgery – Lower limb bypass	Yes	90%
Peripheral Vascular Surgery – Lower limb amputation	Yes	41%
Pulmonary Hypertension Audit	Yes	100%
Long Term Conditions		
Chronic Kidney Disease in primary care	N/A	N/A
Inflammatory Bowel Disease (IBD) programme	No	See supporting statement
National Audit of Dementia	Yes	100%
National Diabetes Audits:		
National Diabetes Audit :Insulin Pump	Yes	100%
National Diabetes Foot care Audit	Yes	50%*
National Diabetes Inpatient Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Audit - Adults	Yes	100%
Renal Replacement Therapy (Renal Registry)	Yes	100%*
UK Cystic Fibrosis Registry	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)Secondary Care	Yes	100%*
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) Pulmonary Rehab	Yes	83%
UK Parkinson's Audit	Yes	100%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Mental Health		
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	100%
Mental Health Clinical Outcome Review	N/A	N/A
Prescribing Observatory for Mental Health (POMH-UK)	N/A	N/A

Older people		
Falls and Fragility Fractures Audit programme (FFFAP):		
National Hip Fracture Database	Yes	100%
National In Patient Falls	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	90%**
National Audit of Intermediate Care (NAIC)	Yes	79%

Other		
Elective Surgery (National PROMs Programme)	Yes	89.5%*
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%

Women's and Children's Health		
Child Health Clinical Outcome Review Programme	N/A	N/A
Diabetes (Paediatric) (NPDA)	N/A	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Paediatric Intensive Care (PICA Net)	N/A	N/A
Paediatric Pneumonia	N/A	N/A
Pain in Children	N/A	N/A

Please note the following

*Data for projects marked with * 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 SNNAP quarterly reports.

Supporting statements

National Emergency Laparotomy Audit (NELA):

Case ascertainment is increasing. The clinical team continue to address challenges with data upload. This should increase data submission to the NELA in 2018-19.

There are a number of issues in relation to case ascertainment for this audit. Reasons for this include web access issues at time of procedure for all surgeons likely to perform an emergency laparotomy, the number of surgeons involved in delivering emergency surgery, and the complexity of data requirements from surgeons and anaesthetists across the full pathway of care. Also the high volume of surgical procedures carried out at the Trust means that the associated audit workload is high within the directorates concerned. The Clinical Effectiveness Unit has maintained a continuous dialogue with the directorates and has provided administrative support, however much of the data collection requires clinical interpretation and consequently the audit continues to fall below expected case submission numbers. Examples where trusts have achieved good case ascertainment include those who have appointed a data co-ordinator with clinical expertise to assist with data collection / follow-up and to ensure each patient is entered onto the database as they present.

Oesophago-gastric Cancer (NAOGC):

Case ascertainment is lower than 100%. Patients diagnosed in District General Hospitals and treated at STHFT, are included in the DGH submission figures to NAOGC, as opposed to STHFT. This is directed by the National Audit.

IBD Registry:

Resource to upload information to the IBD registry has been limited in 2017-18. The Directorate continue to look at ways to engage effectively with the IBD Registry. This has included appointment of additional IBD specialist nurses and additional administrative time. This should increase data submission to the Registry in 2018-19.

The reports of 32 national clinical audits were reviewed by the provider in 2017-18 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided in the examples included below:

The National Pregnancy in Diabetes (NPID) audit

The National Pregnancy in Diabetes audit is a continuous data collection measuring the quality of care and outcomes for women with pre-gestational diabetes when they become pregnant. The audit measures against national standards set out in the NICE (National Institute for Health and Care Excellence) guideline NG3, previously NICE Care Guideline CG63. The audit seeks to address three key questions:

- Were women adequately prepared for pregnancy?
- Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?
- Did any adverse outcomes occur?

The results of the audit found that 69% (95/137) of mothers with type 1 and type 2 diabetes became pregnant with a HbA1c higher than 48 mmol/L and therefore had an increased risk of miscarriage, pre-term labour, congenital malformation, stillbirth and neonatal death. The audit also found that 58% (80/139) of women with diabetes who are pregnant did not receive immediate contact with a joint diabetes and antenatal clinic (<10 weeks gestation). Due to this they missed out on one or more of the following - early medication review; ensuring 5mg folic acid was being taken daily; early Ultra Sound Scan; HbA1c; advice on good diabetes control.

Women with diabetes have an increased risk of having a pregnancy affected by a neural tube defect (NTD). The audit found 50% (69/137) of patients did not start folic acid prior to pregnancy and therefore had a further increased risk of having a pregnancy affected by NTD.

The Trust, in collaboration with Sheffield CCG, is taking the following actions to make improvements:

- Produce E-bulletins to:

  Advise GP's to use Diabetes Anti Natal Clinic referral via the CCG web site for referring women with pre-existing diabetes

  Publicise the pathway
- Introducing an information prescription in SystmOne – this will be designed by the diabetes team and implemented by the CCG and Primary Care Diabetes Leads
- Display Safer Campaign posters in all GP practices
- Ensure a Safer Campaign patient information leaflet is available in all GP practices
- Design preconception cards with contact numbers for the diabetes team and for preconception advice. These will be designed by the diabetes team, funded by the CCG and will be available in all GP practices.

The Trust continues to work with Primary Care to ensure type 1 and type 2 diabetic women:

- Start 5mg of folic acid daily before becoming pregnant
- Keep HbA1c below 48 mmol/mol
- Stop oral glucose-lowering medications apart from Metformin before becoming pregnant and stop statins and ACE inhibitors/ARBs before becoming pregnant
- Are offered immediate contact with a joint diabetes and antenatal clinic (<10 weeks gestation)

STHFT has been successful with an application to join the National Diabetes in Pregnancy Quality Improvement Collaborative.

National Diabetes Insulin Pump Audit

The Insulin Pump Audit is part of the National Diabetes Audit programme, and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit programme. The National Diabetes Audit is managed by NHS Digital in partnership with Diabetes UK and is supported by Public Health England.

The Insulin Pump Audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump.

National standards for the use of insulin pumps were set out in NICE guidance - Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (NICE technology appraisal guidance [TA151] Published date: July 2008).

45.4% of STHFT pump patients received all eight diabetes care processes in 2015, compared to 39.9% nationally (the standard is 100%). STHFT are performing above the national average however, 54.6% of STHFT pump patients failed to receive one or more of the eight care processes. This means that one or more modifiable risk factors of long-term diabetes-related conditions cannot have been assessed.

STHFT are taking the following actions to make improvements:

- As part of ongoing improvements for the STH Diabetes department as a whole, the template used in SystmOne has been updated so that any missing care processes are immediately apparent when a doctor or Diabetic Specialist Nurse goes into a patient record to record any data.
- Outpatient support staff are routinely completing the smoking status form, and know which patients require a urine sample for ACR measurement.
- Analysis of local data as some patients do not consent for inclusion within the National Audit data set. The national data set may not be considered a true reflection of the overall outcomes for the Trust patients.
- Trial of Drop-In Clinics for Under 25 year olds.
- Increasing administrative support.

The Trust expects to see an improvement in outcomes in the next round of the published National Audit.

UK Registry of Endocrine and Thyroid Surgery (UKRETS)

It is a requirement of the HQIP that all thyroid operations are entered onto UKRETS as thyroid surgery has been chosen by the Chief Medical Officer to be one of 13 specialties where consultant level outcomes should be openly available for public viewing.

The outcomes for surgeons at the Trust are better than the national average. A number of local audits looking at subgroups of patients within this larger cohort have been carried out where we have examined a number of specific outcomes including nerve damage rates and hypoparathyroidism in much greater detail than the national audit.

On the basis of local audits, the Trust has implemented several changes to local practice including establishing and validating protocols for post-thyroidectomy hypocalcaemia and practice around perioperative laryngoscopy. These changes have helped in reducing adverse events and length of stay in hospital.

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 are also continually collected and submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk United Kingdom). The Trust has a 100% participation rate.

Local Clinical Audits

The reports of 428 local clinical audits were reviewed by the provider in 2017-18 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of security of medicines in clinical areas

During their inspection in December 2015, the CQC identified that 'Intravenous fluids were not always stored safely and securely' and issued a 'MUST DO' action for the Trust to ensure the safe storage of intravenous fluids. This prompted the requirement to obtain a comprehensive understanding of the scale of the issue across the Trust.

An audit to determine whether the storage of medicines at ward level complies with the national standards was undertaken. A member of the pharmacy governance team and the Trust Security Manager carried out unannounced visits to 90 ward areas. One area was excluded as it was due to close for full refurbishment in the near future. A standard pro forma was used to assess compliance. Information was also gathered about the type of security mechanisms in use (e.g. key, proximity reader, PIN code), and whether non-medicines were also stored in rooms containing medicines on open shelving.

This audit has demonstrated that whilst the majority of areas have a mechanism for securing all medicines, a significant number of areas do not keep the facilities locked. Where proximity card readers have been installed compliance with locking the medicine rooms is 95%, compared with 33% where other security mechanisms are used. The Medicine Safety Committee has therefore recommended that proximity card readers be installed to all medicine room doors, and a business case has been approved to take this forward.

Audit of Surgical Safety Checklist

As an organisation the Trust has implemented the World Health Organisation's Surgical Safety Checklist (SSC) as a

mechanism to reduce patient adverse events and improve patient safety in the perioperative setting.

In 2008, the World Health Organisation (WHO) launched the "Safe Surgery Saves Lives" campaign as a drive to reduce the number of surgical deaths across the globe; the Surgical Safety Checklist was part of this initiative. The checklist consists of five steps which are: - "Team brief," which occurs prior to the commencement of surgery and facilitates the transfer of crucial information to all multi-disciplinary team members. The "Sign-in" then provides a verbal check of patient details prior to induction of anaesthesia. The "Time-out" is where all members of the team confirm together the planned procedure prior to surgical incision. Following surgery the "Sign-out" is completed, where the team verbally check that the correct procedure has been recorded. The final step is the "debrief", where all aspects of the operating day can be discussed in detail.

The efficacy of the Surgical Safety Checklist is dependent upon a number of factors such as optimal communication, effective team working and the participation of the surgical team working collaboratively to minimise risks and harm associated with surgical procedures.

The aim of the audit was to measure the compliance to the STHFT Safer Procedure Policy and identify and address any problems with compliance. A rapid cycle audit was undertaken from May 2017–December 2017 through three cycles of data collection. The first cycle highlighted shortfalls in compliance with the audit standards. When the risk was identified and investigated it was highlighted that:

- Team brief and debrief were not used effectively
- Cases were not discussed on an individualised basis.

A comprehensive action plan was implemented to address the highlighted issues and a further two cycles of data collection were undertaken.

From the third cycle results, it is evident that there have been significant improvements in the Sign In, Time Out and Sign Out steps of the surgical safety checklist. Overall compliance has improved from 90.3% in cycle 1 to 97.3% in cycle 2 and 99.4% in cycle 3.

A notable improvement has been seen in the compliance rate of no distractions/interruptions during all steps of the surgical safety checklist: this includes Sign in, Time out and Sign out. The most recent audit results demonstrate 100% compliance with this standard which is an improvement from 64% for sign in, 88% for time out and 84% for sign out in cycle 1.

The Safer Surgery Checklist Audit continues to be measured to assure sustained improvements in practice.

Audit of Written Consent for Examination and Treatment

Consent must be obtained before any examination or treatment. It may be non-verbal (e.g. offering a wrist for taking a pulse), oral or written. Not all consent needs to be written, but written consent can provide evidence that consent has been discussed with the patient.

Consent is a continuous process rather than a one-off decision. It is important that patients are given continuing opportunities to ask further questions and to review decisions about their health care.

To reflect recent changes in legislation and the findings of an audit of consent which was completed by the Trust's internal auditors in 2016, the Consent to Examination or Treatment Policy was updated and ratified at the Trust Executive Group in January 2017.

A Trust wide rolling programme of audit was commenced following the policy update. The aim of the audit was to measure compliance with the STHFT Consent to Examination or Treatment Policy and to identify and address any problems with compliance. The first areas to commence auditing have now undertaken a second audit cycle and have in place agreed action plans for improvements. It was agreed at the Trust Clinical Management Board that the introduction of a combined patient information leaflet and procedure specific consent form would be piloted and five pilot sites within the Trust have been identified. The Trust has funded changes to the system used to produce the Patient Information Leaflets that will enable the leaflets to be combined with the procedure specific consent form. A combined form will provide consistency in relation to the minimum information given to patients though there is still the requirement to individualise this for each patient based upon material risks. Furthermore, the combined forms are not intended to replace the discussions that should take place with the patient. When signing the consent form the patient is agreeing to the procedure/treatment, to accepting the risks and benefits of the treatment and to having understood the alternative treatments and no treatment options. These will therefore be clearly outlined in the procedure/treatment specific patient information leaflet and further discussed with the patient. Further data collection for the audit should demonstrate improvements in compliance with the revised Trust policy.

c. Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospital NHS Foundation Trust in 2017-18 that were recruited during that period to participate in National Institute of Health Research (NIHR) Portfolio research trials was 11,908. This is 131% of our end of year target. We have made excellent progress in continuing to improve our performance.

During 2017, STH has had significant success in attracting major awards of research funds from National Institute of Health Research (NIHR), including:

- Biomedical Research Centre in Translational Neurosciences. £4.0 million over five years.
- Clinical Research Facility for Early Translational (Experimental Medicine) Research. £3.1 million over 5 years.
- Experimental Cancer Medicine Centre (ECMC). Awarded £1.0 million over five years.
- Devices for Dignity MedTech Co-operative. Awarded £1.4 million over five years.
- The Department of Health has agreed that the current contract for STH to host the National Institute of Health Research (NIHR) Clinical Research Network for Yorkshire and Humber will be extended to the end of March 2022.

During 2017, to increase the awareness of research that takes place, and to highlight how people can get involved, the Trust organised several successful events for patients and the public, and for local researchers.

- In February, we held a Research Event aimed at educating patients and the public about the benefits that research can bring. Approximately 90 patients in attendance were present to learn from leaders in their fields talk about a variety of diseases such as dementia and cancer, and the innovations and breakthroughs that are driving forward current healthcare.
- International Clinical Trials Day is held annually to celebrate the anniversary that James Lind began the first ever clinical trial. The day provides an opportunity to raise awareness of clinical research, what it means, and highlights the myriad of ways that the public can be involved in contributing to ground-breaking medical discoveries. Additionally, it highlights the breadth of research taking place Trust-wide.

In 2017, approximately 80 delegates attended our International Clinical Trials Day event where everyone had the opportunity to see how they could get involved in health research, and took part in discussions about topical research studies being conducted at STH regarding challenges faced by the NHS. To showcase the infrastructure available for conducting high quality research at STH, delegates were taken on a tour of our dedicated National Institute for Health Research funded Clinical Research Facilities.

- For our staff, we held a "Valuing Patients in Research" Workshop to educate them about Public and Patient Involvement (PPI) and to give them an opportunity to hear from patients/researchers about their experiences in PPI. Feedback from attendees was extremely positive and highlighted the benefits of holding such an event.
- In December, we welcomed over 70 patients, members of the public and staff to the public launch event of our National Institute of Health Research Biomedical Research Centre for Translational Neuroscience. This event provided an ideal platform for introducing researchers to Patient and Public Involvement representatives, and for the public to learn about the cutting-edge research that will be conducted over the coming years with the aim of improving the lives of people with chronic neurological diseases.

