Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2008-2009

Excellence as standard

Contents

Annual Accounts 08/09

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

Sheffield Teaching Hospitals NHS Foundation Trust

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Welcome

As one of the largest and most consistently high performing NHS foundation trusts in the country, the Trust continues to offer some of the best care available in today's NHS providing high quality, value for money services at all of its five hospitals; the Northern General, the Royal Hallamshire, Weston Park, Jessop Wing and Charles Clifford Dental hospital.

Among the largest employers in the region, Sheffield Teaching Hospitals NHS Foundation Trust employs around 13,500 talented and dedicated people who continually strive to enhance the patient experience and improve clinical outcomes to meet the needs of the local, regional and national population that we serve. We are the only group of hospitals to be awarded the accolade of Trust of the Year in the Good Hospital Guide twice in three years.

During this year the Trust will have performed over 200,000 inpatient episodes and day cases and around 850,000 outpatient appointments totalling over a million patient episodes. Each year our patient services plan builds on our vision and priorities to ensure we provide high quality health services to our patients and create an environment where staff are empowered to explore new, creative ways of working for the benefit of patients.

Chairman's Statement

Chairman's Statement

Once again it has been a successful year which culminated in being awarded the accolade of Trust of the Year in the Good Hospital Guide for the second time in three years.

The Trust of the Year award is only awarded to an organisation which demonstrates excellence in the things which really matter to patients including safety, quality of care, waiting times, cleanliness of the hospitals, prevention of hospital acquired infections such as MRSA and how responsive a trust is to its patients. The award came just a few weeks after receiving a 'double excellent' rating for the quality of our services and financial management in the Healthcare Commission's Annual Performance Ratings.

We were one of only 42 out of 391 trusts nationally to achieve a double rating of excellent and only one of 12 to have done so in consecutive years.

This was achieved not least, through the dedication and determination of all our staff to improve patient services, whilst at the same time working hard to ensure that the services offered, constitute value for money. The achievements are based on delivering what we know all patients want from their health services and so our priorities during the year have continued to be rigorous infection control, low waiting times, quality clinical care, a good patient experience, research and innovation.

Waiting times are now at an all time low albeit the national target of 18 weeks from referral to treatment has been challenging. Our staff have worked hard to achieve the milestones which were that 95% of outpatients and 90% of inpatients should start treatment within 18 weeks of being referred to hospital. Our actual results were 96% and 91% respectively, which meant that we exceeded these milestones, providing a very high quality of access to our services for patients. National research has also shown that in 2008/09 we have gone a step further and a high proportion of our patients were actually treated within 8-9 weeks.

We also met all the targets for cancer diagnosis and treatment; 100% of suspected cancer patients who were referred by their GP for urgent diagnosis were treated within 62 days and all patients found to have cancer started their treatment within 31 days.

No patients waited more than six weeks for diagnostic tests and MRI scans. As well as offering imaging on demand where patients attending outpatients have the option of having their x-ray or scan on the spot without the need to return for a further appointment, we also extended our opening hours for some services until 8pm in the evening and Saturdays to make it more convenient for patients.

For the past four years we have been one of the most successful groups of hospitals in the country to prevent healthcare associated infections like MRSA and *Clostridium Difficile.* Out of the million patients treated at Sheffield hospitals in 2008/09 there were 24 cases which represents less than a 0.01% chance of a patient acquiring a MRSA blood stream infection. Health Protection Agency figures also show the January to March 2008 figures for *Clostridium Difficile* were the lowest for two years. The reduction in MRSA and *Clostridium Difficile* cases is a direct consequence of our zero tolerance approach to infection control and the commitment of staff to keep patients safe. In February 2009 the Trust was one of only ten in the UK to be recognised for making an outstanding contribution to fighting infection in the Health Care Associated Infections Technology Innovation Programme Awards. The £150k prize is being used to further develop innovative technologies to prevent infection in our hospitals.

Despite sustained pressure particularly around the number of emergency admissions, the Trust has continued to produce an impressive array of developments within an environment of testing financial demands.

As always with an annual report, it is a difficult task selecting only a few highlights from the year but there are some of particular note that I would like to mention. Further projects are highlighted in the Directors' report.

An innovative new service developed in partnership with NHS Sheffield and Sheffield Health and Social Care NHS Foundation Trust has helped dramatically reduce the number of older people attending Accident and Emergency (A&E). Before the Falls Prevention Service was in place, elderly people who had fallen received little support to help reduce the risk of them having another fall and thus facing a further hospital admission or even sustaining more serious injury such as a hip fracture.

Now following an initial assessment by a therapist in A&E, patients who may benefit from the service are offered a range of support from home visits, strengthening exercises and walking aids. The number of people re-attending A&E in the six months after receiving the service has reduced by 74%, while admissions to hospital resulting from a fall have reduced by 38%.

Continuing the theme of prevention is better than cure, a new 'gold standard' service for patients suspected of having heart failure was launched in November. There are approx 7,000 cases of heart failure in Sheffield and many patients are admitted to our wards who unknowingly are suffering from heart failure as well as the condition they have come in for. The new heart failure service ensures early detection and care for these patients because a team of Heart Failure Specialist Nurses undertake early morning rounds in both the Northern General and Royal Hallamshire Hospitals to identify potential sufferers.

Ward staff can also call upon the heart failure nurses to see patients who they think may have symptoms.

A multi disciplinary team of specialist doctors, nurses and therapists then provide the necessary treatment and follow-up care. Over 200 GPs have also attended an educational event to help us develop a faster diagnostic service for GP's to use when they suspect a patient has heart failure.

In January, Margaret Egginton became one of seven volunteers to take part in a new Meal Time Volunteer Scheme piloted at the Northern General Hospital to help and encourage patients to eat. We know good nutrition is essential to a speedy recovery and one thing that affects patients appetite is the environment at meal times. Margaret and her colleagues go onto the ward before a meal is served to make sure patients are ready and indeed can eat by preparing their bedside tables, helping with hand washing, ensuring they have a fresh drink and cutting up food where needed.

Sheffield has always had a role to play in helping shape the future direction of NHS services.

Throughout the year we continued our rolling programme of ward upgrades and invested over £3 million to ensure a further three wards were welcoming and of a high standard.

During March we were honoured to welcome Lord Ara Darzi and NHS Chief Executive David Nicholson to open the new £20 million 36 bed, Critical Care Unit at the Northern General Hospital which houses some of the most advanced intensive and high dependency care technology available today. Lord Darzi was impressed with the 'world-class facilities' and spent time speaking with patients and staff about their experiences.

Sheffield has always had a role to play in helping shape the future direction of NHS services and last year was no different. Our Chief Nurse Hilary Scholefield was appointed as an expert member of the National Quality Board, Chief Executive Andrew Cash was chosen to be part of the National Leadership Council and Voluntary Services Manager Alan Smith was invited by the Department of Health to help produce a strategy on Volunteering in Health and Social Care.

Our clinicians contribution to healthcare was recognised during the year when Professor of Clinical Oncology Barry Hancock, was awarded the OBE. Barry has been a pioneer in cancer research and treatment and is a member of various regional, national and international boards. Professor Chris Welsh, our Chief Operating Officer and Medical Director at NHS Yorkshire and the Humber also received the OBE for services to the NHS.

Two of our Consultant Physicians, Professor Solomon Tesfaye (Diabetologist) and Dr Marios Hadjivassiliou (Neurologist) were awarded the 'Dawn Ind Memorial Chalice' to acknowledge their contributions towards helping patients with painful neuropathy.

Research registrar Dr Andrew Hopper was short listed to receive the British Medical Journal research paper of the year award for his innovative research into coeliac disease. Andrew developed a test for diagnosing coeliac disease more quickly which also avoids patients having to have a biopsy to rule out the disease.

And finally, an estates officer who invented a widget which saved the Trust millions of pounds, a domestic services assistant who has exceptional cleaning standards and always offers a warm welcome to everyone and a volunteer who after forty years of service returned to work voluntarily on our reception desks are
just a few of the stars who were rewarded for dedication to patient care at the Trust's sixth annual Thank You Awards. I am very proud of all our staff and volunteers for their tremendous achievements, which are the basis for this organisation's success and for the excellent quality of care provided to patients. The individuals short-listed for the Thank You awards are no exception and have worked above and beyond the call of duty to ensure that the needs of our patients are at the core of everything we do.

We were very fortunate to yet again have the support of some exceptional charities throughout the year. Last year Sheffield Hospitals Charitable Trust, the umbrella charity, which supports health services

across Sheffield, raised £150,000 as part of the Sheffield Leukaemia and Blood Disorders Appeal. The money funded new equipment needed to complement the extensive ward refurbishments which took place on floors 0 and P at the Royal Hallamshire hospital. We are very grateful for the ongoing support from the charity. Neurocare is another of our proactive charities who have funded an array of equipment to help patients suffering from epilepsy, stroke and Motor Neurone disease as well as continuing to support research into neurological conditions. Thank you for all their tireless generosity. Weston Park Hospital Cancer Charity continues to go from strength to strength thanks to the generosity of the public. The Cancer Charity supports treatment and care at the Trust's dedicated cancer hospital and continues to provide core funding to the Weston Park Cancer Research Centre, which acts as a hub for a multimillion pound programme of research. We would like to thank everyone who has given so generously to the Weston Park Hospital Cancer Charity for making a real difference to people living with cancer in this region.

I would like to take this opportunity to thank every charity and individual person who supports us with their generous donations.

Our foundation status enabled us to work even closer with our local community throughout the year and our membership grew significantly. I have been particularly encouraged to see more younger people joining us as members. The work of the Governors is making a positive impact on services and they were instrumental in attracting members of the public to be involved in joining the Biomedical Research Units Patient and Carer Research Panels. This was a pioneering move as it means the public and carers will help shape how the £7.5m funding for research into bone and heart conditions should be spent.