Following the successes of the last year, in 2018 the Trust will again hold a variety of events including one to celebrate International Clinical Trials Day where key priorities will be attracting people from Sheffield with little or no knowledge of clinical research. To further our engagement with Trust staff, we will be organising our first local Research Conference in 2018 which we hope to make an annual event.

d. Commissioning for Quality and Improvement (CQUIN Framework)

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between the 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 (CQUIN) payment framework.

Further details of the agreed goals for 2017-18 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ and https://www.england.nhs.uk/nhs-standard-contract/cquin/pres-cquin-17-19/.

In 2017-18, £17,626,537 of our contractual income was conditional on achieving the Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield CCG / NHS England. Of the 2.5% of contract income associated with the National

(CCG commissioned) CQUIN schemes, 0.5% was linked to engagement with Sustainability and Transformation Plans and 0.5% was linked to achievement of the Trust's control total. The remaining 1.5% was linked to achievement of CQUIN goals.

In total across all commissioners there were 20 different CQUIN schemes which included a focus on improving the health and well-being of staff, preventing ill health by risky behaviours i.e. use of alcohol and tobacco and the management of the prescribing of drugs for the treatment of Hepatitis C.

During 2016-17 the Trust secured £14,187k.on achieving the Quality Improvement and Innovation Goals.

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 2017-18.

Sheffield Teaching Hospitals NHS Foundation Trust has participated in the Care Quality Commission Local System Review during 2017-18.

This review relates to Sheffield health and social care systems. It asks an overarching question: 'How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?' Sheffield health and social care systems were reviewed on 5-9 March 2018. The final report following the review is yet to be published.

f. Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2017-18 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:

99.9%	For admitted patient care
99.9%	For outpatient care
97.4%	Accident and Emergency Care

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

100%	For admitted patient care
100%	For outpatient care
100%	Accident and Emergency Care

Sheffield Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit process during 2017-18.

Sheffield Teaching Hospitals NHS Foundation Trust continues with the following programmes to improve its data quality:

- The new team (the EPR and DQ Team), created to support and drive forward a coordinated Data Quality agenda across the organisation is now well established.
- The development of reporting dashboards to support improvement to Data Quality , including the Administrative Patient Safety Dashboard.
- The Data Quality Steering Group, chaired by the Assistant Chief Executive, is well established, and is supporting data quality improvement across the organisation .
- The IT Trainers have integrated with the Performance and Information function, to support users in learning from errors, and improve training to focus on data quality.
- The Administrative Profession Programme has been launched with a view to ensure all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Toolkit v.14.1 Assessment final score for 2017-18 was 71% and was graded as green and satisfactory.

g. Learning from Deaths

The National Quality Board published its guidance on Learning from Deaths in March 2017 and updated this guidance in June 2017.

The Trust Executive Group has approved a governance process for the management of the review of acute hospital deaths which involves the Medical Examiner and the Mortality Governance Committee, and requires the appointment and funding of specially trained case note reviewers. A Non-Executive Director has been appointed with the remit of Mortality Governance. These actions are all in line with national guidance.

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

The Trust reports the mandated data to the Public Board on a quarterly basis.

The Trust continues to work collaboratively with the regional group to identify mortality related issues on a local and regional basis and has increased the number of individuals who are trained in case note review.

The proposed structure for learning from deaths within the Trust will ensure that all deaths are reviewed by the Medical Examiner's Office and members of the review teams on a daily basis. This information will be collated weekly, and any reviews that raise potential concerns about an individual patient's care will undergo a second review by a different reviewer, and, where necessary, the Directorate responsible for the patient's care.

On a monthly basis the Trust's Serious Incident Group will receive information on the total number of deaths per month, including details of any where review of the patient record raised concerns about possible lapses in care. The Serious Incident Group will also receive information on the status of any investigation needed. On a quarterly basis, total deaths, total numbers of reviews and the total number of deaths in which poor or very poor care is identified will be discussed at the Trust Executive Group, the Healthcare Governance Committee and the Board of Directors. In addition, any deaths in which lapses in care were thought to have contributed to the patient's death will be identified and reported publically as per the guidance within the national framework.

At present we have trialled this process within the Medical Examiner's Office and used our expert reviewers to review those cases flagged up by the Medical Examiner's Office. Those cases which have been referred to and accepted by the coroner have not been subject to a Structured Judgement Review at this stage as per our published policy.

During 2017-18, 2,919 of Sheffield Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 667 in the first quarter; 655 in the second quarter; 742 in the third quarter; 855 in the fourth quarter.

By 31st March 2018, 1,713 case record reviews (Medical Examiner review / Structured Judgement Review) and six serious incident investigations had been undertaken in relation to the deaths included in data contained within the above paragraph. Deaths in the fourth quarter are still to be reviewed.

In six cases a death was subject to both a case record review (Medical Examiner review / Structured Judgement Review) and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

533 in the first quarter
546 in the second quarter
634 in the third quarter

Deaths in the fourth quarter are still to be reviewed.

There were no cases reviewed in quarter one that were judged to be more likely than not to have been due to problems in the care provided to the patient. Analysis of data for quarter two, three and four is ongoing.

The Trust has been instrumental in contributing to regional and national initiatives concerned with mortality issues. As a result the Trust has trained a number of hospital staff to participate in Structured Judgement Review and this review methodology is endorsed by the Trust in respect of Morbidity and Mortality meetings. A significant proportion of the Trust's Morbidity and Mortality meetings use the review method to conduct their regular meetings. The Structured Judgement Review method has been used widely within the Trust, and the future use of the RCP web-platform will allow greater clarity of the use of Morbidity and Mortality. The Trust has used this method to analyse deaths in patients with fractured neck of femur from the 2015-16 cohort.

Of the reviews of the identified deaths above, one of the key learning points has been with regard to oxygen therapy and its administration. This death remains under consideration by the coroner but key improvement work within the Trust has taken place pending the coronial inquest. This includes asking the Healthcare Safety Investigation Branch (HSIB) for assistance in addressing identified concerns. This has resulted in the HSIB taking forward a national investigation in relation to this issue. Consistent themes have also been identified and continue to inform ongoing improvement work in such areas as Sepsis, Acute Kidney Injury, End of Life Care and Patient Deterioration.

The Trust is also involved in a ScHARR research project that aims to correlate the Medical Examiner assessment of the delivery of health care in deceased patients with the output of Structured Judgement Reviews.

h. 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 four below details the Alerts and Rapid Response Reports which have been responded to during the year 2017-18.

Table Four

Reference	Title	Issued	Deadline (action complete)	Closed
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	6/4/2017	6/10/17	6/10/17
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	5/7/17	16/8/17	16/8/17
NHS/PSA/RE/2017/004	Resources to support safe transition from the luer connector to nrfit for intrathecal and epidural procedures, and delivery of regional blocks	11/8/17	11/12/17	11/12/17
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	27/9/17	8/11/17	6/10/17
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannulae after procedures	9/11/17	9/8/18	Open
NHS/PSA/W/2018/001	Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders	9/1/18	20/2/18	20/2/18
NHS/PSA/D/2016/009	Reducing the risk of oxygen tubing being connected to air flowmeters	4/10/2016	04/07/2017	Open
NHS/PSA/W/2016/010	Central Alerting System: Risk Of Death And Severe Harm From Error With Injectable Phenytoin	9/11/2016	21/12/2016	21/12/2016
NHS/PSA/W/2016/011	Risk Of Severe Harm And Death Due To Withdrawing Insulin From Pen Devices	16/11/2016	11/01/2017	11/01/2017

i. Staff Engagement

The dedication, ongoing commitment and skill of our employees are what makes our hospitals and our community services successful and we continue to appreciate the hard work that they do. We place a high priority on the health and wellbeing of our staff.

Our PROUD values and behaviours will continue to underpin the way we lead and deliver our services 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 us to work compassionately and efficiently to deliver our services.

We recognise the importance of positive staff engagement and good leadership to ensure good quality patient care so we were pleased to be shortlisted for the HSJ Staff Engagement Award in November 2017 in recognition of the work we have done on staff engagement.

During 2017 we began to consult with staff and patients about our People Strategy and we approved this at the start of 2018.

Staff Engagement and Wellbeing

The Trust is committed to developing good leaders and ensuring good staff engagement and wellbeing, as it recognises the importance of these for quality patient care and as such engaging leadership is an integral to the Trust ILM management programmes which continue to be very successful. A staff engagement session is also included on induction for all newly qualified nurses. This year a staff benefits and wellbeing site on the Trust intranet has been further developed to provide staff with easy access to information on staff engagement, rewards and benefits and health and wellbeing initiatives.

During 2017 the implementation of the Trust Staff Engagement Strategy and the Trust Health and Wellbeing Strategy have provided a particular focus on improving staff involvement, motivation and wellbeing for all staff. We continue to look at new ways of supporting our staff and this year with the help of the chaplaincy department we have introduced more mindfulness sessions for staff and managers together with health and wellbeing training for line managers which were well received. We have provided more personal resilience sessions for teams of staff and over 2,500 staff have accessed the Headspace mindfulness and meditation app. The introduction of Health checks for staff over 40 years of age as well as our continued referrals to staff physiotherapy and our new Employee Psychological Services demonstrated our commitment to caring for our staff.

Our Directorate Staff Engagement plans had a particular focus on actions to improve staff motivation through increased recognition and appreciation of staff at departmental level e.g. local recognition schemes, usage of 'Give a little thanks' our electronic recognition system as well as via our Thank You Awards and improving staff involvement through our Microsystems academy systems coaching, Give it a Go Work and the ongoing Listening into Action programme.

Staff Involvement

The Trust participated in the staff Friends and Family Test in quarter one, two and four, as well as undertaking a full census staff survey in quarter three. Engagement events have been held across the Trust during 2017-18, particularly in clinical areas to discuss the findings of the staff Friends and Family Test results. These events have resulted in staff making suggestions, leading to improvements for both staff and patients. It is pleasing to note that the Trust is now recognised as a centre of good practice in its approach, and use of the staff Friends and Family Test data, leading to improvements in both staff and patient experience. The Trust Staff Engagement Lead and Staff Surveys coordinator continue to be invited to share good practice at several NHS Employers events and this year the Trust was asked to write a case study to share practice across the NHS which was published by NHS Employers in October, 'Staff Engagement for Quality Improvement'.

The Trust Executive Group continue to spend time in clinical and non-clinical departments regularly as part of Back to the Floor to take the opportunity to meet with staff and listen to their feedback which has recently been extended to include some Non-Executive Board members. The Chairman meets regularly with the Staff Governors to seek feedback and the Board of Directors meet staff and recognise their efforts.

NHS Staff Survey

Staff engagement is measured every year via the annual NHS Staff Survey, which includes an overall score for staff engagement. This year a full census staff survey was undertaken with over 7,242 responses received with the vast majority of staff completing the survey online.

The Trust staff engagement score for 2017 increased to 3.83 which means the Trust is above average in comparison to other combined acute and community trusts.

It is encouraging to note that 81% of our staff would recommend the Trust to family and friends for treatment, this is well above the NHS average for combined acute and community trusts of 69%. Additionally 68% of our staff would recommend the Trust as a place to work, this again is above the NHS average for combined acute and community trusts of 59%.

Response Rates

2016		2017	
Trust	National Average	Trust	National Average
46%	40%	44%	43%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Top five ranking scores

Key Finding	2015-16		2016-17		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	23%	20%	24%	Same as 2016
KF6 Percentage of of staff reporting good communication between senior management and staff	39%	32%	39%	33%	Same as 2016
KF20 Percentage of of staff experiencing discrimination at work in the last 12 months	9%	10%	8%	10%	improvement
KF1 Staff recommendation of the organisation as a place to work or receive treatment	3.91	3.71	3.92	3.75	improvement
KF16 Percentage of staff working extra unpaid hours	68%	71%	66%	71%	improvement

N.B Please note in 2017 Sheffield Teaching Hospital NHS Foundation Trust was benchmarked in the Combined Acute & Community Group as in previous years.

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Bottom five ranking scores

Key Finding	2015-16		2016-17		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF27 Percentage of staff/ colleagues reporting the most recent experience of harassment bullying or abuse	45%	45%	43%	47%	deterioration
KF24 Percentage of staff/ colleagues reporting the most recent experience of violence	63%	67%	62%	67%	improvement
KF7 Percentage of staff able to contribute towards improvements at work	68%	71%	68%	70%	improvement
KF4 Staff motivation at work	3.86	3.94	3.87	3.91	improvement
KF15 Percentage of staff satisfied with the opportunities for flexible working	52%	51%	51%	51%	Same as 2016

Biggest Improvements since 2016

	Trust 2016	National Combined	Trust	National Combined Acute & Community Average
KF16 Percentage of staff working extra hours	68%	71%	66%	71%
KF9 Effective team working	3.71	3.78	3.74	3.74
KF14 Staff satisfaction with resourcing and support	3.35	3.28	3.39	3.27
KF19 Organisation and management interest in action on health and wellbeing	3.65	3.61	3.68	3.63
KF15 Percentage of staff satisfied with the opportunities for flexible working	51%	51%	51%	51%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

There were no statistically significant deteriorations in any of the 32 key findings .

The Trust has a Staff Engagement Lead and a Staff Engagement Coordinator who work with staff in Directorates to promote the sharing of good practice in both staff engagement and wellbeing across the Trust.

We will continue to work to involve our staff in making improvements at work through a variety of methods. As well as discussions about staff FFT results we hold a variety of events staff to encourage staff involvement and promote the sharing of good practice such as departmental timeouts, the Sharing of Good Practice Festival, Leadership forums, Give It a Go, LIA Pass it on events and the Microsystems Academy Expo to name a few.

We are looking at different ways to motivate and reward our staff during 2018 with the introduction of more local recognition schemes and increased staff benefits as well as introducing new communication methods to ensure more staff are aware of them. We are also looking at what more we can do to support staff and will be introducing Schwartz rounds.

An overall Trust staff engagement action plan has been drawn up to address the areas for improvement that is further supported by individual Directorate staff engagement action plans. These also address the Staff Friends and Family Test findings.

Undertaking a full census staff survey enables a staff engagement score to be calculated for every Directorate so these together with the action plans and Directorate staff Friends and Family Test scores are monitored via the Trust Executive Group/directorate performance review process and the Staff Engagement Executive.

Work Race Equality Standard (WRES)

Key Finding			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	20%	28%	22%
		BME	21%	26%	28%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19%	24%	20%
		BME	23%	26%	24%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	89%	93%
		BME	71%	74%	61%
Q17b	In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	5%	5%
		BME	15%	13%	19%

The Trust has established a diversity post which will focus on workforce matters. The Trust continues to have a LIA scheme focusing on diversity and inclusion focusing on both staff with a disability and BME staff. It is pleasing to note the improvement in the percentage of BME staff believing the Trust provides equal opportunities in career progression following the work of the WRES QI group who have ensured more BME representation on nursing recruitment panels. The 2017 staff survey results show that at 3.96, staff engagement is higher amongst BME staff compared to the Trust average.