And finally we look forward to the coming year when we will begin to implement our new corporate strategy. Key areas of work include options to reconfigure services to better meet the needs of patients, particularly those with long term conditions, encouraging innovation and developing new and formal partnerships in academia, research and commercial enterprise. The latter will ensure that Sheffield Teaching Hospitals is well and truly on the map when it comes to research and development.

We continue to go from strength to strength as an organisation. However our ultimate goal is to ensure that without exception our patients receive excellent clinical outcomes and a positive experience whilst in our care.

David Stone OBE
Chairman

Directors' Report

The year 2008/09 was a key year because we embarked upon a new journey to provide our patients with some of the best health services not just in the UK but in the World. In October we launched a consultation seeking the views of the public, our partners and community groups on the aspirations set out in a new four year corporate strategy called 'Excellence as Standard.'

The strategy sets out how we will respond to the opportunities and challenges created by new national policies for the NHS; and also how we will extend the benefits of our Foundation status more widely in the local and regional community in which we operate. The new direction for the NHS is about creating a high quality and personal service for patients. We have been challenged by Ministers to do this, and our 'Excellence as Standard' strategy aims to develop services which blend the benefits of an innovative, entrepreneurial approach with core public service values - in the 'Sheffield Way'.

The strategy has a drive for quality at the heart of everything we do and builds on the improvements and innovations achieved during 2008/09.

As previously mentioned in the Chairman's report, the commitment by our 13,500 staff and volunteers to achieve the highest standards for our patients was recognised by the Trust of the Year accolade and came just weeks after the Trust was named as one of the top 10% of UK hospitals for the second year running in the official NHS annual health check ratings. Perhaps even more important though was the results of the 2008/09 national NHS Patient Survey which placed us in the top 10% of NHS Trusts for high patient satisfaction with particular praise for our nurses and the quality of clinical care.

Our services for women and their families were also commended during the year. Over 93% of women rated the care they received from staff in the Jessop Wing as excellent, very good or good. The national average was 89%. The views were gathered in a review by the independent Healthcare Commission, which ranked the Jessop Wing as one of the country's better performing maternity units. Investment throughout the year in eight new midwives including a Consultant Midwife, new home from home birthing rooms and a new family room to help support parents visiting premature or sick infants all ensured we continue to provide a friendly environment where families can receive high quality care.

Waiting times are now at an all time low and our outcomes for operations are among the best in the UK.

A national audit reassured Sheffield women that they are receiving smear test results quicker than women in any other part of England, the majority of tests being returned within 14 days. 33,500 smear tests are performed across the city each year; all of which are processed by the cytology screening laboratory at the Royal Hallamshire Hospital.

The Assisted Conception Unit at the Jessop Wing also installed a new state of the art system to enable the electronic tagging of samples used in IVF treatment. This ensures that the right sperm is matched with the right egg and implanted in the right woman. If egg and sperm samples from different couples are brought into the same work area, an alarm instantaneously sounds and the procedure is prevented from being carried out.

Cardiac services also came under the spotlight during the year when the Healthcare Commission published heart surgery survival rates for all UK hospitals. Sheffield cardiac surgeons were among the first in the UK to make their figures

public so that patients could make an informed choice about where to have their surgery. Since then the seven strong team has had consistently high survival rates and the 2008/9 rates for aortic valve replacement, bypass surgery and other types of heart surgery was once again above the national average at 96%.

In June 2008 the cardiac team pioneered a new service to fast track treatment for heart attacks. Primary Percutaneous Angioplasty (PPCI) has been shown to improve survival, reduce disability and shorten the patient's stay in hospital following certain types of heart attack called STEMIs. Paramedic crews will rapidly diagnose a heart attack and alert the hospital's cardiology team via a dedicated phone line that they are bringing in a patient for emergency treatment. The patient is immediately transferred to the cardiac catheter suite for the PPCI procedure. The service is available 24 hours a day, 7 days a week. By the end of March 2009, 150 patients had already benefited from the new service.

The next step in developing what will become our 'Heart Attack Centre' is to extend the service to patients suffering a heart attack in Rotherham. Once this is well established the centre will extend its service to incorporate the rest of North Trent so that all heart attack patients in the area can benefit from this significant development in specialist cardiac care.

In other areas of emergency care the Healthcare Commission rated Sheffield's emergency care service as 'better performing'. Regrettably due to unprecedented demand over the Winter period, the national target of 98% of patients being seen within 4 hours was narrowly missed (97.8%) but plans are in place for 2009/10 to improve this performance by increasing capacity and staffing as well as working with Sheffield City Council to improve the speed of discharge for patients going to nursing homes or needing home care services.

At the Charles Clifford Dental Hospital, the multi million pound redevelopment which began in September 2007 was completed. The project was the most ambitious redevelopment since the hospital was expanded in 1966 and enabled us to increase the number of dental students from a historic baseline of 45 to 75 students per year.

Weston Park Hospital, one of three specialist cancer hospitals in the country, continued a major drive to deliver chemotherapy closer to the patient's home in all the surrounding outreach hospitals, which has been particularly successful. We have introduced a dedicated 'consultant of the day' scheme in which the consultant is available to answer any questions about appropriate admission of sick patients. This has been achieved in advance of a recent national report highlighting the need to improve this aspect of the oncology service nationwide.

A pilot study carried out in 2008 to enable inpatients to have complementary therapy had very positive results and there are plans to extend availability of the therapies to other wards throughout 2009/10.

We are now in the third year of our Adding Value programme, which focuses on improved patient care and better value for money for the taxpayer.

A newly refurbished day room was opened in December by school children from St.Bernard's Catholic High School who raised a magnificent £12,000 after their teacher, Brian Storey, lost his wife Barbara to breast cancer in 2005.

Patient safety is paramount and part of the culture at Sheffield Teaching Hospitals. This was reinforced in 2008/09 when the Board became a member of the Patient Safety First campaign and appointed an Associate Medical Director for Patient Safety.

As already mentioned in the Chairman's report keeping patients safe from infection is paramount and our committed staff are at the forefront of this drive.

The Renal Unit team at the Northern General hospital have brought MRSA rates down to near zero by constantly looking for innovative ways to keep infection prevention at the forefront of everyone's mind. Professional Development Sisters Susan Heritage and Hilary Linton developed a giant snakes and ladders game to highlight best practice in infection prevention and control to junior staff.

As well as managing the day to day challenges of a busy Trust, we have also been actively looking at some of the more strategic issues which will help ensure that the trust moves forward in the future.

A big issue was looking at how we can better configure our services across the city. When the Northern General Hospital and Central Sheffield University Hospitals trusts merged back in 2001 many services were duplicated. Over the years a lot has been achieved in this area and we have now entered the final phase. During the year a Reconfiguration Board was set up comprising clinicians, senior nurses and managers to look at the optimum provision of services to reflect best clinical practice and we began discussing initial views with our Commissioners and health/social care partners to ensure an integrated approach.

We are now in the third year of our Adding Value Programme, which focuses on improved patient care and better value for money for the taxpayer. There are many strands to the programme but essentially it is about cutting out unnecessary waste. This includes the amount of time patients spend waiting for clinic appointments and treatments. Staff are at the forefront of this work as it is they who make the difference between a patient having to wait and receiving their treatment promptly. Staff agree that unnecessary waits are unacceptable.

One example of the Adding Value Programme benefiting patients and staff is the introduction of a new messaging service to help patients remember appointments which was trialled in 2009. Last year there were more than 77,000 missed appointments across the whole of Sheffield Teaching Hospitals

the ‘Releasing time to care’ initiative allows nurses to spend more time caring for patients.

NHS Foundation Trust which could have been used for other patients. The missed appointment slots also cost £60 - £120 per appointment in wasted staffing costs. Research shows that many of the missed appointments were because the patient simply forgot so the new system calls patients on their home or mobile phone one week before their appointment date to remind them and re-arrange an appointment if they cannot attend.

The Adding Value Programme has also supported the ‘Releasing time to care’ initiative launched in early 2008, funding a dedicated project manager, and 39 wards have now completed the scheme which enables nurses to spend more time caring for patients.

Maintaining financial balance in the years ahead remains a significant challenge.

We must deliver further recurrent financial savings consistent with the ‘Adding Value’ principle of delivering efficiency through improvements in patient care.

Taking care of our staff is as important to us as caring for our patients which is why in 2008 we commissioned a ‘Wellbeing at Work’ project to help proactively manage work place stress for everyone who works at our hospitals. Working with The University of Sheffield, the Trust commissioned a study to help the Trust understand the factors which contribute to work place stress. Findings from the pilot have been used to inform the final version of a self assessment tool which will be adopted for use across the Trust in the summer of 2009.

Keeping staff safe is top of our agenda and so throughout the year more than 80% of our frontline staff received training in how to deal with aggressive or abusive patients and visitors. The training is part of a wider violence and aggression policy that outlines the Trust’s zero tolerance of abusive behaviour towards staff.

The Trust is keen to develop our leaders of the future and so we continued the implementation of the Leadership and Management Development Framework programmes run in conjunction with Sheffield Hallam University. We also piloted the NHS Institute’s Productive Leader Programme and plans are in place to cascade this throughout the organisation.

Business continuity is important for any organisation, but particularly for hospitals. We tested our plans in August 2008 when we carried out a planned switch off of all the mains electrical power at the Royal Hallamshire Hospital site to check that the back up generators would automatically take over. The test was a success and we intend to carry out similar tests on our other sites.

We are now counting down to the introduction of the European Working Time Directive (EWTD 2009), which comes into force on 1 August 2009.

Taking care of our staff is as important to us as caring for our patients.

As England's largest NHS Foundation Trust, this new legislation has always represented a challenge since it reduces the maximum average hours of work for all training grade doctors from 58 to 48 hours a week. To ensure that we comply, we have built on the work outlined in last year's Annual Report and Accounts.

Externally, many of our staff have been central to the Strategic Health Authority's work on Lord Ara Darzi's *Next Stage Review* of the NHS, contributing to Healthy Ambitions, Yorkshire and the Humber's response to the review.

We are committed to supporting the delivery of Healthy Ambitions and to making a significant contribution to modernising healthcare enabling us to provide world-class services for local people and for patients who travel further to receive the specialist treatments we provide.

To support this we have worked hard to encourage innovation to ensure our patients have the benefit of the very latest new technologies and therapies.

The number of innovations generated in the Trust this year is higher than in any other NHS organisation in the Yorkshire and Humber Region. At the beginning of 2009 there were 15 innovation projects, compared to nine projects in total in 2008.

We established a new innovations fund called the Bright Ideas Fund, with an initial £85,000 investment designed to provide modest amounts of start-up funding for staff to help them work up new ideas.

Two examples of high impact innovations developed that are being used across the NHS to improve patient care won awards at the Medipex NHS Innovation Awards Ceremony.

Tom Darton's 'blood testing tool for antibiotics' reduces the time it takes to screen potentially infected blood from 1-2 days to four hours, significantly improving the prescribing of antibiotics and reducing the cost, duration and side effects associated with excessive antibiotic use. The impact of this diagnostic test will be that patients will receive the most effective antibiotic therapy at least 24hrs earlier than by current conventional methods.

Local inventor, Andy Speechley was supported by the NIHR Devices for Dignity Healthcare Technology Co-operative hosted by Sheffield Teaching Hospitals to develop the 'Dignity' Mobile Bidet/Dryer Commode which allows disabled and elderly people to clean themselves after using the toilet.

We continue to ensure that commercial opportunities arising from innovation are fully exploited. and 2008 saw our first 'joint venture' with a commercial partner to prototype, develop and market an operating theatres fluid waste disposal system that will save the NHS money and also provide a greener way of disposing of certain types of clinical waste.

Our drive in the field of research and innovation is ensuring high quaity patient care.

Considerable progress has been made since the success of our joint bid with The University of Sheffield to develop two National Institute for Health Research (NIHR) Biomedical Research Units (BRU's), in musculoskeletal and cardiovascular disease. The individual BRU's are developing their activity plans and recruiting research staff, a process that will continue into 2009/10. Both units will ultimately be housed in dedicated facilities that will form part of a new Centre for Biomedical Research, being developed on the Northern General Hospital site and due to open in September 2009.

In 2008 we put in a successful bid on behalf of our partners in South Yorkshire, to become one of the UK's nine Collaborations for Leadership in Applied Health Research and Care Consortia (CLAHRC). The South Yorkshire Consortium (CLAHRC SY) aims to develop the self-management of long-term conditions like diabetes, stroke and obesity through applied research, health technology innovations and the translation of knowledge into quality patient care. The success of our application will result in a £20 million investment in the health of the region.

The Trust played a leading role in the development of a bid to the Department of Health to develop an Academic Health Science Centre (AHSC). The White Rose partnership developed an ambitious plan to stimulate and accelerate translational research initially in the areas of cancer, cardiovascular disease, musculo-skeletal, dental, neuroscience, and infection and immunology. Researchers and clinicians identified that working together, they could achieve much more, much faster. As part of the application process, the partners designed systems for working together that would deliver these benefits, support innovation and help boost the economy via commercial application.

The White Rose proposal was not selected by the Department of Health as part of the first tranche of AHSCs. However, the partners are continuing to work together to deliver these benefits.

Throughout the year, the Trust identified opportunities to make optimum use of its Foundation status and 'punch its weight' in contributing to the local economy. We have a 10-point 'pledge', which sets out how we will help raise attainment and aspiration in Sheffield. For example, we have offered 109 apprenticeship places for local young people to develop skills and gain employment. We have appointed 10 Trust Healthcare Ambassadors who are working with schools to lead careers events and experiential learning and we have worked with the Sheffield 14-19 partnership group to develop a Health and Social Care Diploma.

The Trust is now an active member of Sheffield First, the Local Strategic Partnership, and a Sheffield First partner member has been appointed to our Governors' Council. We have developed proactive links with the City's Economic Partnership, Creative Sheffield and also with the Sheffield Chamber of Commerce. Plans to develop a medical technology innovation centre, will support more proactive links with local industry and also an international function that could help encourage inward investment. Working with Creative Sheffield, our expertise in medical technology has been cited as a key factor in the decision of a Portuguese company called Tomorrow's Options to establish a subsidiary in Sheffield that will bring new jobs into the local economy.


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We began work to establish a healthcare academy from which all vocational education services will ultimately be delivered. The Academy is a collaborative venture between the Trust and Sheffield City College with financial support from the Sheffield Work and Skills Board, Yorkshire and Humber Strategic Health Authority and Skills for Health. Work to set up the Academy, which will be the only one of its type in the Yorkshire and Humber Region, will continue throughout 2009/10. Once established, it will also directly support the Trust's ambition to become a world-class teaching hospital.

We recognise that being part of the NHS, we have an important role to play in reducing carbon emissions, a key cause of climate change. During the year, the Trust worked with partners at national, regional and local level to develop a sustainable development action plan. They include ensuring business plans and service specifications include actions on sustainable development and any redesign of patient care and treatment pathways are low or zero carbon.

Our work in 2008/9 has given us a solid base on which we can move forward to achieve the aspirations set out in our corporate strategy.

The Trust continues to work with local communities and patient user groups in a variety of ways to ensure that we meet the needs of our diverse community. During the year staff from the infectious diseases department have been working with the refugee community, while other staff have gone out to the travelling community to ensure that pregnant women receive antenatal care.

A telephone interpreting service has been introduced that provides instant access to a large number of languages, improving the quality of care for many of our patients.

A Muslim chaplain has recently been appointed to work across the healthcare community. We have improved access for wheelchair users across our sites. We continue to work with local schools, colleges, job centres and external agencies to recruit a diverse workforce and to attract volunteers from across the community. The Trust will be developing a Single Equality Scheme in consultation with both service users and staff during 2009/10.

Our work in 2008/9 has given us a solid base on which we can move forward to achieve the aspirations set out in our corporate strategy. We want to have the best possible clinical outcomes for each patient; to ensure their experience of our services is as convenient and personal as possible; and that our staff feel committed and able to perform at their best. In short we want to match the best standards not just in the UK, but across the world. We will do this by focussing on 'quality outcomes' and by undertaking top quality teaching and research.

Andrew Cash.

Andrew Cash OBE

Chief Executive
on behalf of the Directors

Management Commentary 08/09

Management Commentary

Our ultimate goal is to ensure that without exception our patients receive excellent clinical outcomes and a positive experience whilst in our care.

In October 2008 the Trust produced its vision for the next four years, outlining our aspiration to deliver 'excellence as standard' under the key themes of clinical excellence, patient experience and staff engagement.

These aspirations are based on delivering what we know all patients want from their health services and so our priorities during the year have continued to be rigorous infection control, low waiting times, quality clinical care, a good patient experience, research and innovation. There have been significant developments in all these areas throughout 2008/9, despite testing financial demands.

Clinical excellence

Healthy Ambitions

Many of our staff have been central to the Strategic Health Authority's work on Lord Ara Darzi's *Next Stage Review* of the NHS, contributing to Healthy Ambitions, Yorkshire and the Humber's response to the review.

This work, to develop a local clinically led vision for improving health and health care, was chaired by Professor Chris Welsh, the Trust's Chief Operating Officer. Eight sub group chairs including Dotty Watkins, the Trust's Head of Midwifery who chaired the maternity and newborn pathway, and Dr David Levy who chaired the end of life pathway assisted him. A&E Clinical Director Francis Morris co-led the region's review of the Acute Episode

pathway. We are committed to supporting the delivery of Healthy Ambitions and to making a significant contribution to modernising healthcare enabling us to provide world-class services for local people and for patients who travel further to receive the specialist treatments we provide.

Achieving high standards

Waiting times are now at an all time low albeit the national target of 18 weeks from referral to treatment has been challenging. National research has also shown that in 2008/9 we have gone a step further and a high proportion of our patients were actually treated within 8-9 weeks.

The Trust is expected to achieve a number of national and local targets relating to access for treatment and waiting times. The table opposite sets out our performance for this year.

Our hospitals are rated as some of the best in the UK for high levels of patient satisfaction.

Target	Standard	Performance
Waiting Time in A& E	98% of patients will wait less than 4 hours from arrival to admission or discharge.	Under achieved - 97.8%
Outpatient Waiting times	No patient shall wait longer than 13 weeks from GP referral.	Achieved
Inpatient Waiting times	No patient shall wait longer than 26 weeks for inpatient admission.	Achieved
Referral to treatment times	90% of admitted patients and 95% of non admitted patients will be treated within 18 weeks.	Achieved
Genitourinary Medicine waiting times	All patients should be offered an appointment to be seen within 48 hours of contacting the service.	Achieved
Revascularisation Waiting times	No patient shall wait longer than 13 weeks for cardiac revascularisation.	Achieved
Waiting time for Rapid Access Chest Pain Service	All patients referred to the Rapid Access Chest Pain Service shall be seen within 2 weeks.	Achieved
Referral to treatment time - non-admitted patients	95% if patients who do not require admission to hospital shall be treated within 18 weeks of being referred.	Achieved
Referral to treatment time - admitted patients	90% if patients who require admission to hospital shall be treated within 18 weeks of being referred.	Achieved
Time to reperfusion for patients who have had a heart attack	Percentage of eligible patients with acute myocardial infarction receiving thrombolysis treatment either by injection or by infusion within 60 minutes of calling for help.	The majority of patients attending the trust in this way proceed directly to Percutaneous Cardiac Intervention, so do not require thrombolysis treatment.
Ethnic Group Indicators	85% of finished consultant episodes should have a valid 2001 census coding for ethnic category.	Achieved

All patients urgently referred by their GP with suspected cancer were seen for a outpatient appointment within two weeks.