We are launching a Reverse Mentoring scheme with the support of Stacey Johnson, Associate Professor, University of Nottingham. We hope that this will improve our WRES statistics, as well as help us learn about new ways of being more inclusive and adaptable in our organisation. We have a member of our Workforce Information team working with the Director of the Workforce race equality programme at NHS England, so we can make more progressive step changes during 2018.

Leadership and Management Development

We have continued to work on embedding the PROUD values into the Trust ethos. These values are increasingly being incorporated into the recruitment process for all staff and are used for all newly qualified staff nurses, clinical support workers and apprentices. The Trust uses a Performance, Values and Behaviour based appraisal process to further embed the PROUD values and to provide staff with quality well-structured appraisals.

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

Values Based Recruitment

We have continued using the PROUD values to recruit in the assessment centre process and having seen the benefits of this will be rolling it out to all staff. To enable us to do this we have purchased a system that enables us to screen all candidates on application to ensure we have staff with the right caring compassionate values working at STHFT

j. Annual Patient Surveys

Seeking and acting on patient feedback remains a high priority. The Trust continues to undertake a wide range of patient feedback initiatives regarding the services they receive. Survey work during 2017-18 included participation in the National Survey Programme for inpatient, cancer and maternity services. National results, including comparative scores, will be available during 2018.

Throughout 2017, a series of local satisfaction surveys have been undertaken covering inpatient, outpatient and community patients, as well as a specific End of Life Care Survey. The Trust has scored well on questions relating to cleanliness; being treated with respect and dignity; communication; and confidence in clinical staff. During 2018, a survey of the experience of carers has commenced.

During 2017-18, the Care Quality Commission published results from the 2016 National Inpatient Survey, 2016 National A&E Survey, 2016 National Cancer Survey and the 2017 National Maternity Survey.

National Inpatient Survey 2016

The National Inpatient Survey 2016 was carried out across 149 acute and specialised NHS Trusts. All adult patients (aged 16 and over) who had spent at least one night in hospital, and were not admitted to maternity or psychiatric units during July 2016, were eligible to be surveyed. 1,180 eligible patients from this Trust were sent a survey, and 505 were returned, giving a response rate of 43%. This is compared to the national response rate of 44%.

Compared to 2015, the Trust did not score significantly better on any questions, and scored significantly worse on one question.

Questions where the Trust scored significantly worse in 2016:

Question	2015	2016
Planned admission: admission date changed by hospital	9.5/10	9.2/10

Compared to other trusts participating in the National Inpatient Survey, the Trust scored similar to most other trusts on all questions. This is a slight improvement on 2015 where the Trust scored 'about the same' as other

trusts on all questions except one, where we scored worse, this question is presented below:

Question	All trusts 2016	STH 2015	STH 2016
The hospital and ward: Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.1/10	7.7/10	8.1/10

In response to this result, the requirements in relation to single sex facilities allow for bathrooms to be shared where they contain specialist equipment. The need for specialist equipment is not captured in the survey and this could explain the results. It is noted that this is the same for all trusts nationally. Following the 2015 survey, further work was undertaken to improve signage regarding this issue and this may be the reason behind the improved score during 2016.

In terms of the question relating to overall experience, the Trust scored the same (8 .1) as the national average (8.1). Overall, this Trust saw an improvement in 24 out 65 questions in 2016 compared with 2015, the same score was achieved on 11 questions, and scores deteriorated on 30 questions. Results and comments from the National Inpatient Survey have been considered alongside other patient experience data, and workstreams are either planned or in place to address priority areas where improvements can be made.

National Cancer Survey 2016

The National Cancer Survey 2016 was carried out across 146 acute hospital NHS trusts on all adult patients (aged 16 and over) with a primary diagnosis of cancer, discharged following an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2016. 2,529 eligible patients from the Trust were sent a survey, and 1,513 were returned, giving a response rate of 66%. This is compared to the national response rate of 66%.

The Trust scored within the expected range on 43 questions, above the expected range on six questions and below the expected range on two questions. Areas where the Trust scored above the expected range include: patients feeling that treatment options were completely explained, possible side effects explained in an understandable way, being given information about support groups, being told who to contact if worried post discharge, being given all the information needed prior to radiotherapy treatment and being given all the information needed prior to chemotherapy treatment.

Areas where the Trust scored below the expected range were: being given easy to understand written information about the type of cancer they had, and the GP given enough information about the patient's condition and treatment.

Directorates and teams providing care for patients with cancer have used the patient comments from the National Cancer Survey, which provide substance and context to scores, to produce an action plan to improve services for patients. Actions include:

Lead Cancer Nurse and all Cancer Clinical Nurse Specialists to review patient information. Information packs at initial diagnosis have being streamlined and teams have been encouraged to support written information with a verbal discussion.

Increase awareness amongst nursing staff in relation to signposting to financial advisors. Area specific information packs developed to cover services across the whole of South Yorkshire.

Develop posters and make available to all areas illustrating how to access free prescriptions.

2016 National A&E Survey

The National A&E Survey 2016 was carried out across 137 acute and specialised hospital NHS trusts with a Type 1 (department is a major, consultant led A&E Department with full resuscitation facilities operating 24 hours a day, seven days a week) or Type 3 (department is an A&E/ minor injury unit with designated accommodation for the reception of accident and emergency patients) accident and emergency department.

Patients were eligible for the survey if they were aged 16 years or older, had attended an emergency department during September 2016, and were not staying in hospital during the sampling period. 1,182 eligible patients from the Trust were sent a survey, and 287 were returned, giving a response rate of 24%. This is compared to the national response rate of 27%.

Due to the change in sampling month, results from 2016 are not comparable with previous years. Compared to other trusts participating in the National A&E Survey, the Trust scored similar to other trusts on most questions, significantly better on one question and significantly worse on two questions.

Questions where the Trust scored better in 2016:

Question	All Trusts	STH 2016
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.3/10	8.2/10

Questions where the Trust scored worse in 2016:

Question	All Trusts	STH 2016
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.2/10	5.0/10
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.2/10	9.1/10

Survey results and comments were shared with the A&E directorate who have agreed an action plan.

National Maternity Survey 2017

The 2017 survey of women's experiences of maternity services involved 130 NHS acute trusts in England. More than 18,000 service users responded giving a national response rate of 37%. Women were eligible for the survey if they had a live birth during February 2017, were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home.

Antenatal

- The Trust scored 'about the same' as other trusts in all questions for antenatal
- The Trust did not score significantly worse in any question from the 2015 scores
- The Trust scored significantly higher than 2015 on one question.

Question	2015	2017
During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?	7.3/10	8.2/10

Labour and Birth

- The Trust scored 'about the same' as other trusts in all questions for labour and birth and were not significantly higher or lower than 2015 in any question.

Postnatal Care

- The Trust scored 'about the same' as other trusts in most questions, except the below question where the Trust scored worse than most other trusts.

Question	STH	Lowest Score	Highest Score
Were you given enough information about any emotional changes you might experience after birth?	6.8/10	6.4/10	8.5/10

- The Trust scored significantly higher than 2015 on 5 questions

Question	2015	2017
Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	7.3/10	8.8/10
Did you feel that the midwife or midwives that you saw always listened to you?	8.4/10	9.1/10
Did the midwife or midwives that you saw take your personal circumstances into account when giving you advice?	7.9/10	8.7/10
Were you given enough information about your own physical recovery after the birth?	6.2/10	7.4/10
Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?	6.0/10	7.3/10

k. 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 three days and where possible, we aim to take a proactive working approach to solving problems as they arise.

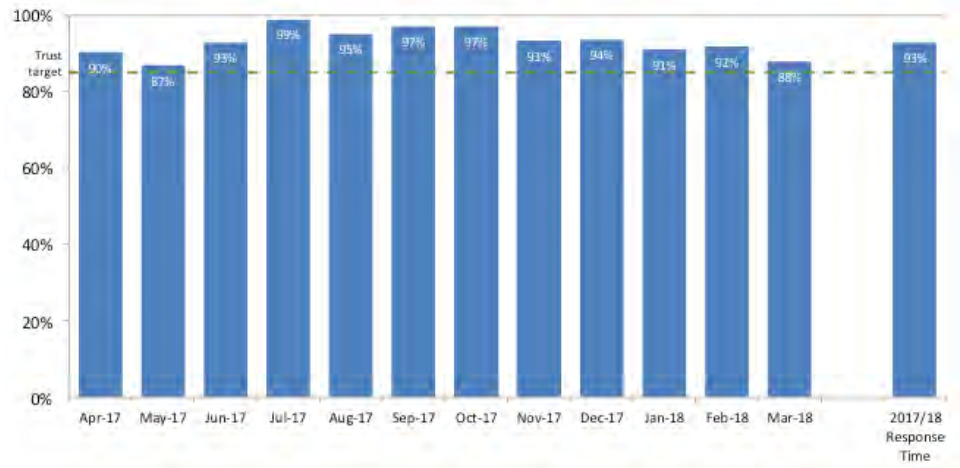
During 2017-18, we received 1,718 informal concerns which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) and if staff feel they can be dealt with quickly by taking direct action, or by putting the 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 an informal concern.

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.

During 2017-18 1,451 complaints requiring a more detailed and in-depth investigation were received. Table five provides a monthly breakdown of formal complaints and informal concerns received. Of the complaints closed during 2017-18, 41% (578/1,402) were upheld by the Trust. The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints made regarding government departments and other public sector organisations and the NHS in England. They are the final step of the complaints process, giving complainants an independent and last resort to have their complaint reviewed. During 2017-18 the PHSO closed 10 cases regarding the Trust 30% (3/10) of which were either fully or partially upheld.

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New informal concerns received	152	166	151	137	139	145	149	133	127	132	144	143	1718
New formal complaints received	102	120	100	111	132	111	143	128	85	142	124	153	1451
All concerns combined	254	286	251	248	271	256	292	261	212	274	268	296	3169

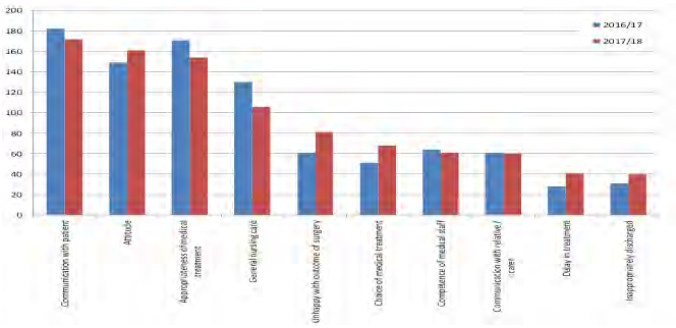
Chart 4 - Chart four - Trust Complaints Response Times



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. A monthly dashboard report focuses on key performance indicators for complaints handling and other feedback, supported by a more detailed quarterly report. The 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 five shows the breakdown of complaints by theme. The findings show that the top four themes are the same as those identified last year. When presented as a percentage, complaints relating to 'communication with patient' are 1% lower this year, while complaints relating to 'attitude' are 0.5% higher. The rest of the themes identified are the about the same as last year, with a variation of just a 1% or less.

Chart Five - Subject raised in formal complaints



There continues to be an ongoing programme of work across the Trust to improve staff attitude and communication, with initiatives such as customer care training and the implementation of the PROUD values.

We remain committed to learning from and taking action as a result of complaint investigations. A selection of actions taken as a result of complaints is featured in quarterly and annual reporting.

I. Friends and Family Test

The Trust continues to participate in the Friends and Family Test (FFT), which is carried out in inpatient, outpatient, A&E, maternity, and community services. The FFT asks a simple, standardised question with a six point scale, ranging from 'extremely likely' to 'extremely unlikely'. During 2017-18, the total percentage of patients who scored 'extremely likely' and 'likely' across all five elements of the FFT was 94%.

The Trust has also chosen to ask a follow-up question in order to understand why patients select a particular response. The FFT allows us to look in more detail at patient feedback at individual ward and service level where our scores consistently compare well nationally, with good response rates being achieved. FFT also provides us with a high volume of free-text comments as well as voice messages.

The Trust uses a number of different methods to carry out FFT depending on the patient group and care setting. Postcards remain a reliable method of collecting the views of patients therefore this method continues to be used in most inpatient areas and within maternity services. Interactive Voice Messages (IVM) and Text Messages (SMS) are the main methods of carrying out FFT in A&E, outpatients and community.

To aim to increase response rates in the Inpatient FFT, for wards who did not meet the 30% response rate target, SMS/IVM was trialled on 10 wards in 2016-2017. Following a review of response rates, scores and methods, most wards have continued to use postcards with the exception of two wards. Response rates are continually reviewed to ensure areas receive a good response rate whilst ensuring they use the most appropriate method for their area and patients.

From November 2017, the reporting of the GP Collaborative service changed and it is no longer reported within the Community FFT but is now reported under the A&E element of the FFT. There was concern that this may have an impact on response rates as the GP Collaborative accounted for approximately 15% of all eligible patients within Community. The impact will be monitored.

Activity in outpatients increased during 2017-18 and it was agreed through the Patient Experience Committee to set an 80% cap on outpatients FFT, meaning that 80% of outpatients receive the survey. This ensures that high numbers of responses are received whilst managing the FFT cost effectively. The cap started in September 2017 with a view to trial the cap for three months and assess any impact on the response rate. It was estimated that the response rate would drop to between 6% and 7%. There was an initial 3.7% drop in September to (7.4%), which then maintained through October (8.3%) and November (7.1%). The response rate did not drop lower than estimated and is still above the national response rate. As it has maintained at an average of 7.6% over three months, it was agreed by the Trust's Patient Experience Committee that the cap would continue and the internal response rate target was therefore lowered from 9% to 7%.

Although there are no national targets for response rates, the Trust is committed to maintaining good response rates for FFT to ensure feedback data is robust. Therefore, the Trust works to a response rate target for inpatients of 30%, and A&E and maternity services of 20%, outpatient 9% and community 17%. These response rate targets were based on previous performances to ensure existing standards are maintained. It was agreed that the original response rate target of 17% for community was no longer achievable and therefore a new response rate of 12.5% was agreed at the Patient Experience Committee.

Over the last 12 months, 150059 FFT responses were received across all areas of FFT. Inpatients (30%), A&E (21%), maternity (28%), and outpatients (9%) all achieved their locally set response rate target during this time. Over the last 12 months the response rate for Community was 12%, this is below target response rate, although Trust performance was considerably better than the national response rate for community which was 4% for 2017-2018.

FFT results are monitored through monthly reports that present response rates, positive and negative scores and links to patient comments for all wards and departments.

Table six outlines the scores and response rates across all areas of FFT comparing 2016-2017 with 2017-2018.