Cancer Waiting times

We also met all the targets for cancer diagnosis and treatment. The table below sets out our performance against national targets for this year.

Target	Standard	Performance
Referrals for Suspected Cancer.	All patients shall be seen for a first outpatient appointment within two weeks when urgently referred by their GP with suspected cancer.	Achieved
Waiting time from decision to treat to treatment for treatment for Cancer.	All patients shall receive their first definitive treatment within 31 days of the treatment decision being agreed by the patient. There is a 2% allowance for clinical exceptions.	Achieved
	From December 2008 this covers all cancer treatments, including second or third treatments and treatment of recurrence of cancer, where the treatment is surgery or drug treatment.	Not known at this stage - data not published nationally yet.
Waiting time from referral to treatment for Cancer.	All patients shall receive their first definitive treatment for cancer within 62 days of GP urgent referral for suspected cancer. There is a 5% allowance for clinical exceptions.	Achieved
	From December 2008 this includes referrals from national screening programmes and from consultants where they request that the patient is managed on a two month pathway.	Not known at this stage - data not published nationally yet.

Developing a patient centred diagnostics service

Currently nobody is waiting more than six weeks for a diagnostic scan, with the vast majority being seen within three weeks. We are also offering imaging on demand for scans such as MRI, CT and Ultrasound, which historically were booked on another day. Extended opening hours for some services has also been introduced to enable patients to have their tests up to 8pm in the evening and at the weekend.

The majority of patients needing a non urgent scan are seen within three weeks. Nobody waits more than six weeks.

Gold standard heart care

Cardiac services also came under the spotlight during the year when the Healthcare Commission published heart surgery survival rates for all UK hospitals. Sheffield Cardiac surgeons were among the first in the UK to make their figures public. This enables patients to make an informed choice about where to have their surgery. Since then the seven strong team of heart surgeons at the Northern General's Chesterman Cardiac Centre have had consistently high survival rates.

In June 2008 the cardiac team in close partnership with Yorkshire Ambulance Service pioneered a new service to fast track treatment for heart attacks. Primary Percutaneous Angioplasty (PPCI) has been shown to improve survival, reduce disability and shorten the patient's stay in hospital following certain types of heart attack called STEMIs.

Paramedic crews will rapidly diagnose a heart attack and alert the hospital's cardiology team via a dedicated phone line that they are bringing in a patient for emergency treatment. The patient is immediately transferred to the cardiac catheter suite for the PPCI procedure.

The service is available 24 hours a day, 7 days a week. By the end of March 2009, 150 patients had already benefited from the new service

The next step in developing what will become our 'Heart Attack Centre' is to extend the PPCI service so that patients suffering a heart attack in the Rotherham area are brought directly to the Northern General Hospital for PPCI before being transferred to Rotherham District Hospital for rehabilitation and ongoing care.

We provide a gold standard of cardiac care to our patients

Once this is well established the centre will extend its service to incorporate the rest of North Trent so that all heart attack patients in the area can benefit from this significant development in specialist cardiac care.

New Heart Failure service

Last year the Trust set up a multidisciplinary team to create a vision for a clinically excellent, coordinated and innovative service for patients with heart failure. The result was a new heart failure service, launched in December 2008.

The service comprises an expanded nurse specialist team and a single point of contact for community and hospital referrals. The nurse specialists review patients on the medical admissions units, identifying those with heart failure at the start of their admission and plan their care through to discharge. They also assess and advise on the management of patients referred from wards across the Trust. The nurses also run eight heart failure clinics per week to optimise the medication of patients discharged from hospital and provide ongoing support and advice.

There are designated heart failure beds on the medical wards Robert Hadfield 2 at the Northern General Hospital and Q2 at the Royal Hallamshire. This focuses the management of heart failure patients into a specialist area with a team of medical and nursing staff who are highly experienced in the management of their condition.

Weekly multidisciplinary team meetings chaired by specialist heart failure cardiologists agree and coordinate the ongoing treatment plan for each patient; while specialist multidisciplinary team meetings are also held on a weekly basis for patients who would benefit from complex treatments such as pacemaker implantation or cardiac surgery.

The service database generates communication from the hospital to GPs and holds the clinical details of patients admitted with a heart failure diagnosis, allowing ongoing audit of the quality of patient care.

In January the Heart Failure Team, with colleagues from NHS Sheffield, hosted an educational event attended by more than 200 Sheffield GPs. This led to the agreement and implementation of a new, faster diagnostic service from the Trust for GP's to use when they suspect a patient has heart failure.

We intend to develop and improve the Heart Failure Service as a high profile specialty within the Trust and will continue to work closely with colleagues in primary care ensuring that patients with this chronic and highly disabling condition can benefit from uniformly high standards regardless of their 'port of entry' into the new service.

Leading the way in cancer care

Sheffield is fortunate to have one of only three specialised cancer hospitals in the UK in the form of Weston Park Hospital. However, there are other cancer services provided across the Trust and therefore all cancer services are co-ordinated through a Cancer Services Steering Group that seeks to ensure that all the services operate to the same high standards and meet the developing access times.

The Cancer Reform Strategy is a key driver for the Steering Group and this will encourage the Trust to further localise some of the treatments currently centralised in the Trust.

Throughout the year a number of Improving Outcomes Guidelines (IOGs) were implemented within the Trust to further improve upon the high standard of cancer care our patients have come to expect.

These include:

- head and neck cancers - the Trust is the host of the Network Specialist Multi Disciplinary Team and one of two specialised surgical sites along with Chesterfield Royal Hospital
- skin cancer - the Trust will host the Specialised Network Multi Disciplinary Team and provides specialised treatments including Mohs' surgery. In Mohs' surgery, the tumour is removed piece by piece. Each piece removed is microscopically examined straight away. If examination under the microscope shows that some cancer might still be present, then more tissue is removed and examined. This process continues until there are no signs of any cancer cells left. This technique minimises the removal of healthy skin while making sure that the cancer has all been taken away.
- The Trust is a recognised Centre with a focus for young people in the Teenage Cancer Unit at Weston Park

- Bone Marrow Transplantation and other complex treatments for blood-born cancers are now provided in newly refurbished accommodation at the Royal Hallamshire Hospital.

During the year preparations have been made to implement the Improving Outcomes Guidelines for Brain and Central Nervous System cancers mostly involving the Neuro-services directorate which will provide all aspects of care including the most specialised treatments and for the Improving Outcomes Guidelines for supportive and palliative care.

Weston Park Hospital continues to expand its activities in the Cancer Network.

There has been a major drive to deliver chemotherapy close to the patient's homes in all the outreach hospitals, which has been particularly successful. More complex regimens are now given in liaison with the oncologist and specialist chemotherapy nursing staff within the hospital.

Nursing staff in outpatients play a vital role in the assessment of patients requiring chemotherapy and have participated in a nurse led telephone follow-up pilot that evaluated positively.

To improve the quality of the care we provide, we have introduced a dedicated 'consultant of the day' scheme in which the consultant covers acutely ill patients and fields any questions about appropriate admission of sick patients. This has been done in advance of a recent national report highlighting the need to improve this aspect of the oncology service nationwide.

Therapy radiographers are increasingly taking on roles previously undertaken by doctors within the Radiotherapy Department. These roles are competency based and include study up to Masters level. As well as providing excellent career development, it frees consultant medical time to carry out more complex tasks, improves staff utilisation and the quality of the patient experience including reduced waiting times.

Complementary therapy is an important aspect of the care provided to our patients and staff work closely with the complimentary therapy service provided at the Cancer Support Centre. These therapies have proved extremely popular with patients undergoing radiotherapy. A pilot study for inpatients has also evaluated positively and there are plans to extend availability to other wards at the hospital.

Investing in women's services

Our services for women and their families were also commended during the year. Over 93% of women rated their care as 'excellent', 'very good' or 'good'. The national average was 89%.

The views were gathered in a review by the independent Healthcare Commission, which ranked the Jessop Wing as one of the country's 'better performing' maternity units. Investment throughout the year in new 'home from home' birthing rooms, birthing chairs and a new family room to help support parents visiting premature or sick infants all ensured we continue to provide a friendly environment where families can receive high quality care. We also provided funding for eight new midwives including a Consultant Midwife.

The Assisted Conception Unit at the Jessop Wing also installed a new state of the art system to enable the electronic tagging of samples used in IVF treatment. This ensures that the right sperm is matched with the right egg and implanted in the right woman.

If egg and sperm samples from different couples are brought into the same work area, an alarm instantaneously sounds and the procedure is prevented from being carried out.

An innovative falls prevention service is helping elderly patients stay out of hospital.

A national audit reassured Sheffield women that they are receiving smear test results quicker than women in any other part of England, the majority of tests being returned within 14 days. 33,500 smear tests are performed across the city each year; all of which are processed by the cytology screening laboratory at the Royal Hallamshire Hospital.

In other areas of emergency care, NHS watchdog the Healthcare Commission rated Sheffield's emergency care service as 'better performing'.

Regrettably due to unprecedented demand over the Winter period, the national target of 98% of patients being seen within 4 hours was narrowly missed (97.8%). However plans are in place for 2009/10 to improve this performance by increasing capacity and staffing. We are also working with Sheffield City Council to improve the speed of discharge for patients going to nursing homes or needing home care services.

Releasing time to care

A dedicated project manager was funded in 2008/09 and since its launch in early 2008, 39 wards have now completed the scheme which enables nurses to spend more time caring for patients.

Meal time volunteer scheme

One of the most important factors in a patient's recovery is a nutritious diet, but their appetite can often be adversely affected during a stay in hospital. The mealtime environment has been shown to be key in encouraging patients to eat well. This is an area where volunteers can help once they have been given specific training, which is why we have developed a mealtime volunteer scheme. The scheme, which began in February 2009, not only provides a new role for volunteers but should also be of major benefit to patients. It is being piloted on Hadfield 6 at the Northern General Hospital with a view to being rolled out across the Trust in future.

Studies have shown that thinking about food half an hour before a meal actually helps digestion. Consequently, volunteers taking part in the scheme arrive on the ward before a meal is served and help to make sure patients are ready to eat; help fill in menu cards; prepare bedside tables for meals; offer hand washing facilities to patients; ensure patients have a fresh drink available and encourage patients to eat and drink.

The scheme is proving popular with both volunteers and patients.

Hospital Follow Up Programme

The Trust works closely with colleagues from the health community in Sheffield to find new ways to improve care. One such development, which followed a three-month pilot in 2006, is the Falls Prevention Service run in partnership with NHS Sheffield and Sheffield Health and Social Care NHS Foundation Trust.

This innovative service is helping to reduce the number of older people attending Accident and Emergency and Minor Injuries Units following a fall. Before it was in place, elderly people who had fallen received little support to help reduce the risk of their having

another fall and thus facing a further hospital admission or even sustaining more serious injury such as a hip fracture.

Following an initial assessment by a therapist in A&E or the Minor Injuries Unit, patients who may benefit from the service are now referred to one of the falls specialist therapy assistants, who work across the city as part of the Physiotherapy Service. They can offer a range of support from home visits to the provision of equipment and walking aids.

Balance and strengthening exercises can also be provided either in the patient's own home or with others in a group setting.

The number of people re-attending A&E in the six months after receiving the service has reduced by 74%, while admissions to hospital resulting from a fall have reduced by 38%. 97% of patients, who have received support from the service rated it as either 'excellent' or 'good' and over half felt their risk of future falls had been reduced.

Mental Health Strategy

There is a complex interplay between mental and physical health. The Trust provides services for people who are particularly vulnerable or present a high risk of suffering from mental health problems. These needs have to be addressed if we are to achieve high quality care and good clinical outcomes.

Following a stakeholder event, held in June 2007, and a citywide consultation, the Trust has produced its first mental health strategy. The strategy aims to orientate our services to the mental health needs of patients, to support a positive approach to mental health promotion and care, and to provide clear direction for the development of the services we provide. However, it recognises that we cannot achieve these aims alone and builds upon the collaborative work already underway between service users, carers and health and social care professionals.

The Trust is now a member of the Sheffield Mental Health Partnership Board and has been in discussion with commissioners about service improvements. We completed a baseline review across directorates to identify significant issues, resulting in the first wave of a training programme being commissioned. Improvements have been achieved in a number of services including Accident and Emergency,

Medical Assessment Unit, maternal mental health and the care of patients with dementia. However, this is only the first step in a long learning and development process that aims to improve the way we understand and care for people with mental health needs.

Patient safety is paramount and part of the culture at Sheffield Teaching Hospitals.

Optimum service delivery

As well as managing the day to day challenges of a busy trust, we have also been actively looking at some of the more strategic issues which will help ensure that the trust moves forward in the future.

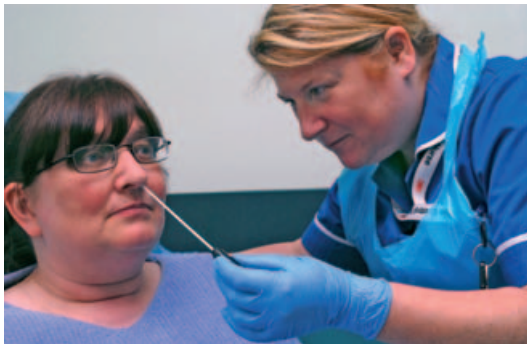
A big issue was looking at how we can better configure our services across the city. When the two trusts merged back in 2001 many services were duplicated. Over the years a lot has been achieved in this area and we have now entered the final phase. During the year a Reconfiguration Board was set up comprising clinicians, senior nurses and managers to look at the optimum provision of services to reflect best clinical practice and we began discussing initial views with our Commissioners and health/social care partners to ensure an integrated approach.

Patient Safety First

Patient safety is paramount and part of the culture at Sheffield Teaching Hospitals.

In the Autumn of 2008, we appointed an associate medical director with a specific remit for patient and healthcare governance and patient safety to work alongside the head of governance as part of the existing governance structure.

At the same time, the Trust signed up to the Patient Safety First (PSF) campaign. This campaign aims to make patient safety everyone's highest priority. We have set up a patient safety board which is in addition to existing governance structures and there have been several presentations made to the Clinical Management Group, the Governance Committee, the Nurse Directors Group and the Trust Board between January and April 2009. Intensive care, medications and perioperative work streams have been established. The intensive care work stream is looking at harm resulting from



infections due to being on a ventilator and from central venous catheters (deeply placed drips).

Other safety initiatives that have already started, or will have done so by May 2009 are:

- Preventing blood clots in the legs and lungs
- Looking at serious infections in patients with a reduced immune system at Weston Park Hospital (neutropenic sepsis).
- Introduction of a maternity early warning scoring system to aid the detection of mothers who are becoming unwell.

Zero tolerance approach to infections

Infection prevention and control continued to be one of our highest priorities during the year. For the past four years we have been one of the most successful groups of hospitals in the country to prevent healthcare associated infections like MRSA and *Clostridium Difficile.*

The Trust exceeded the Government's target to reduce cases of MRSA bacteraemia by 20%, with 24 cases recorded during the year. This represents a 33% reduction over the year and a 76% reduction since the target was introduced in 2003/04. This means there was less than a 0.01% chance of a patient acquiring a MRSA blood stream infection in our hospitals.

The ward accreditation programme, a system of ensuring local and national best practice in all wards and departments, has been strengthened during 2008/09 to include even higher standards of cleanliness and hand hygiene.

This has resulted in a further 30% reduction in MRSA infections. This means that the Trust now has one of the lowest rates of MRSA of any hospital in the country. We have also worked in partnership with NHS Sheffield on two major projects, the introduction of an infection prevention and control e-learning programme for all grades of staff and an MRSA decolonisation programme. The first of its kind nationally, this programme allows patients who screen positive for MRSA to visit specialist clinics and receive expert advice and decolonisation.

This was made possible by the extension of MRSA screening to all patients coming into the Trust's hospital for an operation or as part of emergency treatment. Other hospitals will be expected to achieve this standard by 2011.

We have had similar success in reducing the occurrence of *Clostridium Difficile* and exceeded the local target, agreed with NHS Sheffield for reducing the incidence of *Clostridium Difficile.*

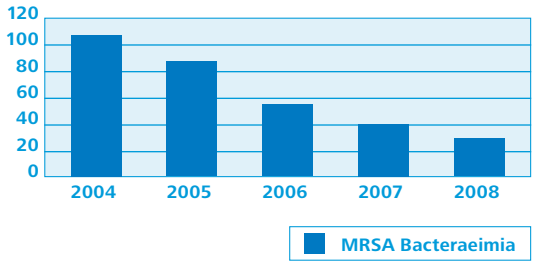
Having laid solid foundations through the ward accreditation programme we introduced a number of other initiatives in 2008/09 which contributed to the ongoing reduction including a specialist cohort ward at the Northern General Hospital for patients with *Clostridium Difficile* infection.

We also introduced a restricted antibiotic policy and continued with a targeted deep cleaning and ward refurbishment programme. Over £3m has been spent on improving older accommodation with three wards being completely refurbished.

In common with all other NHS hospitals the Healthcare Commission inspected the Trust's performance against the standards set by the Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections.

The Healthcare Commission recognised many examples of excellent practice and we scored three green ratings (positive) and one amber rating. The amber rating was because a small number of mattresses were found to have marks under the protective covers.

We immediately took action to remove the mattresses and they were replaced by the manufacturer because the covers were faulty.



They were permeable to liquids when they should not have been. The amber rating also referred to keeping clean linen on trolleys rather than in a cupboard on the ward which has also been rectified. The Healthcare Commission was satisfied that we took immediate action on all these points and no further work was required in these areas.

However, we are determined not to become complacent and expect to achieve further progress in 2009/10.

The infection prevention and control team will continue to extend the use of leading edge technologies. They have been at the forefront of the use of hydrogen peroxide vapour technology and steam cleaning to clean wards and departments and the use of ultrasonic cleaning for equipment. In recognition of this work the team was one of 10 awarded a national prize for having made an outstanding contribution to fighting infection. The award of £150k, made in February 2009, will help us to continue the work.

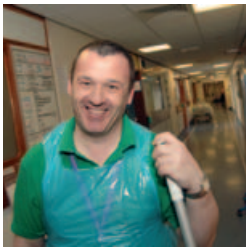
Exploiting new technology

To ensure that we provide the best possible services for our patients, we are constantly working to introduce leading edge technology or improve our existing systems.

Many of the new systems that we began to introduce during the financial year 2007/08, details of which appeared in the Annual Report and Accounts for that year, are now beginning to bring real benefits.