	2016/2017				2017/2018			
FFT Area	Positive Score	Negative Score	Response Rate	No of Response	Positive Score	Negative Score	Response Rate	No of Response
Inpatient	95.7%	1.7%	29.8%	35855	96%	2%	30%	37204
Outpatient	93.9%	2.6%	8.9%	97125	94%	2%	9%	80138
Maternity	95.6%	1.3%	31.2%	5402	95%	1%	28%	5065
Community	88.4%	3.7%	15.5%	13256	89%	3%	12%	9422
A&E	86%	8.1%	24%	15943	87%	7%	21%	18230
Trust Total	93.2%	3%	12.1%	167581	94%	3%	12%	150059

When the Trust's response rate targets are not being met, the relevant areas are highlighted in the monthly reports.

In October 2017 the Trust's internal auditors, 360 Assurance, undertook an audit of FFT. The audit made the following recommendations.

- The Trust to record the reasons for discrepancies in FFT postcards on the tracking spread sheet to confirm that these have been investigated and to facilitate the identification of error patterns.

Amendments were made straight away to capture the reasons for discrepancies.

m. 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. There have been no breaches of this standard during 2017-18.

n. Coroners' Regulation 28 (Prevention of Future Death) Reports

When reviewing a death the Coroner has a duty to consider whether a person or an organisation should be taking steps to prevent similar deaths under Regulation 28 of the Coroner's (Investigations) Regulations 2013. A Coroner will issue a Prevention of Future Death report when there is a concern that the circumstances creating a risk of further deaths could recur or continue to exist. The person or organisation must then respond in detail regarding the action taken or to be taken, or must explain why no action is proposed. The Trust has not received any Prevention of Future Death reports during 2017-18.

o. Never Events

Never Events are defined as 'serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.

During 2017-18 three Never Events occurred at the Trust. These were in relation to the following:

- Misplaced naso-gastric Tube
- Wrong level neck surgery
- Wrong site surgery (this incident occurred in 2013 and was fully investigated at the time but was not escalated and reported as a Never Event)

Learning from serious incidents and Never Events is shared through different forums within the Trust. Three of the Never Events highlighted in this report involve processes undertaken within operating services and these reports have been reviewed at the Safer Surgery Steering Group. Actions taken as a result include the following:

- The minor operations checklist will be used for similar procedures and will be checked alongside the consent form
- The Procedural Marking Policy is to be incorporated into all procedures.
- Procurement of line placement imaging software
- Increased radiology consultant presence at weekends

- Taking steps to ensure that the operating team are aware of objects within the surgical field which may lead to confusion on an x-ray image
- To source an appropriate 'marking needle' produced commercially

The third never event occurred during 2013 and, whilst the incident was managed appropriately and relevant actions were taken within the directorate at the time, it was not escalated and reported as a never event. Assurances have been provided that, since 2013, a number of changes have been put in place to ensure that this would not happen again. These include increased staff awareness of incident reporting.

All the incidents are shared at the Trust's Safety & Risk Committees to ensure that wider learning and actions are developed and implemented.

p. Duty of Candour

In 2017-18 the Patient and Healthcare Governance team continued to roll out training for staff on the statutory Duty of Candour requirements, which form part of the regulatory compliance of the Trust. A 360 Assurance audit undertaken in 2016 found that the knowledge of staff about Duty of Candour, including being open and transparent, was good throughout the Trust.

The process for recording incidents that trigger Duty of Candour is integrated into the Datix system to provide ongoing assurance that the requirements are being met. During this period 345 incidents were identified as being both 'patient safety' and graded as moderate, major or catastrophic. Of these, 203 were highlighted as requiring the statutory duty to be implemented, only seven incident records did not state who was to lead the process.128 incidents highlighted that Duty of Candour did not apply despite reaching the appropriate severity code.

A further analysis of the 'did not apply' incidents was undertaken, and it was found that 50 incidents were linked to pressure ulcers which were present on the patient's admission and a further 33 were easily identifiable as being no harm incidents.

Summary compliance 'spot check' audits take place every quarter to provide assurance that directorates are complying with the Duty of Candour and these are reported to the Safety & Risk Committees.

An e-learning package on Duty of Candour was developed during the year and this is now available on PALMS.

q. Safeguarding Adults

The Trust is part of a wider network of agencies including the Sheffield Local Authority, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Children's Hospital, South Yorkshire Police, South Yorkshire Fire and Rescue, and NHS Sheffield CCG, who make up the Sheffield Adult Safeguarding Partnership (SASP). The SASP Executive Board leads and holds these individual agencies to account, to ensure the safety and well-being of adults at risk of abuse and neglect who are living in or accessing services or amenities in Sheffield.

The Trust has training, policies, guidance and processes in place to support staff to identify and report all types of abuse of patients, carers, family members, visitors or staff. This includes the reporting of Female Genital Mutilation and radicalisation. The Trust's Safeguarding Adults team works in close collaboration with the Trust's Safeguarding Children's team, the maternity services Vulnerabilities team, Emergency Department (ED) and Human Resources to identify and support adults at risk who are subject to domestic violence and abuse.

r. Seven Day Service

A national Seven Day Services Forum was established by Professor Sir Bruce Keogh, NHS England Medical Director, in 2013 and asked to concentrate its first stage review on urgent and emergency care services and their supporting diagnostic services. The Seven Day Services Forum's Summary of Initial Findings was presented to the Board of NHS England in December 2013. One of its recommendations was that the NHS should adopt ten evidence-based clinical standards for urgent and emergency care and supporting diagnostics to end current variations in outcomes for patients admitted to hospital at the weekend. NHS England's Board agreed to all of the Forum's recommendations, including full implementation of the clinical standards.

The ten standards are as follows:

Standard 1: Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital

Standard 3: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the

responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Standard 4: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services. Consultant directed diagnostic tests and completed reporting will be available seven days a week:

- Within one hour for critical patients
- Within 12 hours for urgent patients

Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant directed interventions that meet relevant speciality guidelines, either on-site or through formally agreed networked arrangements with clear protocols. This includes critical care, interventional radiology, interventional endoscopy, emergency general surgery, urgent radiotherapy, PCI, cardiac pacing, renal replacement therapy.

Standard 7: Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

Standard 8: All patients on Acute Medical Units, Acute Surgical units, Intensive therapy units and all high dependency areas are seen by a consultant twice daily. All patients on general wards should be reviewed during a consultant delivered ward round at least once in every 24 hours seven days a week unless it has been determined that this would not affect the patients care pathway.

Standard 9: Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Standard 10: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

To support quality improvement and measure progress in the achievement of seven day hospital services the Trust has taken part in the NHS England case note review since April 2016. This covers the management of patients admitted as an emergency, measuring practice against the four priority clinical standards. The four priority clinical standards are:

- Clinical Standard 2: Time to 1st Consultant Review
- Clinical Standard 5: Consultant Directed Diagnostics
- Clinical Standard 6: Consultant Directed Interventions
- Clinical standard 8 Ongoing Review

The long association between the Trust and the seven day services agenda means that significant progress has been made. There is however recognition that further progress is needed and this is reflected in the Trust's financial plans.

The list of projects that are directly or indirectly related to the implementation of the four clinical standards is lengthy but includes the following significant elements:

- Allocation of funding to enhance consultant presence at the weekends
- Progress towards a 24/7 safety net of coordinated care across the Trust
- Establishing a 7/7 consultant directed echocardiography service
- Embedding the agenda within the Workforce Strategy
- Increased consultant presence within specific directorates
- Increased capacity within the assessment areas
- Introduction of Board Rounds

The Trust is also mindful of the desired implementation of the remaining six standards and has made significant progress in several areas especially in regard to implementation of standard nine (Transfer to Community, Primary and Social care).

3.1 Quality performance information 2017-18

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

Prescribed Information	2015-16	2016-17	2017-18
The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period National Average: 1 .00 Highest performing trust score: 0 .73 Lowest performing trust score: 1.25 (Figures for October 16- September 17)	0 .96 Banding: as expected	0.98* Banding: as expected	Oct 16-Sept 17 0.96 Banding: as expected
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National average:31.5% Highest trust score: 59.8% Lowest trust score: 11.5% (Figures for October 16- September 17)	27 .3%	29.0%	29.1%
The Sheffield Teaching Hospitals NHS Foundation Trust considers that these data are as described as the data are extracted from the NHS Digital SHMI data set. The SHMI makes no adjustment for palliative care because there is considerable variation between trusts in the way that palliative care codes are used. Adjustments based on palliative medicine treatment specialty would mean that those organisations coding significantly for palliative medicine treatment specialty would benefit the most in terms of reducing the SHMI value (the ratio of Observed/Expected deaths would decrease because the expected mortality would increase). Hence, SHMI routinely reports percentage patient deaths with palliative care coding as a contextual indicator to assist with interpretation of data. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by: Performing quarterly analysis of the data underpinning the SHMI to provide a detailed understanding of the metric. SHMI diagnosis groups with a higher than expected O/E** ratio are scrutinised. This may involve any or all of the following steps; analysis of the data using variation analysis benchmarking tools, review by coding auditor, review by clinician / Clinical Director (via Structured Judgement Review method or alternative). Responses / actions are discussed at the Mortality Governance Committee and reported in a quarterly Trust Mortality Report to the Healthcare Governance Committee.			

Prescribed Information	2015-16	2016-17	2017-18
In addition, following publication in June 2017 of the updated guidance on Learning from Deaths by the National Quality Board, a governance process for the management of acute hospital deaths has been approved that will ensure that all deaths are reviewed by the Medical Examiner's Office and members of the review teams on a daily basis (See section on Learning from Deaths page 108). *The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12month period i.e. Oct 2015 - Sept 2016. SHMI results are published five months and three weeks in arrears because of the need to validate the data nationally. The value for April 2016 - March 2017 was released on 21 September 2017 and reported as 0.98. This can be validated via the NHS Choices website. ** O/E ratio is the ratio of observed deaths divided by expected deaths			

Prescribed Information	2015-16 Finalised	2016-17 Provisional	2017-18 Provisional
Patient Report Outcome Measures (PROMs) The Trust's EQ5D patient reported outcome measures scores for:			
Groin hernia surgery			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.080 0.088 0.157 0.021	0.077 0.089 0.140 0.000	0.077 0.089 0.122 0.000
Varicose vein surgery			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.102 0.096 0.150 0.018	* 0.096 0.134 0.000	* 0.096 0.134 0.000
Hip replacement surgery primary			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.418 0.438 0.512 0.320	0.417 0.445 0.537 0.310	
Hip replacement surgery revision			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	* 0.283 0.374 0.224	0.291 0.292 0.362 0.239	
Knee replacement surgery primary			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.304 0.320 0.398 0.198	0.317 0.324 0.404 0.242	
Knee replacement surgery revision			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.282 0.258 0.335 0.19	0.249 0.273 0.297 0.000	

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 as improved the patient's quality of life more than a lower score.

Due to the length of time before post-operative questionnaires are sent out NHS Digital have limited data for Hip and Knee replacements. The next publication is due to be released on 14th June.

Please note that groin hernia and varicose vein have been removed from the programme as at October 2017.

* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received .The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the NHS Digital PROMs data set. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its

services, by reviewing;

- Adherence to Antibiotic Policy in Elective THRs
- Length of post-operative inpatient stay following elective primary hip and knee arthoplasty
- Review of post-operative pain management for patients undergoing hip and knee replacement
- Trust level analysis of data
- Review and comparison of patient feedback, expectations and outcomes

Prescribed Information	2015-16	2016-17	2017-18
Readmissions The percentage of patients aged: 0 to 15; and 16 or over, 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. Comparative data is not available 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 up to October 2015 and then from Lorenzo. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, continuing to enhance assessment areas with the recent opening of a new Frailty Unit on the NGH site and the Urology Assessment Unit on the RHH site that both serve to reduce readmissions and improve pathways for patients. Trials in Geriatric Medicine including the development of 'Okay to Stay' plans, closer working with Care Homes and the 'Red Bag Project' have also shown some encouraging signs and we are looking to expand these further. Expanding our ambulatory care offering is also a priority in the coming months.	0% 14.3%	0% 14.7%	0% 14.88%
Responsiveness to personal needs of patients The Trust's responsiveness to the personal needs of its patients during the reporting period. National average: 72% (this is based on the average scores across all NHS trusts who are contracted with Picker Europe, the CQC's national surveys contractor) The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor. The Sheffield Teaching Hospital NHS Foundation Trust continues to take action to improve this rate, and so the quality of its services, by implementing a new local inpatient survey during 2016-17. The new survey is sent to 2000 inpatients one month in each quarter. Each quarter, patients from the sample are asked six core questions, including one on privacy and dignity and follow-up questions which are themed and change each quarter, as follows: • April 2017 – Noise, food, and staff. • July 2017 – Discharge. • October 2017 – Communication. • January 2018 – Environment. Local inpatient survey results to questions relating to responsiveness to personal needs of patients during 2017-18 are as follows: • Did you always feel safe while on the ward? – 88% • Did hospital staff treat you with respect and dignity? – 91% • Did you always get the help you needed to eat? – 87%	76.9%	74.7%	80.4%

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Friends and Family Test - Staff who would recommend the Trust (from Staff Survey) The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: Combined acute & community trusts – 68% All trusts – 69% Highest performing trust score:(Combined acute & community trusts): 91% Lowest performing trust score: (Combined acute & community trusts): 48% The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by seeking staff views and involving them in improving the quality of patient services via Listening into Action, Microsystems Academy, Staff Friends and Family Test and our ongoing staff engagement work.	76%	81%	81%
Friends and Family Test - Patients who would recommend the Trust The percentage 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. The Friends and Family Test scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings 1 (Extremely Likely) and 2 (Likely). The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Healthcare Communications, verified by UNIFY and reported by NHS England. The Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services: • A monthly report is circulated across the Trust enabling staff to keep on top of scores and response rates, as well as review the comments that patients have left about their experience. • The Patient Experience Committee monitors FFT scores for all elements of the FFT each month and takes the necessary action should the positive score fall in any particular area of the Trust. • Monthly FFT scores are compared with the 12 month Trust score as well as the 12 month National score to monitor performance.	All areas 92% Inpatient 96% A&E 83% Maternity 96% Outpatient 94% Community 86%	All areas 93% Inpatient 96% A&E 86% Maternity 96% Outpatient 94% Community 88%	All areas 94% Inpatient 96% A&E 88% Maternity 95% Outpatient 94% Community 89%

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Patients risk assessed for venous thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. Comparative data is not available The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by having established processes in place that check if a patients has had a VTE risk assessment. Where this has not been completed this is followed up and completed.	95.18%	95.2%	95.29%
Rate of Clostridium Difficile The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period. Comparative data is not available *The rate shown is provisional until the Public Health England denominator rates are published. The denominator used is the 2016-17 figure as this is unlikely to change significantly. During 2017-18 there have been 83 cases of C.difficile infection attributable to the Trust. The national threshold for 2017-18 was 87 Trust attributed cases. All Trust attributable cases now have a root cause analysis to identify if there has been any lapse in care. At publication 14 cases have been highlighted as possibly having a lapse in care. Quarter 4 cases are still being reviewed. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by the Public Health England. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the a range of 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 C.difficile experienced by patients admitted to the Trust.	14.4	20.3	15.5*

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Rate of patient safety incidents			(April- Sept 2017)
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	17,714	20,089*	10,070**
Number of Incidents reported			
The incident reporting rate is calculated from the number of reported incidents per thousand bed days and the comparative data used is from the first 6 months of 2016 **Cluster average: 40.21 Highest performing Trust score: 70.23 Lowest performing Trust score: 22.24	33.4	37.15*	37.6**
The number and percentage of patient safety incidents that resulted in severe harm or death. **Cluster reporting data: 38 (0.3%) Highest reporting Trust: 1908 (1.3%) Lowest reporting Trust: 3 (<0.1%)	23 (0.1%)	18* (0.1%)	23** (0.2%)
* The figures for 2016-17 are different to those documented in last year's Quality Report as they have now been validated. **Full information for the financial year 2017-18 is not available from the National Reporting and Learning System (NRLS) until November 2018. 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. 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.			

3.1 QUALITY PERFORMANCE INFORMATION

Mandated Indicators in the Risk Assessment Framework and the Single Oversight Framework

Measures of Quality Performance	2015-16	2016-17	2017-18
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			Q1, Q2 and Q3 data used
Urgent GP referral for suspected cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	83%	83%	78.32%
National Standard	85%	85%	85%
Urgent GP referral for suspected cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	96.31%	96.31%	94.82%
National Standard	90%	90%	90%
Data Source: Open Exeter National Cancer Waiting Times Database			
Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	*	86.77%	88.64%
National Standard	95%	95%	95%
*At the end of September 2015, the Trust introduced a new Accident and Emergency tracking system, as part of the move to a new Electronic Patient Record. This has presented various technical difficulties and challenges to accurately did capture data on patients wait in A&E. Due to this we did not report our A&E waiting time data nationally during 2015-16.			
MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust	0	2	3
Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust	0	2	3
Sheffield Teaching Hospitals NHS Foundation Trust threshold	0	0	0
Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	87.3%	85.4%	88.21%
National Standard	90%	90%	90%

3.1 QUALITY PERFORMANCE INFORMATION

Measures of Quality Performance	2015-16	2016-17	2017-18
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	95.9%	93.16%	94.44%
National Standard	95%	95%	95%
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	93.5%	93.5%	95.70%
National Standard	92%	92%	92%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability			
Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	Yes	Yes	Yes
Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments?	Yes	Yes	Yes
Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Yes	Yes	Yes
Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Yes	Yes	Yes
Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Yes	Yes	Yes
Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes	Yes	Yes
Never Events (Count)			
Sheffield Teaching Hospital NHS Foundation Trust Performance	4	6	3

3.1 QUALITY PERFORMANCE INFORMATION

Measures of Quality Performance	2015-16	2016-17	2017-18
Hospital Standardised Mortality Ratio (HSMR)			(Feb 17-Jan 18)
Sheffield Teaching Hospital NHS Foundation Trust Performance	103%	105%**	102%
National Benchmark	100%	100%	100%
Data source: Dr Foster			
**This figure is different from last year as it represents the whole year (April 2016 – March 2017) rather than Jan 2016-Dec 2016 as reported in last year's Quality Report.			
Data Completeness for Community Services			
Referral to treatment information:	62%	65%	62%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Referral information:	100%	100%	100%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Treatment activity information:	100%	100%	100%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Maximum 6-week wait for diagnostic procedures			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97.34%	98.93%	92.95%
National Standard	99%	99%	99%

Governor Involvement in the Quality Report Steering Group

January 2018 saw the commencement of the new overarching Quality Board. The Quality Board has taken over the work of the Quality Report Steering Group which concentrated on fewer priorities while the new Board will focus on many more quality objectives and will oversee delivery of the Trust's annual quality improvement priorities.

Attention is continuing to focus on patient safety and the patient experience. All objectives will be relevant and meaningful and while some will be achievable in the short term there will be many longer term aims.

As previously there are governors on the Board and our contribution is welcomed and valued. We are looking forward to participating in new developments, as well as assisting with longer term aims.

Kath Parker
Patient Governor 20th April 2018

Statement from NHS Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has reviewed the information provided by Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) 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 representation of the Trust's performance.

STHFT 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. The report fairly articulates where this has been achieved and also where this has been more challenging.

During 2017/18 the Trust has achieved a number of key Constitutional standards and key quality performance measures with particularly high achievement in the incomplete 18ww target. However, the Trust has continued to experience challenges in the delivery of the 95% A&E target, a number of the cancer wait targets and more recently in diagnostic waits during the year.

The CCG's overarching view is that STHFT continues to provide, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. This quality report evidences that the Trust has achieved positive results in a number of its key objectives for 2017/18. Where issues relating to clinical quality have been identified in year, the Trust has been open and transparent and the CCG has worked closely with the Trust to provide support where appropriate to allow improvements to be made.

The CCG jointly agreed the identified priority areas for improvement in 2018/19 which are reflected in the locally agreed Service and Development Improvement Plan. Our aim is to pro-actively address issues relating to clinical quality so that standards of care 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:

Mandy Philbin

Chief Nurse

and

Cath Tilney

Deputy Director of Contracting

3rd May 2018

Statement from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny Policy Development Committee

The Healthier Communities and Adult Social Care Scrutiny Committee would like to thank the Trust for this opportunity to comment on the draft 2017/18 Quality Account.

The Trust engaged with the Committee early on in the Quality Account process, and commends the Trust on the robust process put in place in to identify Quality Priorities for this year. We are pleased to see clear outcome measures against each priority, and clear plans for how they will be achieved.

During our work this year, we have considered the issue of transfers of care. We are pleased to see that the Statement on Quality notes the progress that has been made in this area, particularly around partnership working; and more importantly, that challenges remain. The Committee will be looking for further improvements in this area next year. Beyond this, the Committee has not been made aware of any concerns over the Trust's performance or service delivery.

The Committee is concerned to see that 3 'Never events' have been recorded this year. The Committee notes that the learning from these events is shared through Trust forums and will be seeking assurance that these are not repeated.

The Committee's comments are put together in a period when the full and final performance information is not available. We are therefore unable to take a comprehensive overview of performance, but note with some concern that urgent suspected cancer GP referral to treatment times are below the National Standard.

We recognise that these are challenging times for the NHS, and would like to take this opportunity to thank all the staff at the Teaching Hospitals who work so hard to deliver vital services across the city.

1st May 2018

Statement from Healthwatch Sheffield

Thank you for inviting us to comment on this year's Quality Account. We value our relationship with the Trust and your enthusiasm to involve Healthwatch Sheffield in the development and oversight of your quality priorities. We welcome your new approach to the management of your quality objectives within the Quality Board and we are pleased to participate in this Board.

We are satisfied with the progress made against 2017/18's quality priorities and are pleased to see that they will continue to be built on in 2018/19. We are particularly pleased that you plan to roll out safety huddles to all wards in Medicines and Pharmacy Services (MAPS) and Geriatric and Stroke Medicine (GSM) in 2018/19.

We welcome the new quality priorities for 2018/19 and the clear outlining of quarterly objectives for each one. Priorities with timescales of longer than one year would benefit from clarity about what you plan to achieve in year two, to help us to see the long term plan. We strongly support two priorities in particular, to 'improve working in partnership with our patients, their families and carers towards shared goals' and 'significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard'. We look forward to supporting the implementation of these quality objectives during 2018/19.

During this year we have highlighted the duty on all providers of NHS care to properly implement the Accessible Information Standard, and we have shared with you the experiences of Deaf people using STHFT services that have often fallen short of expectations. We welcomed the action plan you have put in place in response to these problems and note that the implementation of the Standard is particularly relevant to your quality priorities for 2018/19, to 'improve the process and quality of consenting within STHFT with a focus on ensuring patients are provided with individualised information' and 'ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, and meet the needs of both patients and national good practice guidelines'.

We are pleased to note that the proportion of patients who would recommend the trust to friends and family slightly increased last year, with community and A&E seeing the largest increases in this measure of patient satisfaction.

We feel that your account generally reflects the experiences shared with us by services users and their families about Sheffield Teaching Hospitals. We have been happy with the way the quality board is utilising patient experience to develop quality objects and we look forward to working with the trust on this over the coming year.

30th April 2018

4.2 STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

Statement of Directors' Responsibilities for 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.

NHS Improvement 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 the data quality for the preparation of the quality report.

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

The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017-18 and supporting guidance.

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 2017 to March 2018
- papers relating to quality reported to the board over the period April 2017 to March 2018
- feedback from commissioners dated 3rd May 2018
- feedback from governors dated 20th April 2018
- feedback from local Healthwatch organisations dated 30th April 2018
- feedback from Overview and Scrutiny Committee dated 1st May 2018
- the trust's draft complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
- the latest national patient surveys, dated May 2017 (Inpatients), October 2017 (Emergency Department), January 2018 (Maternity) and July 2017 (Cancer)
- the latest national staff survey published March 2018
- the Head of Internal Audit's annual opinion of the Trust's control environment discussed at the Audit committee of 21 May 2018.
- CQC inspection report dated 9 June 2016

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

The performance information reported in the Quality Report is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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

22 May 2018

Sir Andrew Cash OBE
Chief Executive

22 May 2018

4.3 INDEPENDENT AUDITOR'S LIMITED ASSURANCE 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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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 NHS Improvement.

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2017/18; 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 supporting guidance and the six dimensions of data quality set out in the Detailed requirements for external assurance on Quality Reports 2017/18.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, 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 2017 to April 2018;
- Papers relating to quality reported to the Board over the period April 2017 to April 2018;
- Feedback from NHS Sheffield Clinical Commissioning Group, dated 3 May 2018;
- Feedback from governors, dated 20 April 2018;
- Feedback from the Healthwatch Sheffield, dated 30 April 2018;
- Feedback from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny Policy Development Committee, dated 1 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the year April 2017 to March 2018 (draft version 1);
- The latest national patient surveys;
- The latest national NHS staff survey;
- Care Quality Commission inspection report, dated June 2016;
- The Head of Internal Audit's annual opinion over the Trust's control environment for the period April 2017 to March 2018; and
- Any other information included in our review.

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. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

4.3 INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We permit the disclosure of this report within the annual report for the year ended 31 March 2018, 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, except 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;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is 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.

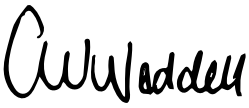
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, 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 and supporting guidance.

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 2018:

- 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 and supporting guidance
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2017/18; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.



Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham DH1 5TS

24 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) 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 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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue Recognition There is a risk of fraud in the financial reporting relating to revenue recognition due to the potential to inappropriately record revenue in the wrong period. Due to there being a risk of fraud in revenue recognition we consider it to be a significant risk on all audits. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting such that we consider revenue recognition to be a Key Audit Matter at the Trust. We identified specific risks in relation to revenue recognition to be in the following areas: • Recognition of income and receivables around the year end; • Recognition of Sustainability and Transformation Fund (STF) income during the year. **Valuation of Land and Buildings** Land and buildings are the Trust's highest value assets. In 2017/18 the Trust moved to an alternative site valuation method. This reduced the value of these assets significantly and was subject to a significant degree of estimation and judgement. Management engaged the Valuation Office Agency (VOA) as an expert to assist in determining the fair value of these assets to be included in the financial statements. Changes in the value of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual	Our approach involved a range of substantive procedures including: • testing of material income and material year-end receivables; • testing receipts in the pre and post year-end period to ensure they have been recognised in the right financial year; • reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care and, if necessary, seeking direct confirmation from third parties or their external auditors; and • testing of STF income and agreeing the consistency of the returns made to NHS Improvement during the year and in-year financial reporting. There were no significant findings arising from our work on revenue recognition. Our approach involved: • assessing the scope and terms of engagement with the VOA; • assessing how management used the VOA's report to value land and buildings in the financial statements; • assessing and challenging the VOA's methodology and their procedures to ensure independence, objectivity and quality (including consulted our own expert to assess the VOA's work); and • considering regional valuation trends (provided by our valuation expert) to assess the reasonableness of the movement in valuations. In addition, we: • assessed the Trust's approach to the alternative site valuation; and • tested the reasonableness of the data used to derive the model for the alternative site valuation. There were no significant findings arising from our work on the valuation of land and buildings.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements.

Based on our professional judgement, we determined materiality for Sheffield Teaching Hospitals NHS Foundation Trust for the financial statements as a whole as follows:

Overall materiality	£15m
Basis for determining materiality	Approximately 1.5% of operating expenses from continuing operations
Rationale for benchmark applied	Operating expenses from continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.25m, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

An overview of the scope of our audit

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. The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed in the "Key audit matters" section of this report. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18; and
- the other information published together with the audited financial statements in the Annual 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

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2017/18 ; or • the Annual Governance Statement 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 have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.
Use of resources	
We are required to report to you if the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.	We have nothing to report in respect of this matter.
Other information	
We are required to read the other information and report to you if the other information is: • materially inconsistent with the audited financial statements or our knowledge obtained in the course of performing our audit; or • otherwise appears to be materially misstated. We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.	We have not identified any such material inconsistencies or misstatements.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

The Chief Executive as Accounting Officer is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are also required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the C&AG in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements 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 Code of Audit Practice.

Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham DH1 5TS

24 May 2018

Financial Statements

Foreword to the accounts
Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2018 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, operating as NHS Improvement, has, with the approval of the Secretary of State for Health, directed, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of that Act.

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.

Andrew Cash.

Sir Andrew Cash OBE
Chief Executive
22 May 2018

Statement of Comprehensive Income for the year ending 31 March 2018

	NOTE	2017/18 £'000	2016/17 As restated £'000
Operating Income from continuing operations	3.1	1,077,062	1,058,882
Operating Expenses from continuing operations	4.1	(1,072,470)	(1,040,117)
OPERATING SURPLUS		**4,592**	18,765
FINANCE COSTS			
Finance income	7.1	217	172
Finance expense- financial liabilities	7.2	(3,083)	(3,113)
Finance expense- unwinding of discount on provisions		(3)	(38)
Public Dividend Capital Dividends payable		(10,274)	(10,359)
Net Finance Costs		**(13,143)**	(13,338)
Gains on disposal of assets		190	339
(DEFICIT) / SURPLUS FROM CONTINUING OPERATIONS		**(8,361)**	5,766
Other comprehensive income			
Impairment		(24,257)	52
Revaluation		19,877	1,362
Other reserve movements		0	0
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(12,741)**	7,180

The notes on pages 147 to 177 form part of these accounts.

All income and expenditure is derived from continuing operations, and the (deficit) / surplus is attributable to the owners of the Trust (the Taxpayer).

Statement of Financial Position 31 March 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	8.1	9,726	11,572
Property, plant and equipment	9.2	416,116	428,710
Investments	11	0	0
Trade and other receivables	13.2	4,761	3,900
Total non-current assets		**430,603**	**444,182**
Current assets			
Inventories	12.1	13,172	14,640
Trade and other receivables	13.1	53,997	54,246
Current asset investments	14	0	0
Cash	21	74,914	68,330
Total current assets		**142,083**	**137,216**
Current liabilities			
Trade and other payables	15.1	(97,360)	(92,292)
Borrowings	16.1	(2,432)	(2,548)
Provisions due within one year	19	(889)	(914)
Other liabilities	17.1	(14,977)	(13,907)
Total current liabilities		**(115,658)**	**(109,661)**
Total assets less current liabilities		**457,028**	**471,737**
Non-current liabilities			
Borrowings	16.2	(39,370)	(41,629)
Provisions due after one year	19	(2,765)	(2,820)
Other liabilities	17.2	(1,446)	(1,169)
Total non-current liabilities		**(43,581)**	**(45,618)**
Total assets employed		**413,447**	**426,119**
FINANCED BY:			
Taxpayers' equity			
Public Dividend Capital		329,262	329,193
Revaluation reserve	20	32,949	38,904
Income and expenditure reserve		51,236	58,022
Total Taxpayers' equity		**413,447**	**426,119**

The financial statements on pages 142 to 177 were approved by the Board on 22 May 2018 and were signed on behalf of the Board by

Andrew Cash.