Picture Archiving and Communications System (PACS)

We began to introduce the picture archiving and communications system (PACS), which allows images to be stored digitally rather than on film, in October 2007. It has now been installed in all out-patient clinic rooms, all ward nurse stations, all operating theatres, MDT rooms and other meeting and education rooms where access to imaging is a necessity or advantage.



We are constantly working to introduce leading edge technology to benefit our patients.

Over 200 staff have been trained in the use of PACS which has made it possible to sustain the vast majority of our imaging service without the need for films. Images are now stored electronically and can be moved to any location prepared for PACS instantaneously. In due course this will include GP Practices.

Electronic Ordering and Reporting of Diagnostic Investigations

After successful pilots, the ICE web-based test ordering and results reporting system, designed to replace the old manual and electronic systems, has been fully introduced across the Trust to enable result viewing. We also plan to rollout the requesting system and to enable patient results to be shared between GPs and hospital consultants.

Digital Dictation

Over 1,300 staff are now using the new digital dictation system, introduced early in 2008. This is one of the biggest implementations of this type of technology in the NHS and has lead to a significant improvement in document turn-around times. It is becoming common practice for consultants to dictate letters straight after seeing patients rather than leaving them all to the end of clinics. This enables secretaries to type up letters immediately following each attendance; ensuring documentation is ready for signature at the end of the clinic.

Patient Records Development Programme

As its name implies, the Patient Records Development Programme was set up to improve the administration and management of our patient records. The Programme has three main components, a project to develop a single patient number, the Single Patient Administration System (PAS) and the Inter-professional Patient Record (IPPR).

When the Trust was established, the five individual hospitals that were merged to create it all had separate systems for numbering their patient records. Considerable work has been undertaken over the last four years to introduce a single patient number across all the Trust's sites. During 2008 we have been able to reduce this to two systems and the final plans are now in place to achieve a single patient number for the whole Trust in 2009.

Similarly, there are currently two patient administration systems in operation and a large-scale project is underway to move to a single system during the next year. This represents a major step forward and will help to simplify administrative procedures, reduce duplication and is a key step in the move towards the electronic patient record.

The IPPR will be a single inter-professional paper record for each patient in which all healthcare professionals write and will replace the multiple records system currently in place.

It is planned that this will be fully implemented by May 2010. The IPPR will mean a huge culture change for the way in which we write and maintain records, and will enable greater inter-professional working as well as supporting safe and effective patient care.

Choose and Book

We have also made significant progress during 2008/09 in the introduction of the Choose and Book programme. Choose and Book is a national electronic referral service, which gives patients a choice of the place, date and time for their first outpatient appointment at a hospital or clinic.

GPs can now book nearly all of our services through this system, with only a number of small specialist services not yet available, and about 50 per cent of our referrals are made this way. Services for upper and lower gastro-intestinal cancer will be available on choose and book early in 2009/10.

Improving the Hospital Environment, Our Buildings and Equipment

Ensuring that our buildings, the equipment we use and the general environment in our hospitals are of the highest standard makes a major contribution to the quality of the care we provide.

New facilities, like the £20m Critical Care Unit at the Northern General Hospital, which was officially opened by Lord Darzi in March 2009 and which was described in last year's Annual Report, are obvious examples of this. The unit, which has capacity for 36 highly dependent patients, is a world-class facility with some of the most advanced intensive and high dependency care technology available today. However, it is also vital for us to continue to improve our existing accommodation and during 2008/09 we spent over £3m on completely refurbishing three of our older wards.

Work also progressed during the year on several major projects that will come to fruition during 2009/10 and beyond.

Theatre Admissions Unit

The Trust's Board has approved a capital investment of £2.9m for the development of a theatre admissions unit at the Royal Hallamshire Hospital. The new Unit will have the potential to admit 9,000 - 13,500 patients a year and will open in October 2009.

The development of a theatre admissions unit will bring a number of benefits. It will reduce the length of time patients stay in hospital and increase the number of operations carried out as a day case.

Clinical Skills Centre

Funding has been secured to build a state of the art multi disciplinary Sheffield Clinical Skills Training and Assessment Unit (SCTAU), The project is a partnership with The University of Sheffield, Sheffield Hallam University, Sheffield Health and Social Care NHS Foundation Trust, NHS Sheffield and local GPs. The new unit represents a significant strategic development in the local clinical education infrastructure. It will enhance the quality of care provided to patients, improve the quality and consistency of skills teaching and strengthen the organisational and professional ties between the member organisations.

New Radiopharmacy

Our current radiopharmacy, at Weston Park Hospital, is now well over 20 years old and so a new unit will be built at the Northern General Hospital. It should be operational by early 2010. A state-of-the-art facility, it has been designed not only to conform to current standards but also those predicted for the future.

£4.2m Hand and Burns Unit development

In early 2009 a £4.2m Hand Unit development was approved which will be a major enabling scheme for reconfiguration across the Trust as well as enabling even better care standards and efficiencies in Plastic Surgery. The proposal is to develop a joint plastics/orthopaedics Hand Unit at the Northern General Hospital.

Development of Clinical Engineering

The Trust is in the process of introducing a number of developments to improve clinical engineering. The medical equipment management group, which has bases at both the Royal Hallamshire and the Northern General Hospital sites, now has 36,000 items of medical equipment on their database compared to 17,000 three years ago. To accommodate the extra demand, facilities are being expanded on Floor I at the Royal Hallamshire Hospital and into the east wing of the nurses' home at the Northern General Hospital.

A new state of the art Clinical Skills Centre represents a significant strategic development in the local clinical education infrastructure.

As well as providing accommodation for services that already have a reputation for being at the cutting edge of the management and development of medical equipment and radiation protection, these developments will improve productivity and efficiency and facilitate innovation. Staff will benefit from the improved facilities, but most importantly, patients can feel secure in the knowledge that medical equipment is safe and always available to meet their needs.

Charles Clifford Dental Hospital

The redevelopment of the Charles Clifford Dental Hospital, which began in September 2007, has now been completed. The most challenging part of the project was keeping the building live during the work and minimising the impact on undergraduate teaching and patient treatment.

The initial phase of the development was a joint collaboration with the University of Sheffield to build a new wing to the School of Clinical Dentistry. The Trust contributed £2m to this scheme, which enabled NHS staff to move from the hospital to join university colleagues in the new wing thus freeing up space for the expansion of clinical facilities.

The project, which was completed in March 2009, is the most ambitious redevelopment since the hospital was expanded in 1966. It has enabled us to increase the number of dental students from a historic baseline of 45 to 75 students per year. The new building provides additional space to incorporate 56 new state of the art dental chairs in a modern layout benefiting patients, students and staff. We now have a total of 150 dental chairs in brand new clinics with purpose designed waiting and reception areas.

Preparing for Emergency

The NHS Emergency Planning Guidance 2005 sets out the responsibilities of NHS Trusts to ensure they have plans in place to respond to a major incident or serious internal event such as loss of water or electricity.

Ensuring that we are able to cope with this kind of eventuality is a significant factor in the way we run our business. The Executive Director responsible for emergency preparedness is the Chief Operating Officer.

An emergency planning manager, a flu pandemic project manager and an emergency planning assistant support him.

Over the last year the Emergency Planning Team has identified a number of key work streams, in particular the need to review our Major Incident Plan, business continuity planning and planning for a possible flu pandemic.

In February 2009 we held the first of three major incident seminars scheduled for the year. Attended by 64 delegates from across the Trust, it looked at communication and co-ordination during an incident, the role of volunteers, support and care of relatives, security, traffic management and communicating with the public. The discussions and the decisions made will form the basis of a revised Trust-wide Major Incident Plan.

Business continuity is important for any organisation, but particularly for an NHS Trust. Should our work be interrupted for whatever reason, we need to be able to continue to provide key services to our patients as far as is reasonably practicable. We have a number of business continuity leads whose role it is to ensure we have contingency plans for any number of internal incidents. These plans came into effect in August 2008 when we carried out a planned switch off of all the mains electrical power at the Royal Hallamshire Hospital site.

This was needed to check that the back up generators would automatically take over powering the hospital through the essential supply network. The test was a success and we intend to carry out similar tests on our other sites.

In July 2008 we set up a Flu Planning Steering Group, with members drawn from Infection Control, Critical Care, Supplies, Nursing, Pharmacy and Occupational Health. Our plan, drawn up to enable us to cope with a potential flu pandemic, was written in consultation with local and citywide flu planning groups. As required, it was submitted to the Department of Health in December 2008. An abridged version of the plan will be available on the Trust website in the near future.

Patient experience

Arts in health

The power of the arts in healthcare is often disregarded but it is of real significance to the quality of life in a hospital. It is not only the body but also the spirit that needs to heal and a patient's state of mind can greatly influence their physical health. We value these benefits and, with generous funding from Sheffield Hospitals' Charitable Trust, have appointed an Arts Co-ordinator, Kerry Blackett, to work within the Patient Partnership Department to develop an innovative arts in health programme called Zest.

In September 2008 people from Sheffield's art community, hospital governors, senior managers, patients, volunteers and ward staff attended a consultation workshop to move the project forward. Information from the event will be used to develop an 'Arts in Health' strategy for the Trust.

Since beginning in July 2008, Zest has already brought music and drama to wards and departments.
Pupils from Tapton School played for people waiting in outpatient clinics at the Royal Hallamshire Hospital, while at the Northern General students from Norton College presented Fragments of War, a drama incorporating wartime reminiscences.