Sir Andrew Cash, OBE
Chief Executive

22 May 2018

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 2017	426,119	329,193	38,904	58,022
(Deficit) for the year	(8,361)			(8,361)
Transfers between reserves	0		(1,575)	1,575
Impairments	(24,257)		(24,257)	
Revaluation gains on property, plant and equipment	19,877		19,877	
Public Dividend Capital received	69	69		
Taxpayers' Equity at 31 March 2018	**413,447**	**329,262**	**32,949**	**51,236**
Taxpayers' Equity at 1 April 2016	416,799	327,053	39,168	50,578
Surplus for the year	5,766			5,766
Transfers between reserves	0		(1,678)	1,678
Impairments	52		52	
Revaluation gains on property, plant and equipment	1,362		1,362	
Public Dividend Capital received	2,140	2,140		
Taxpayers' Equity at 31 March 2017	**426,119**	**329,193**	**38,904**	**58,022**

Statement of Cash Flows 31 March 2018

	NOTE	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus from continuing operations		4,592	18,765
Non-cash income and expenditure			
Depreciation and amortisation	8.1 / 9.1	28,783	30,371
Net Impairments	4.1	17,164	5,991
Income recognised in respect of capital donations (cash and non-cash)	3.1	(824)	(1,023)
Decrease / (Increase) in Trade and other Receivables		477	(21,089)
Decrease in Inventories		1,468	1,260
Increase / (Decrease) in Trade and other Payables		4,698	(7,784)
Increase / (Decrease) in Other Liabilities		1,347	(532)
(Decrease) in Provisions		(83)	(1,014)
Other operating cashflows		(500)	(628)
NET CASH GENERATED FROM OPERATIONS		**57,122**	**24,317**
Cash flows from investing activities			
Interest received		194	185
Purchase of intangible assets		(475)	(5,552)
Purchase of Property, Plant and Equipment		(34,143)	(26,124)
Sales of Property, Plant and Equipment		390	138
Receipt of Cash Donations to purchase capital assets		500	628
Net cash used in investing activities		**(33,534)**	**(30,725)**
Cash flows from financing activities			
Public Dividend Capital received		69	2,140
Loans repaid		(1,446)	(1,445)
Capital element of finance lease rental payments		(287)	(443)
Capital element of Private Finance Initiative Obligations		(643)	(582)
Interest paid		(1,063)	(1,131)
Interest element of finance lease		(78)	(93)
Interest element of Private Finance Initiative obligations		(1,942)	(1,890)
Public Dividend Capital Dividend paid		(11,740)	(9,722)
Cash flows from other financing activities		126	1,169
Net cash used in financing activities		**(17,004)**	**(11,997)**
Increase / (Decrease) in cash and cash equivalents		**6,584**	**(18,405)**
Cash and Cash equivalents at 1 April	21	68,330	86,735
Cash and Cash equivalents at 31 March	21	**74,914**	**68,330**

Notes to the Accounts

1 Accounting policies and other information

NHS Improvement in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with the HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, that which is judged to be the most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of the financial provision for that service in public documents.

1.2 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.

1.3 Basis of consolidation/Interests in other entities

With effect from 1 April 2017, Sheffield Hospitals Charity became an independent charity, rather than being an NHS Charity as in 2016/17. The Trust has established that it is not a corporate Trustee of any of its supporting or linked Charities and does not have the power to exercise control so as to obtain economic benefits, meaning consolidation is not appropriate. Additionally the transactions and balances are immaterial in the context of the Trust operations.

The Trust has a number of minor interests in the following entities, none of which are material to the Trust's operations.

Name	Nature of Relationship
Epaq Systems Ltd	Minor share-holding in low net worth company
Wetwash Ltd (Formerly Zilico Ltd)	Minor share-holding in low net worth company
Elaros 24/7 Ltd	Minor share-holding in low net worth company
Independent Care Products Ltd	Minor share-holding in low net worth company
Devices for Dignity Ltd	No return to the Trust
Medipex Ltd	No return to the Trust
Legacy Park Ltd	No return to the Trust

No consolidation has therefore been undertaken for these entities.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimates (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant impact on the amounts recognised in the financial statements.

- Basis of consolidation/Interests in other entities – see note 1.3.

Sources of estimation uncertainty

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 and Useful economic lives – see paragraph 1.11 and note 9.5.
- Revenue Estimates – see paragraph 1.5. This income is estimated based on the average speciality 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 1.24 and note 13.3.
- Provisions – see paragraph 1.20 and note 19.

1.5 Revenue

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue 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. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially completed spell is accrued and agreed with the commissioner.

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

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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.

1.6 NHS Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Grants payable

Where grant funding is not intended to be directly related to the activity undertaken by the grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT.

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

1.10 Corporation tax

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

1.11 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised if:

- 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 and either
- the item individually has a cost of at least £5,000; or
- collectively, has a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Property, Plant and Equipment are also capitalised where they 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

All property, plant and equipment assets are initially measured 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Assets that were most recently held for their service potential but are surplus (with no plan to bring it back into use) are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written out and charged to operating expenses.

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.

Useful Economic Lives of Property, Plant and Equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are set out in note 9.5 to the accounts.

1.12 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale 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, where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally generated assets (e.g. goodwill, brands, mastheads, publishing titles, customer lists and similar items) are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset, so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible 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;
- the availability of adequate technical, financial, and other resources to complete the intangible asset and sell or use the asset; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use, by reference to an active market

or, where no active market exists, at the lower of amortised replacement cost and value in use where the asset is income generating. Internally developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for Property, Plant and Equipment.

Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in note 8.4 to the accounts.

1.13 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of impairment loss is credited to expenditure.

1.14 Donated assets

Donated non-current assets are capitalised at current value in existing use if they are held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluation, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Leases

Leases are classified as finance leases when substantially all of the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and buildings components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight line basis over the lease term.

1.17 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 unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- payment for the fair value of services rendered
- repayment of the finance lease liability, including finance cost, and
- payment for the replacement of the components of the asset during the contract "lifecycle replacement".

Services rendered

The cost of services rendered in the year is recorded under the relevant expenditure headings within "operating expenses".

PFI assets, liability and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum

lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to "finance costs" within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ("lifecycle replacement") are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a "free" asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) cost formula.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows, using HM Treasury discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of +0.10% (2016/17 + 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

Period	Period Definition for expected cash flows	2017/18 Rate (%)	2016/17 Rate (%)
Short term	Up to and including 5 years	-2.42%	-2.70%
Medium term	Over 5 years and up to and including 10 years	-1.85%	-1.95%
Long term	Over 10 years	-1.56%	-0.80%

All percentages are in real terms.

1.21 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution 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 Resolution on behalf of the NHS Foundation Trust is disclosed at note 19, but is not recognised in the Trust's accounts.

1.22 Non clinical risk pooling

The 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 NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excess payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the Trust's control; or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed (in note 24), unless the probability of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. No contingent assets are disclosed in the accounts.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 Financial assets

Recognition and de-recognition, measurement and classification

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss, held to maturity investments, available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at 'fair value through profit and loss'

Financial assets at 'fair value through profit and loss' are held for trading. A financial asset 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.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

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 that are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method less any impairment. Interest is recognised using the effective interest method.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications in this category or are not classified in any of the other categories. They are measured at fair value, with changes in value, other than impairment losses, taken to Other Comprehensive Income. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

Impairment

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses are recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows 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 expenditure.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.25 Financial liabilities

Recognition and de-recognition, and measurement

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest rate method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is that rate which exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Public dividend capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less 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), and

- any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing net assets.

In accordance with the requirements laid down by the Department of Health and Social Care 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.

1.27 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling (the functional currency) at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 21 to the accounts.

1.29 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 the Trust not been bearing its 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.

1.30 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. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

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.

For functions that the Trust has transferred to another NHS body, the assets and liabilities are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the new assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.31 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.32 Accounting standards that have been issued but have not yet been adopted

The DHSC Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption.

Accounting Standard	Expected Effective Date
IFRS 9 – Financial Instruments	2018/19
IFRS 15 – Revenue from contracts with customers	2018/19
IFRS 16 – Leases	Still subject to HM Treasury consideration
IFRS 17 – Insurance contracts	Still subject to HM Treasury consideration
IFRIC 22 – Foreign currency transactions	2018/19
IFRIC 23 Uncertainty over Income Tax treatments	2018/19

The application of the Standards as revised would not have a material impact on the accounts of the Trust for 2017/18, were they applied in that year, although IFRS 16 will require close consideration.

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 reviews the operating and financial results of the Trust on a monthly basis and considers the position of the Trust as a whole in its 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 Operating income

Operating Income from Activities (by nature)	2017/18 £'000	2016/17 £'000 *As Restated
Elective income	169,164	165,534
Non Elective income	190,793	173,834
Outpatient income	115,445	118,448
A&E Income	21,848	19,682
Other NHS Clinical income**	325,853	324,618
Income re Community Services	66,256	66,385
Private Patient Income	3,849	3,575
Total income from activities	**893,208**	**872,076**
Other operating income		
Research and development	39,379	38,842
Education and training	51,841	54,536
Received from NHS Charities - Donation of physical assets (non-cash)	92	17
Received from NHS Charities - Receipt of grants / donations for capital acquisitions	500	628
Received from other bodies - Receipt of grants / donations for capital acquisitions	232	378
Non-patient care services to other bodies	47,665	48,091
Sustainability and transformation fund income	27,567	23,858
Other***	15,873	19,803
Operating lease income	699	649
Operating lease income - contingent rent	6	4
Total other operating income	**183,854**	**186,806**
TOTAL OPERATING INCOME	**1,077,062**	**1,058,882**

*The above split of income from Operating Activities (by Nature) has been produced on a slightly different basis to prior years. This now is more consistent with how NHS Improvement monitor this in-year. The 2016/17 comparative has been restated on the same basis.

**Other NHS Clinical Income consists mainly of high cost drugs (£122,792k), Non drugs cost per case income (£40,454k), Critical Care Income (£48,959k), with the balance of £113,648k relating to sundry block contract income across a range of specialties.

***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 (covering 40% of the other total income) relate to the provision of car-parking, catering, and nursery facilities.

Commissioner Requested Services for the year totalled £937,217k (2016/17 £919,510k). Non Commissioner Requested Services were £139,845k (2016/17 £139,372k).

3.2 Operating lease income

	2017/18 £'000	2016/17 £'000
Rents recognised as income in the period	699	649
Contingent rents recognised as income in the period	6	4
	705	653
Future minimum lease payments due		
Re Land		
- not later than one year;	33	42
- later than one year and not later than five years;	110	117
- later than five years.	294	322
Total	**437**	**481**
Re Buildings		
- not later than one year;	646	596
- later than one year and not later than five years;	1,832	1,923
- later than five years.	2,953	3,190
Total	**5,431**	**5,709**
Total - All categories		
- not later than one year;	679	638
- later than one year and not later than five years;	1,942	2,040
- later than five years.	3,247	3,512
Total	**5,868**	**6,190**

3.3 Operating income from activities (by source)

	2017/18 £'000	2016/17 £'000
Clinical Commissioning Groups and NHS England	877,651	857,186
NHS Foundation Trusts	87	65
NHS Trusts	0	0
Department of Health and Social Care (DHSC) Income	0	0
Local Authorities	5,468	5,636
NHS Other	2,170	2,087
Non NHS: Private patients	3,129	3,047
Non NHS: Overseas patients (non-reciprocal)	720	528
NHS injury scheme (formerly the Road Traffic Act Scheme)	3,816	3,339
Non NHS: Other*	167	188
Total Operating Income from activities	**893,208**	**872,076**

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

3.4 Overseas visitors (relating to patients charged directly by the Trust)

	2017/18 £'000	2016/17 £'000 *As restated
Income recognised in year	720	528
Cash payments received in year (relating to invoices raised in current and previous years)	159	258
Amounts added to provision for impairment of receivables	298	390
(relating to invoices raised in current and previous years)	397	298
Amounts written off in year (relating to invoices raised in current and previous years)	47	143

*2016/17 comparative for cash payments received in year restated to correct prior year misstatement.

4 Operating expenses

4.1 Operating expenses comprise:

	2017/18 £'000	2016/17 £'000 *As restated
Purchase of Healthcare from NHS and DHSC Bodies	17,889	17,677
Purchase of Healthcare from non NHS and DHSC bodies	21,719	22,269
Staff and Executive Directors' costs	633,240	613,808
Non-Executive Directors' costs	187	187
Drugs costs	148,262	148,115
Supplies and services - clinical	101,930	101,189
Supplies and services - general	8,206	8,137
Establishment	8,021	8,904
Research and Development	27,975	28,259
Transport	839	901
Premises	36,739	35,488
Increase in bad debt provision	1,195	62
Change in provisions discount rate	33	266
Depreciation on property, plant and equipment	26,731	28,407
Amortisation of intangible assets	2,052	1,964
Net Impairments of property, plant and equipment	16,979	5,986
Net Impairments of intangible assets	185	5
Operating lease costs	880	987
Audit services - statutory audit**	54	54
Other auditor remuneration - quality report review**	9	9
Clinical negligence	10,700	8,775
Legal fees	1,580	1,084
Consultancy costs	1,183	1,623
Internal audit costs	157	161
Training, courses and conferences	2,313	2,190
Redundancy	0	14
Charges to operating expenditure for on-SoFP for IFRIC 12 Schemes	611	591
Insurance	652	513
Other Services	1,620	2,111
Losses, ex gratia & special payments	64	36
Other	465	345
Total Operating Expenses	**1,072,470**	**1,040,117**

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

*2016/17 comparatives are restated in respect of Premises, Insurance and 'Other' costs so as to re-analyse the charges to the heading for operating expenditure for on-SoFP for IFRIC 12 Schemes.

*2016/17 comparative costs in respect of Purchase of Healthcare from NHS and Department of Health and Social Care (DHSC) bodies and Staffing/Executive Directors' costs have been aggregated to achieve consistency with the analysis mandated in the Trust's Financial Return proformas.

**An analysis of the work of the Auditors and the associated fees for the respective work is included on pages 32 to 33 of the Annual Report.

4.2 Arrangements containing an operating lease - current year expenditure

	2017/18 £'000	2016/17 £'000
Minimum lease payments	880	987
Contingent rents	0	0
Less sublease payments received	0	0
Total	**880**	**987**

4.3 Arrangements containing an operating lease - future years' commitments

	2017/18 £'000	2016/17 restated* £'000
Future minimum lease payments due:		
Within 1 year	675	716
Between 1 and 5 years	1,262	1,419
After 5 years	348	518
Total	**2,285**	**2,653**

5 Staff Costs

5.1 Employee expenses

	2017/18 Total £'000	2016/17 Total £'000
Salaries and wages	515,055	496,785
Social Security Costs	45,199	43,309
Apprenticeship Levy *	2,429	0
Employer contributions to NHSPA	59,438	56,515
Other pension costs	103	63
Agency / contract staff	11,016	17,136
Total	**633,240**	**613,808**

* The Apprenticeship Levy became chargeable from 1 April 2017.

The above figure of £633,240k is net of the amount of £548k (2016/17 £1,792k) in respect of capitalised salary costs included in fixed asset additions (notes 8.1 and 9.1).

In 17/18 the capitalised salary recharge value includes retrospective VAT recovery on contractor charges. The VAT recovery position was concluded with HMRC in April 2017.

5.2 Early retirements due to ill health

	2017/18	2017/18	2016/17	2016/17
	£'000	Number	£'000	Number
Number of early retirements agreed on the grounds of ill health		15		9
Cost of early retirements agreed on grounds of ill health	674		548	

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:

	2017/18	2016/17
Number of non NHS invoices paid	212,507	211,366
Number of non NHS invoices paid within 30 days	201,249	199,508
Percentage of invoices paid within 30 days	94.70%	94.39%
	£'000	£'000
Value of non NHS invoices paid	411,575	432,349
Value of non NHS invoices paid within 30 days	394,605	409,935
Percentage of invoices paid within 30 days	95.88%	94.82%
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 Financing

7.1 Finance income

	2017/18	2016/17
	£'000	£'000
Bank account interest	217	172
Total	**217**	**172**

7.2. Finance costs - interest expense

	2017/18 £'000	2016/17 £'000
Capital loans from the Department of Health and Social Care	1,063	1,130
Finance Lease interest	78	93
Finance Costs in PFI Obligations		
Main Finance Costs	1,165	1,203
Contingent Finance Costs	777	687
Total	**3,083**	**3,113**

7.3 Impairment of assets

	2017/18 £'000	2016/17 £'000
Loss or damage from normal operations	284	301
Abandonment of assets in course of construction	420	217
Changes in market price	38,959	6,455
Reversal of impairments	(22,499)	(982)
Net Impairments charged to operating expenses	**17,164**	**5,991**

8.1 Intangible non-current assets 2017/18

	Total £'000	Software licences £'000
Gross Cost at 1 April 2017	18,522	18,522
Additions - purchased / internally generated	391	391
Impairments charged to operating expenses	(185)	(185)
Additions - donated	0	0
Disposals	(9)	(9)
Gross cost at 31 March 2018	**18,719**	**18,719**
Amortisation at 1 April 2017	6,950	6,950
Provided during the year	2,052	2,052
Impairments	0	0
Reclassification	0	0
Disposals	(9)	(9)
Amortisation at 31 March 2018	**8,993**	**8,993**
Net Book Value at 31 March 2018	**9,726**	**9,726**

8.2 Intangible non-current assets 2016/17

	Total £'000	Software licences £'000
Gross cost at 1 April 2016	13,554	13,554
Additions - purchased / internally generated	5,011	5,011
Additions - donated	0	0
Disposals	(43)	(43)
Gross cost at 31 March 2017	**18,522**	**18,522**
Amortisation at 1 April 2016	5,024	5,024
Provided during the year	1,964	1,964
Impairments	5	5
Disposals	(43)	(43)
Amortisation at 31 March 2017	**6,950**	**6,950**
Net Book Value at 31 March 2017	**11,572**	**11,572**

8.3 Analysis of intangible non-current assets

	31 March 2018 £'000	31 March 2017 £'000
Net Book Value		
- Purchased	9,706	11,528
- Donated	20	44
Total 31 March	**9,726**	**11,572**

8.4 Economic life of intangible non-current assets

	Min Life Years	Max Life Years
Intangible assets		
Software licences	5	8

9 Property, plant and equipment

9.1 Property, plant and equipment 2017/18

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'001	£'000
Gross Cost at 1 April 2017	568,223	14,710	367,476	2,076	10,165	135,563	1,099	25,677	11,457
Additions - purchased	34,672	0	258	0	29,691	4,594	52	0	77
Additions - donated	324	0	92	0	0	232	0	0	0
Additions - assets purchased from cash donations	500	0	43	0	332	116	0	0	9
Impairments charged to operating expenses	(39,068)	(2,991)	(35,709)	(133)	(235)	0	0	0	0
Impairments charged to revaluation reserve	(24,348)	(1,622)	(22,726)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	22,500	0	22,496	3	1	0	0	0	0
Reversal of impairments credited to revaluation reserve	91	0	91	0	0	0	0	0	0
Reclassifications	0	0	11,179	0	(16,914)	3,589	0	1,685	461
Other Revaluations	(6,689)	0	(6,623)	(66)	0	0	0	0	0
Disposals	(8,581)	0	(128)	0	0	(6,665)	0	(407)	(1,381)
Cost or valuation at 31 March 2018	**547,624**	**10,097**	**336,449**	**1,880**	**23,040**	**137,429**	**1,151**	**26,955**	**10,623**
Accumulated Depreciation at 1 April 2017	139,513	0	25,332	252	0	83,674	860	21,971	7,424
Provided during the year	26,731	0	14,342	118	0	9,839	80	1,436	916
Impairments recognised in operating expenses	411	0	126	0	0	266	8	2	9
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	2	0	0	(2)	0	0	0
Other Revaluations	(26,566)	0	(26,342)	(224)	0	0	0	0	0
Disposals	(8,581)	0	(128)	0	0	(6,665)	0	(407)	(1,381)
Depreciation at 31 March 2018	**131,508**	**0**	**13,332**	**146**	**0**	**87,112**	**948**	**23,002**	**6,968**

9.2 Analysis of property, plant and equipment

Net book value									
- Purchased at 31 March 2018	371,603	9,628	283,039	1,574	22,791	47,152	187	3,937	3,295
- Finance Leases at 31 March 2018	1,542	0	0	0	0	1,542	0	0	0
- PFI at 31 March 2018	14,361	0	14,361	0	0	0	0	0	0
- Government granted assets at 31 March 2018	2,855	0	2,838	0	0	0	0	0	17
- Donated at 31 March 2018	25,755	469	22,879	160	249	1,623	16	16	343
Total at 31 March 2018	**416,116**	**10,097**	**323,117**	**1,734**	**23,040**	**50,317**	**203**	**3,953**	**3,655**

The Trust has undertaken a revaluation of the land and property estate at 1st April 2017 based on an alternative site valuation model. Further details regarding the impact of this revaluation can be found in the Director of Finance's report (analysis of financial performance) on pages 27 to 28 of the Annual report.

9.3 Property, plant and equipment 2016/17

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2016	563,920	14,710	357,540	2,076	17,031	133,021	1,208	25,885	12,449
Additions - purchased	24,735	0	1,125	0	17,415	5,960	0	44	191
Additions - donated	395	0	128	0	0	257	0	10	0
Additions - assets purchased from cash donations	628	0	0	0	522	106	0	0	0
Impairments charged to operating expenses	(6,671)	0	(6,454)	0	(217)	0	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	982	0	982	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	52	0	52	0	0	0	0	0	0
Reclassifications	0	0	16,846	0	(24,586)	7,139	0	85	516
Revaluations	(2,743)	0	(2,743)	0	0	0	0	0	0
Disposals	(13,075)	0	0	0	0	(10,920)	(109)	(347)	(1,699)
Cost or valuation at 31 March 2017	**568,223**	**14,710**	**367,476**	**2,076**	**10,165**	**135,563**	**1,099**	**25,677**	**11,457**
Accumulated depreciation at 1 April 2016	127,989	0	13,770	131	0	84,301	856	20,843	8,088
Provided during the year	28,407	0	15,667	121	0	10,038	99	1,473	1,009
Impairments	297	0	0	0	0	255	14	2	26
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	(4,105)	0	(4,105)	0	0	0	0	0	0
Disposals	(13,075)	0	0	0	0	(10,920)	(109)	(347)	(1,699)
Depreciation at 31 March 2017	**139,513**	**0**	**25,332**	**252**	**0**	**83,674**	**860**	**21,971**	**7,424**

9.4 Analysis of Property, Plant and Equipment

Net book value									
- Purchased at 31 March 2017	382,576	14,055	301,052	1,676	9,969	48,235	213	3,695	3,681
- Finance leases at 31 March 2017	1,953	0	0	0	0	1,953	0	0	0
- PFI at 31 March 2017	13,548	0	13,548	0	0	0	0	0	0
- Government grant assets at 31 March 2017	2,887	0	2,865	0	0	0	0	0	22
- Donated at 31 March 2017	27,746	655	24,679	148	196	1,701	26	11	330
Total at 31 March 2017	**428,710**	**14,710**	**342,144**	**1,824**	**10,165**	**51,889**	**239**	**3,706**	**4,033**

9.5 Economic life of property, plant and equipment

	Minimum Life (years)	Maximum Life (years)
Land	Infinite	Infinite
Buildings excluding dwellings	14	38
Dwellings	14	19
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	10
Furniture & Fittings	10	10

9.6 Non-property valuations

Depreciated historical cost is the basis for determining fair value for the Trust's non-property assets. This is not considered to be materially different from fair value.

9.7 Property valuations

Net book value of assets covered by valuation method	Land	Buildings excluding dwellings	Dwellings
	£'000	£'000	£'000
Modern Equivalent Asset (no Alternative Site)	0	0	0
Modern Equivalent Asset (Alternative Site)	10,097	323,117	0
Market value in existing use	0	0	1,734
Fair value (surplus PPE land and buildings)	0	0	0
Total at 31 March 2018	**10,097**	**323,117**	**1,734**

The Trust has undertaken a revaluation of the land and property estate at 1st April 2017 based on an alternative site valuation model. Further details regarding the impact of this revaluation can be found in the Director of Finance's report (analysis of financial performance) on pages 27 to 28 of the Annual Report.

10 Non-current assets for sale and assets in disposal groups 2017/18

There were no non-current assets for sale and assets in disposal groups in either financial year.

11 Non-current asset investments

The Trust has holdings in the following companies that are commercially developing intellectual property. The Trust's holdings in these companies carry a minimal value at the Balance Sheet date (31 March 2018 and 31 March 2017). None of the entities are material to the Trust's operations, nor classified as subsidiaries, associates or joint ventures under relevant accounting standards.

Companies in which the trust owns shares

	Shareholding
Epaq Systems Ltd	43.59%
Elaros 24/7 Ltd	13.70%
Independent Care Products Ltd	10.00%
Wetwash Ltd (Formerly Zilico Ltd)	4.68%

Companies limited by guarantee

Devices for Dignity Ltd	Member
Medipex Ltd	Member
Olympic Legacy Park Ltd	Member

12 Inventories

12.1 Inventories

	31 March 2018 £'000	31 March 2017 £'000
Drugs	6,140	5,612
Energy	304	323
Other (implantable devices, etc.)	6,728	8,705
Total	**13,172**	**14,640**

12.2 Inventories recognised in expenses

	31 March 2018 £'000	31 March 2017 £'000
Inventories recognised in expenses	106,969	108,940
Write down of inventories recognised as an expense	65	197
Total Inventories recognised in expenses	**107,034**	**109,137**

13 Receivables

13.1 Trade and other receivables falling due within one year

	31 March 2018 £'000	31 March 2017 £'000 *As Restated
NHS Receivables	36,937	36,069
Provision for impaired receivables (note 13.3)	(4,754)	(3,644)
Prepayments	3,630	3,705
Accrued income	7,346	7,199
Interest receivable	34	11
Public Dividend Capital dividend receivable	891	0
VAT receivable	892	1,029
Other receivables	9,021	9,877
Total falling due within one year	**53,997**	**54,246**

13.2 Trade and other receivables falling due after more than one year

Other receivables - NHS Injury Scheme	4,761	3,900
Total falling due after more than one year	**4,761**	**3,900**
Total Trade and Other Receivables	**58,758**	**58,146**

*31 March 2017 comparative balances in respect of Other Receivables and Related Party Receivables have been aggregated as 'Other Receivables' to achieve consistency with the analysis mandated in the Trust's Financial Return proformas. Details of Related Party Receivables are provided in note 25.

13.3 Provision for impairment of receivables

	2017/18	2016/17
	£'000	£'000
At 1 April	3,644	3,771
Increase in provision	1,407	669
Utilised	(85)	(189)
Unused amounts reversed	(212)	(607)
At 31 March	**4,754**	**3,644**

13.4 Analysis of impaired receivables

	2016/17	2015/16
Ageing of impaired receivables	£'000	£'000
0-30 days*	6	0
30-60 days	9	7
60-90 Days	97	23
90-180 days	131	110
over 180 days	4,511	3,504
Total	**4,754**	**3,644**
Ageing of non-impaired receivables past their due date		
0-30 days	4,138	3,946
30-60 days	725	321
60-90 Days	160	1,608
90-180 days	1,726	711
over 180 days	3,193	2,256
Total	**9,942**	**8,842**

*Non-impaired receivables are stated gross of credit notes raised to certain of the Trust's major commissioners in respect of 17/18 activity. Credits of £16.7m are therefore excluded from the 17/18 0-30 day category.

Receivables are impaired when there is evidence to indicate that the Trust may not recover, in full, sums due. This can be on the basis of legal advice, insolvency of debtors, or other economic factors. Impaired receivables are written off only when all reasonably possible means of recovery have been exhausted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables.

NHS receivables are considered recoverable because the majority of trade is with Clinical Commissioning Groups (CCG's) as commissioners for patient care services. As CCG's are funded by the Government to purchase NHS patient care services, credit scoring is not considered necessary. Similarly, other receivables with related parties are with other Government bodies, so credit scoring is not considered necessary.

Prepayments and accrued income are neither past their due date, nor impaired.

Other trade receivables become due immediately as the Trust does not offer extended credit terms.

14 Current asset investments

The Trust has had no current asset investments in either financial year.

15 Payables

15.1 Trade and other payables

	31 March 2018	31 March 2017
	£'000	*As restated
Amounts falling due within one year:	£'000	£'000
NHS payables	13,926	12,168
Trade payables	21,549	27,051
Trade payables - capital	9,447	8,502
Other payables	8,889	7,981
Accruals	31,040	24,127
Social Security and other taxes	12,509	11,888
Public Dividend Capital payable	0	575
Total current trade and other payables	**97,360**	**92,292**
Amounts falling due after more than one year:	£'000	£'000
Total non-current trade and other payables:	0	0
Total trade and other payables	**97,360**	**92,292**

*31 March 2017 comparative balances in respect of NHS Payables, Related Party Payables and Other Trade Payables have been aggregated and reclassified as 'Trade Payables' to achieve consistency with the analysis mandated in the Trust's Financial Return proformas. Details of Related Party Payables are provided in note 25.