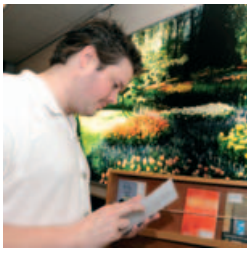
Commenting on the play, a patient on Brearley 6 said,

"It was a wonderful play and so nice to have something different here."

Volunteers now run weekly creative workshops on four wards, soon to be increased to six. Zest's readers' project holds weekly sessions with stroke patients, providing company for those who have few or no visitors and giving them the opportunity to interact with each other, share experiences and talk about topics unrelated to hospital or illness. Volunteer, Cressida Brennan who has been involved in the project for six months said,

"Even in the short space of time I've been on the readers' project I have witnessed a difference in some of the patients, it's quite amazing how this group workshop can raise the confidence of a patient."

Keeping Patients Informed



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

That is why our priority during 2008/09 was to establish a good infrastructure to support the delivery of high quality patient information across the Trust.

Much of this work focused on establishing clear guidelines for developing patient information and communicating these guidelines to staff.

Patient information training

A new series of bi-monthly training sessions began in April 2008. They are open to all staff with an interest or involvement in producing new patient material.

The training is based on the Patient Information Toolkit, developed last year, and provides practical skills in leaflet and information production. To date feedback has been extremely positive.

Interpreter services

For many people who use our services English is not their first language. To help us meet their needs, we have introduced a telephone interpreting service across the Trust. This has proved very successful and the majority of interpreting is now undertaken by telephone.

The service offers quick and easy access to interpreters, and provides a high quality, efficient and confidential service.

What Our Patients Tell Us

National in-patient survey

Short waiting times, quality care and high standards of cleanliness were just some of the reasons why patients placed Sheffield Teaching Hospitals NHS Foundation Trust in the top 10% of the UK's best performing hospitals according to the 2008 Annual NHS patient survey.

The survey, carried out by the Picker Institute on behalf of the Care Quality Commission considered responses from over 72,000 adult inpatients at 165 hospital trusts.

449 patients completed questionnaires after their treatment at Sheffield Teaching Hospitals. The response rate was 54%, which was the same as the national average.

The Trust was rated above average for overall experience and nursing care as well as featuring in the top 20% of hospitals in more than half of the categories including:

- The quality of care provided for patients
- Treating patients with respect and dignity
- Confidence in the doctors and nurses
- Doctors and nurses working well together
- Short waiting times to be admitted to hospital
- Doctors and nurses washing their hands regularly
- Having enough nurses on duty
- Being given information and having the opportunity to talk to doctors/nurses
- Pain relief
- Giving information about medication

In comparison with 2007 we had improved in a number of areas, performing significantly better in nine questions.

We are consistently placed in the top 10% of UK hospitals for 'excellent' quality of services and financial management

In particular the survey showed a 9% improvement in patients being able to find a staff member to discuss concerns and an 11% increase in the number of patients who felt that test results had been explained well. Overall ratings of care remain extremely high, with 95% of patients rating their care as excellent, very good or good.

We always use feedback from surveys to improve services and have identified some areas where improvements do need to be made.

One such is in giving patients increased opportunity to tell us their views on the quality of care they have received. We are developing action plans to address this.

National emergency department survey

A national survey of emergency departments was carried out during May and June 2008. The Trust performed particularly well in relation to waiting times. Positive comments were also received from patients regarding Accident and Emergency staff. Other key areas where we scored well include privacy when discussing details with the receptionist and being asked permission for a medical student to be present. Feedback from the survey is being used to make further improvements.

Patient and Public Involvement

We are committed to delivering patient-focussed services that make a real difference to the care we provide. To help us achieve this, we take every opportunity to listen to what people say about current services and standards of care and to involve them in new developments.

A major initiative during the year was the establishment of two new patient and carer research panels, linked to each of the Trust's new biomedical research units. The panels will play an important role in influencing the work of the units.

They will be actively involved throughout the research process, including developing patient information sheets, contributing views to prioritise research and advising on methods of disseminating research results. Twenty panel members have been recruited and meetings are due to start in April 2009.

One group of service users with whom we have an ongoing programme of involvement is people with disabilities and they helped us complete a Trust wide audit of our facilities during 2008. Priorities for improvement include installation of a new emergency pull cord system in disabled toilets and a rolling programme for the installation of electronic doors for easier access.

Implementation has now started on a new system to allow patients to give on the spot comments about the care they receive. This means we will receive regular, ongoing feedback from patients.

Wards will display posters to show what patients have said and any improvements that have been made as a result.

Change for the better

Complaints are an essential part of our learning process. They enable patients, their families or carers to share their experiences with us and provide comments and suggestions.

As part of our ongoing commitment to improving services and following a national review of NHS complaints management, we are implementing a number of key changes to ensure that complaints we receive are managed effectively and lessons learnt wherever possible. These changes include:

- The introduction of a risk assessment process to assess all new concerns and ensure that they are managed appropriately;
- A more personal approach, contacting complainants personally wherever possible to discuss in detail their concerns and agree a plan of action for the management of their complaint;
- Increased use of independent clinical reviews or second opinions where there is a clinical issue that requires an independent opinion;
- Restructuring key roles to bring together complaints, informal concerns and patient feedback from surveys or patient and public involvement projects to ensure that an overview is maintained of the whole patient experience.

During the year, the Trust received 666 complaints 90% of which were responded to within the target of 25 working days. The comments and suggestions we received have enabled us to take action to improve our services.

In particular:

- Specialised cancer services staff are designing a patient handheld record for young people who are having care from two different specialities to improve communications;
- Changes have been made in obstetrics and gynecology to the system of obtaining the results of investigations, ensuring that all results are followed up and acted on in a timely manner;
- A complainant's experience is now being used as a case study in breast-feeding training sessions.

Adding Value

The Trust is always working to deliver high quality patient care in the most efficient and effective way possible. To this end during 2008/09 we continued to develop the Adding Value Programme and associated cross-organisational workstreams. The programme was originally launched in 2006/07 to deliver productivity and efficiency savings of £90m over a three-year period. Early in 2008, we commissioned support from PricewaterhouseCoopers to assist us with the development of robust plans for 2008/09 and beyond and to help to improve the governance arrangements to monitor and manage the agreed outcomes.

As a result we developed 18 workstreams cutting across the Trust, each with identified productivity and efficiency savings for 2008/09. A dedicated team was also set up to support the delivery and governance of the programme. This enables us to coordinate and track the wide range of productivity and efficiency projects that are now in place.

A key workstream during the year was clinical coding. This involved Trust wide coding summits, led by the Chief Executive, which have contributed to increased accuracy of clinical information, reflecting an accurate case mix and ensuring we get paid appropriately for the work we do.

The management of acutely unwell medical patients has also been a priority.

We focused on work to improve the patient experience while at the same time reducing length of stay and the number of unnecessary bed nights.

Changes have been made to surgical pathways through effective use of the Pre-operative Assessment Unit at the Northern General Hospital. On-day cancellation rates have reduced and the hospital's Theatre Admissions Unit has driven up the number of patients treated as day cases. Work to increase theatre utilisation has ensured treatment of extra patients (1500 additional cases) this year compared to the previous year.

Work has been underway over the last few months with Directorates and clinical/ non clinical teams to see how else we can become more efficient and as a result add value to our patients' care.

The key themes of the work this year are focussed on the whole care pathway or patient journey in addition to projects which are directorate specific.

Over the coming year we will be considering if there are better, quicker or more innovative ways of delivering a patient's care.

For example, there is the establishment of a centralised Theatre Admissions Unit at the Royal Hallamshire Hospital, which has been developed within the Surgical Systems Workstream.

This will reduce the need for pre-operative and some post-operative overnight stays for patients undergoing surgery at the hospital. This reduced length of stay means we use our resources more efficiently, have the opportunity to treat more patients, whist improving the quality of patient care across a range of specialities.

Sickness levels showed a downward trend in the last quarter of the year and the target figure of 4.3% was achieved. The reduction from 4.9 - 4.3% (over a 12-month period) represented an actual decrease of 12% in sickness absence rates.

The rationalisation of pharmacy provision through the consolidation of dispensaries and the closure of the manufacturing and aseptic units at the Northern General Hospital have delivered tangible productivity gains. This has also helped to introduce seven day working as the norm with associated benefits for patients and reduced length of stay.

Through a range of purchasing projects, the procurement workstream has delivered non-pay savings of over £3m across the directorates. We are already benefiting from a contract with Xerox to install more intelligent, energy efficient networked printers, which also automatically order consumables.

More effective management of our print services will also assist in a reduction in the Trust's energy costs.

In nursing we have continued to focus on ensuring the correct skill mix and judicious use of bank and agency staff. This AV programme has supported the delivery of the 'Productive Ward' initiative launched in early 2008, funding a dedicated project manager, and 39 wards have now completed the scheme.

We are also working to maximise the benefits from the introduction of new technologies across the Trust, including Picture Archiving and Communications System (PACS) and Anglia ICE.

At the other end of the technology scale, we are the process of implementing an outpatient appointment confirmation service. In any one year the Trust has around 18,500 patients who do not turn up for outpatient appointments. Although there can be a number of reasons for this, sometimes patients forget their appointment date and time. The confirmation service uses both mobile and home phone numbers to deliver a message confirming appointment details and asking the patient in turn to confirm whether or not they are attending.

By having advance notification we hope to be able to reuse many appointment slots, with the potential benefit of shortening overall waiting times.

The corporate workstream has sponsored the introduction of a salary sacrifice scheme, which allows staff members to save money by purchasing bikes, bus passes and childcare vouchers pre tax and National Insurance.

Our vision is to provide world class services.with 'excellence as standard' in everything we do.

There are also associated savings for the Trust. In addition this workstream hosted a review of arrangements for healthcare governance within clinical directorates and corporate departments.