15.2 Early retirements detail included in payables above

	31 March 2018		31 March 2017	
	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	8,300		7,891	

16 Borrowings

16.1 Current borrowings

	31 March 2018 £'000	31 March 2017 £'000
Capital Loans from the DHSC	1,445	1,445
Obligations under finance leases	363	460
Obligations under Private Finance Initiative contracts	624	643
Total Current Borrowings	**2,432**	**2,548**

16.2 Non-current borrowings

Capital Loans from the DHSC	20,400	21,845
Obligations under finance leases	1,300	1,490
Obligations under Private Finance Initiative contracts	17,670	18,294
Total Non-Current Borrowings	**39,370**	**41,629**
Total Borrowings (Current and Non-Current)	**41,802**	**44,177**

17 Other Liabilities

17.1 Current other liabilities

	31 March 2018 £'000	31 March 2017 £'000
Deferred Income	14,977	13,907
Total Current Other liabilities	**14,977**	**13,907**

17.2 Non-current other liabilities

Deferred Income	1,446	1,169
Total Non-Current Other Liabilities	**1,446**	**1,169**
Total Other Liabilities (Current and Non-Current)	**16,423**	**15,076**

18 Financial obligations

18.1 Finance lease obligations

	31 March 2018 £'000	31 March 2017 £'000
Gross lease liabilities	1,849	2,148
of which liabilities are due		
- not later than one year;	435	536
- later than one year and not later than five years;	1,414	1,612
- later than five years.	0	0
Finance charges allocated to future periods	(186)	(198)
Net lease liabilities	**1,663**	**1,950**
- not later than one year;	363	460
- later than one year and not later than five years;	1,300	1,490
- later than five years.	0	0

18.2 Private finance initiative (PFI) obligations (on statement of financial position)

	31 March 2018 £'000	31 March 2017 £'000
Gross PFI liabilities	31,549	33,359
of which liabilities are due		
- not later than one year;	1,749	1,809
- later than one year and not later than five years;	6,323	6,420
- later than five years.	23,477	25,130
Finance charges allocated to future periods	(13,255)	(14,422)
Net PFI liabilities	**18,294**	**18,937**
- not later than one year;	624	643
- later than one year and not later than five years;	2,163	2,129
- later than five years.	15,507	16,165

18.3 Amounts payable to service concession operator

	2017/18 £'000	2016/17 £'000
Interest charge	1,165	1,203
Repayment of finance lease liability	643	582
Service element	611	591
Capital lifecycle maintenance	382	403
Contingent rent	777	687
	3,578	**3,466**

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

	2017/18	2016/17
	£'000	£'000
Service Element	611	591
Depreciation	341	435
	952	**1,026**

18.5 Finance charges in respect of Private Finance Initiative (PFI) transactions

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

18.6 PFI scheme details

Estimated capital value of PFI scheme	£14,361K
Contract start date	December 2004
Contract handover date	March 2007
Length of project (years)	32
Number of years to end of project	18 years, 9 months
Contract end date	December 2036

18.7 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 2018 Hadfield Block	31 March 2017 Hadfield Block
	£000	£000
Within one year	632	611
2nd to 5th years (inclusive)	2,691	2,599
Later than 5 years	11,556	12,130

18.8 Total future payments committed in respect of PFI

	31 March 2018 Hadfield Block	31 March 2017 Hadfield Block
	£000	£000
Within one year	3,707	3,578
2nd to 5th years (inclusive)	15,777	15,230
Later than 5 years	67,688	71,024
Total	**87,172**	**89,832**

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.

The contract contains payment mechanisms providing for deductions in the unitary payment made by the Trust for poor performance and unavailability.

The unitary charge for the scheme is subject to an annual uplift for future price increases. The operators are responsible for providing a managed maintenance service for the length of the contract, after such time these responsibilities revert to the Trust.

During the reported period there were no changes to the contractual arrangements of the scheme.

19 Provisions for liabilities and charges

	Current		Non Current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£'000	£'000	£'000	£'000
Pensions relating to former staff	204	281	2,725	2,780
Legal claims	685	538	40	40
Agenda For Change	0	43	0	0
Other	0	52	0	0
Total	**889**	**914**	**2,765**	**2,820**

	Pensions relating to former staff	Legal claims	Agenda For Change	Redundancy	Other	**31 March 2018 Total**	31 March 2017 Total
	£'000	£'000	£'000	£'000	£'000	**£'000**	£'000
At start of period	3,061	578	43	0	52	**3,734**	4,710
Change in discount rate	33	0	0	0	0	**33**	266
Arising during the year	114	525	0	0	0	**639**	629
Utilised during the year	(199)	(180)	0	0	0	**(379)**	(437)
Reversed unused	(83)	(198)	(43)	0	(52)	**(376)**	(1,472)
Unwinding of discount	3	0	0	0	0	**3**	38
At 31 March 2018	**2,929**	**725**	**0**	**0**	**0**	**3,654**	**3,734**
Expected timing of cashflows							
Within one year	204	685	0	0	0	**889**	914
Between one and five years	812	40	0	0	0	**852**	839
After five years	1,913	0	0	0	0	**1,913**	1,981

Pensions relating to former staff represents the liability relating to staff retiring before April 95 (£530k) and Injury Benefit Liabilities (£2,399k).

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 NHS Resolution, 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 NHS Resolution and not included above. The provision for such cases totals £420k.
- A number of other legal cases, not being handled by NHS Resolution, are also recorded under this heading. These total £305k.

£333,018k is included in the provisions of NHS Resolution at 31/03/2018 in respect of clinical negligence liabilities of the Trust (31/3/2017 £253,843k).

20 Revaluation reserve

	Total Revaluation Reserve	Revaluation Reserve -intangibles	Revaluation Reserve -property, plant and equipment
	£'000	£'000	£'000
Revaluation reserve at 1 April 2017	38,904	0	38,904
Transfer by absorption	0	0	0
Impairments	(24,257)	0	(24,257)
Revaluations	19,877	0	19,877
Transfers to other reserves	(1,575)	0	(1,575)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2018	**32,949**	**0**	**32,949**
Revaluation Reserve at 1 April 2016	39,168	0	39,168
Transfer by absorption	0	0	0
Impairments	52	0	52
Revaluations	1,362	0	1,362
Transfers to other reserves	(1,678)	0	(1,678)
Other recognised gains and losses	0	0	0
Revaluation reserve at 31 March 2017	**38,904**	**0**	**38,904**

21 Cash and cash equivalents

	31 March 2018	31 March 2017
	£'000	£'000
At 1 April	68,330	86,735
Net change in year	6,584	(18,405)
At 31 March	**74,914**	**68,330**
Analysed as cash held		
at commercial banks and in hand	159	284
at Government Banking Service	74,755	68,046
Cash and cash equivalents as in the SoFP	**74,914**	**68,330**

Third party assets held by the NHS Foundation Trust	31 March 2018	31 March 2017
	£'000	£'000
Monies held on behalf of patients	4	4

22 Capital commitments

Commitments under capital expenditure contracts at the Statement of Financial Position Date were £10.1m (31 March 2017, £21.354m). The major components of these commitments are as follows:

	Property, Plant & Equipment
	31 March 2018
Scheme	£'000
Lift Refurbishment - Royal Hallamshire Hospital and Jessop Wing	4,762
Fluoroscopy Room Replacement - Royal Hallamshire Hospital and Northern General Hospital	1,263
Northern General Eye Centre Equipping	904
Plain Film Room Replacement - Royal Hallamshire Hospital and Northern General Hospital	652
Catheter Laboratory Equipment Replacement - Northern General Hospital	434
Barnsley Road Entrance	336
IT Infrastructure Replacement	232
Other	1,480
Total	**10,063**

23 Events after the reporting period

There are no events after the reporting period to highlight.

24 Contingencies

	31 March 2018 £000	31 March 2017 £000
Gross value	(233)	(225)
Amounts recoverable	0	0
Net contingent liability	(233)	(225)

Contingencies represent the consequences of losing all current third party legal claim cases (see note 19).

25 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 pension benefits can be found in the Remuneration Report in the Annual Report. The Declaration of Directors' interests is to be found on page 30 of the Annual Report.

The Department of Health and Social Care 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:

	2017/18		2016/17	
	Income	Expenditure	Income	Expenditure
	£'000	£'000	£'000	£'000
NHS Sheffield CCG	401,904	119	393,702	128
NHS Bassetlaw CCG	6,118		6,394	
NHS North Derbyshire CCG	21,573		21,822	
NHS Barnsley CCG	24,325		25,278	
NHS Rotherham CCG	22,772		23,558	
NHS Doncaster CCG	13,100	12	14,769	
NHS Hardwick CCG	3,468		4,175	
NHS Wakefield CCG	1,749		1,179	
NHS North Lincolnshire CCG	1,356		1,685	
NHS Lincolnshire West CCG	1,248		1,048	
NHS England	401,487	4	379,826	22
Health Education England	52,031		54,588	
Community Health Partnerships		(108)		833
NHS Resolution	59	11,198		9,368
National Blood Authority	476	5,894		6,296
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	7,257	11,111	7,062	11,202
Sheffield Health and Social Care NHS Foundation trust	1,381	2,695	1,401	3,025
Sheffield Children's NHS Foundation Trust	9,612	4,537	9,061	4,105
Barnsley Hospital NHS Foundation Trust	5,243	1,793	5,280	1,893
Chesterfield Royal NHS Foundation Trust	2,157	3,718	1,997	3,479
The Rotherham NHS Foundation Trust	4,115	2,404	4,429	2,392
Bradford Teaching Hospitals NHS Foundation Trust	98	2,642	51	3,095
Calderdale and Huddersfield NHS Foundation Trust	36	1,177	30	1,206
Hull and East Yorkshire Hospitals NHS Trust	260	1,905	269	1,964
Leeds Teaching Hospitals NHS Trust	168	7,200	320	7,181
Mid Yorkshire Hospitals NHS Trust	107	913	243	904

In addition, the Trust has had a number of material transactions with other joint enterprises, government departments and other central and local government bodies. Most of these transactions have been with the Department of Education in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises. Income from the University of Sheffield and Sheffield City Council totalled £3,288k and £5,314k respectively.
Expenditure on goods and services was in the sum of £12,718k from the University of Sheffield and £5,426k from Sheffield City Council.

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 (NHS Improvement from 1 April 2016), and the Department of Health and Social Care. 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 £58,758k at 31 March 2018, (£58,146k at 31 March 2017, note 13.2) £32,077k (£43,268k at 31 March 2017) 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 Statement of Financial Position date.
The remainder of the balance comprises monies owed from NHS Trusts and Foundation Trusts in respect of clinical support services provided. £3,327k was receivable from the University of Sheffield at 31 March 2018, (31 March 2017, £3,383k) in respect of clinical and estates support services provided.
During the year the Trust purchased healthcare from Thornbury Private Hospital in the sum of £4,420k (2016/17 £4,812k) and from Claremont Hospital in the sum of £5,784k (2016/17 £5,702k). Certain of the Trust's clinical employees have an interest in these companies. Certain Clinical services were provided to these organisations.
Indebtedness at 31 March 2018 stood at £119k and £113k owing from Claremont and Thornbury respectively, whilst £410k and £59k was owed.

Payables falling due within one year of £97,360k (31 March 2017, £92,292k, note 15.1) include £13,926k owing to NHS bodies (31 March 2017, £12,168k). This sum includes monies owing to other NHS Trusts and Foundation Trusts for clinical support services received. Certain entities with whom the Trust trades are considered related parties. These entities are to an extent controlled and / or influenced by certain Trust Executive and Non-Executive Directors by the nature of their engagement with that body. As mentioned in the Directors' Report, a full Register of Directors' Interests is maintained by the Assistant Chief Executive. The Trust is satisfied that any conflicts of interest which may arise are declared, and that therefore all transactions with related parties according to the definition above are at arm's length. All material values are disclosed in the table and notes above. 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 Charity. Grants received in the year from this Charity amounted to £1.7m (2016/17 £2.7m).

The Trust has also received revenue and capital payments from a number of other charitable funds. During the year, certain of the trustees of the charitable trusts from whom the Trust has received grants were members of the NHS Foundation Trust Board.

26. Financial instruments

26.1 Financial assets

	Loans and receivables	Assets at fair value through the SoCI	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	46,024				46,024
Cash and cash equivalents at bank and in hand (at 31 March 2018)	74,914				74,914
Total at 31 March 2018	**120,938**	**0**	**0**	**0**	**120,938**
Trade and other receivables excluding non financial assets	47,066				47,066
Cash and cash equivalents at bank and in hand	68,330				68,330
Total at 31 March 2017	**115,396**	**0**	**0**	**0**	**115,396**

26.2 Financial liabilities by category

Liabilities as per Statement of Financial Position	Other financial liabilities £000	Liabilities at fair value through the SoCI £000	Total £000
Borrowings excluding Finance lease and PFI liabilities	21,845		21,845
Finance lease obligations	1,663		1,663
Obligations under Private Finance Initiative contracts	18,294		18,294
Trade and other payables excluding non financial assets	75,962		73,728
Provisions under contract	0		0
Total at 31 March 2018	**117,764**	**0**	**115,530**
Borrowings excluding Finance lease and PFI liabilities	23,290		23,290
Finance lease obligations	1,950		1,950
Obligations under Private Finance Initiative contracts	18,937		18,937
Trade and other payables excluding non financial assets	72,423		72,423
Provisions under contract	0		0
Total at 31 March 2017	**116,600**	**0**	**116,600**

26.3 Maturity of financial liabilities

	31 March 2018 £'000	31 March 2017 £'000
In one year or less	78,395	74,972
In more than one year but not more than two years	2,400	2,548
In more than two years but not more than five years	6,844	6,852
In more than five years	30,125	32,228
Total	**117,764**	**116,600**

26.4 Fair values of financial assets and liabilities at 31 March 2018

The fair value of the Trust's financial assets and liabilities at 31 March 2018 equates to the book value. The book value of financial assets and liabilities is shown in notes 26.1 and 26.2.

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. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups, and the way those Clinical Commissioning Groups 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 nineteen years and nine months, 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 4.00% 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 2018 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 and Social Care, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

27 Third party assets

The Trust held £3,846 at bank and in hand at 31 March 2018 (31 March 2017, £3,792), 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.

28 Losses and special payments

	2017/18 Number	Value £'000	2016/17 Number	Value £'000
Losses				
Cash Losses	1	0	8	1
Fruitless payments and constructive losses	1	3	0	0
Bad debts and claims abandoned	101	85	290	189
Stores losses (including damage to buildings and property)	28	87	13	204
	131	**175**	**311**	**394**
Special Payments				
Extra-contractual payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Compensation payments	1	15	0	0
Special severance payments	0	0	0	0
Ex-gratia payments	88	17	89	11
	89	**32**	**89**	**11**

No individual items exceeding £300,000 were incurred in either year.

These losses are reported on an accruals basis.

29 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 £10,274k (2016/17 £10,359k).

For more information or if you would like this document provided in a different language or large print please contact:

The Communications Department
Sheffield Teaching Hospitals NHS Foundation Trust
8 Beech Hill Road
Sheffield
S10 2JF

Tel: 0114 266 8989
www.sth.nhs.uk
email: makingadifference@sth.nhs.uk