During the year, the Trust disposed of its surplus properties and a space utilisation strategy is being developed to ensure that estate is used as efficiently as possible in future.

New guidance on the use of taxis was introduced, which has cut down waste in this area. Using national rail rather than ambulance transportation for patients travelling out of the county has delivered further savings.

Service line reporting (a way of knowing how much a patient's care has cost) was piloted in 2008/09 providing directorates with an improved level of financial and performance information. This will be rolled out across the Trust in 2009/10 allowing services to gain a better understanding and control of their resources and identify further opportunities to improve efficiency.

We also invested in Prince2 project management training to develop project management capability across the Trust and to improve project delivery.

Maintaining financial balance in the years ahead remains a significant challenge.

We must deliver further recurrent financial savings consistent with the 'Adding Value' principle of delivering efficiency through improvements in patient care. Effective leadership, clinical ownership and staff engagement continue to be the key drivers in delivering these service improvements now and into the future.

Working With Our Community

We are committed to the community we serve.

This is reflected in our work at all levels: through our involvement in national initiatives that will change the way we provide care and services for that community, by working directly with local people and by encouraging them to become involved in what we do.

Vision for the Future

In October 2008 the Trust produced its vision for the next four years, outlining our aspiration to deliver 'excellence as standard' under the key themes of clinical excellence, patient experience and staff engagement.

An extensive internal and external consultation took place over a six-month period involving our members, staff and major stakeholders including commissioners, the Strategic Health Authority, Foundation Trusts in the North Trent Network, the Universities, Sheffield City Council and MPs.

In addition, the summary document was circulated to patient interest groups, GPs, voluntary bodies who support the Trust and other local stakeholders to comment. Twenty-seven meetings and events took place with external stakeholders and almost 1000 members of staff took part in face-to-face discussions with the Chief Executive about the strategy. Feedback was also received from members of the public. All internal and external feedback has been collated and considered prior to the final strategy being implemented in the new financial year.

Contributing to the Local and Regional Economy

The Corporate Strategy sets out our aims to become a good corporate citizen.

This includes encouraging and supporting partnership working which benefits the health, economic and social wellbeing of our community. This is an important role for a leading edge Foundation Trust that is constituted as a Public Benefit Corporation.

In March 2008 a Business Development and External Affairs Director was appointed to help fulfil this role. The Trust is now an active member of Sheffield First, the Local Strategic Partnership, and is closely involved in steering the delivery of strategic aims and objectives that comprise the Local Area Agreement for Sheffield. The Trust also sits on the Health and Wellbeing Thematic Partnership.

We have recruited a new Sheffield First partner member of the Governors' Council.

Throughout the year, the Trust has identified opportunities to make optimum use of its Foundation status and 'punch its weight' in contributing to the local economy. We have drawn up and committed to deliver a 10-point 'pledge', which sets out how we will help raise attainment and aspiration in Sheffield. For example, we have offered 109 apprenticeship places in Care, Administration and Estates, providing opportunities for local young people to develop skills and gain meaningful employment. We have appointed 10 Trust Healthcare Ambassadors who are working with designated schools to lead careers events and experiential learning. We have worked with the Sheffield 14-19 partnership group to develop a Health and Social Care Diploma Facility to build relationships with the workforce of the future, including work experience facilities.

The Trust has developed proactive links with the City's Economic Partnership, Creative Sheffield and also with the Sheffield Chamber of Commerce.

We worked productively with these partners to start to develop new opportunities that will benefit our patients and staff as well as the wider economy. We have drawn up plans to develop a medical technology innovation centre, which will support more proactive links with local industry and also an international function that could help encourage inward investment. Working with Creative Sheffield, our expertise in medical technology has been cited as a key factor in the decision of a Portuguese company called Tomorrow's Options to establish a subsidiary in Sheffield that will bring new jobs into the local economy. We are also a member of Yorkshire Forward's Health and the Economy Forum.

We developed a partnership with the Sheffield branch of John Lewis and are exploiting joint learning and development opportunities that will help deliver a better quality service to our patients and their customers respectively. We are working towards establishing other productive strategic partnerships that will bring benefits to patients including the possibility of commercial pharmaceutical and medical technology collaborations.

The Trust has continued to support Mekelle Hospital in Ethiopia and our staff have provided training, expertise and advice to help develop healthcare in one of the poorest countries of the world. During 2008/09 staff from the Medical Engineering Department in particular made a substantial contribution.

Sustainable Development

We recognise that being part of the NHS, we have an important role to play in reducing carbon emissions, a key cause of climate change.

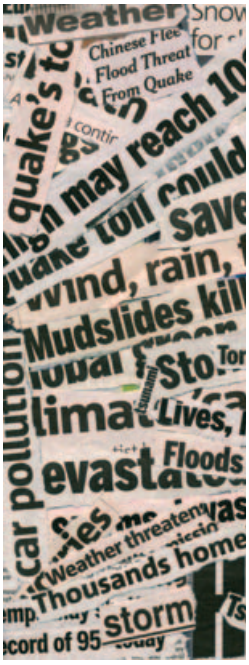
During the year, the Trust worked with partners at national, regional and local level to develop a sustainable development action plan. After Board discussions in September and January a number of key objectives were set. These are designed to ensure sustainable development across the Trust and
within the local community.

They include ensuring:

- Business plans and service specifications include actions on sustainable development;
- Redesign of patient care and treatment pathways are low or zero carbon;
- All capital projects incorporate environmental improvements;
- Procurement policies take account of sustainability requirements;
- Health and environmental impact assessments are included in proposed service developments;
- The sustainable development agenda is included in the competences and knowledge framework for staff.

Progress has already been made. Non-executive Director, Iain Thompson and the Trust's Chief Executive, Andrew Cash have been appointed as our sustainability and corporate citizenship champions and a project team has been established to work on sustainability. We have also appointed PricewaterhouseCoopers to carry out a baseline assessment of the Trust's position and to produce a sustainable development action plan. This is due to be presented to the Board in May 2009.

Our membership of the Sheffield First Partnership also enables us take an active role in promoting sustainable development in the city.



The Trust will be developing a Single Equality Scheme in consultation with both service users and staff during 2009/10.

Equality and Diversity

The Trust continues to work with local communities and patient user groups in a variety of ways to ensure that we meet the needs of our diverse community.

During the year staff from the Infectious Diseases Department have been working with the refugee community, while other staff have gone out to the travelling community to ensure that pregnant women receive antenatal care.

A telephone interpreting service has been introduced that provides instant access to a large number of languages, improving the quality of care for many of our patients.

A Muslim chaplain has recently been appointed to work across the healthcare community. We have improved access for wheelchair users across our sites. We continue to work with local schools, colleges, job centres and external agencies to recruit a diverse workforce and to attract volunteers from across the community. The Trust will be developing a Single Equality Scheme in consultation with both service users and staff during 2009/10.

Healthcare Academy

We began work to establish a healthcare academy from which all vocational education services will ultimately be delivered. The Academy is a collaborative venture between the Trust and the Sheffield College with financial support from the Sheffield Work and Skills Board, Yorkshire and Humber Strategic Health Authority and Skills for Health. Work to set up the Academy, which will be the only one of its type in the Yorkshire and Humber Region, will continue throughout 2009/10. Once established, it will also directly support the Trust's ambition to become a world-class teaching hospital.

Unsung heroes

The Trust is lucky in attracting a lot of people willing to become volunteers and help us in our work, but we are keen to involve more young people in what we do.

During the year, we appointed a Young People's Volunteer Coordinator, Amanda Kearsley, to manage the Young People's Volunteer Project. The project supports those young people already involved with the Trust, ensuring that they are given appropriate opportunities and gain positively from their experience. To attract new volunteers Amanda has created a group on Facebook, where information about the project is posted and where our young volunteers can contact each other and share their experiences.

Travel and Transport

The increasing effects of global warming mean that sustainable travel is becoming ever more important.

Like other large organisations, the Trust is constantly faced with the conflict between the need of staff to get to work and the environmental impact of car travel. However, with the help of the Trust's Travel Plan we hope to manage our travel and transport needs in a more sustainable manner.

The plan aims to cut the number of car journeys and encourage staff, visitors and patients to travel in more environmentally efficient ways and in June 2008 we appointed a Travel Plan Coordinator, Claudia Morris, to provide added impetus to its implementation.

We have also joined The University of Sheffield, Sheffield Children's Hospital, South Yorkshire Passenger Transport Executive, Museum Sheffield and Sheffield City Council to form HUMUS - Hospitals, Universities, Museums United in Sheffield.

It is hoped this partnership will bring considerable influence to bear on improving travel in the city that will be to everyone's benefit.

As part of the initiatives included in the plan, we now offer free personalised journey planners to all our new staff. The planners provide details of the transport links available from the individual's home address to their place of work. They also include quarterly update information on service changes that will affect that journey.

Since the Trust joined 'Liftshare', the national car share database in 2007/08, the numbers signing up and benefiting from the service have grown considerably with registrations trebling since its launch. Registration is free and staff that do register do not have to agree to share with anyone unless they are completely happy to do so. There are significant benefits to car sharing, not only are there cost savings for the individual, but congestion and carbon emissions are also reduced. To encourage staff to join the scheme, the Trust is exploring possible incentives for the year ahead such as designated parking spaces for car sharers.

As well as running two park and ride schemes servicing the central campus and a hospital shuttle bus, we have continued to work in close partnership with South Yorkshire Passenger Transport Executive (SYPTE) and other partners to provide better public transport access to our hospital sites. We held regular transport roadshows in collaboration with SYPTE during the year. The roadshows provided an excellent forum to inform staff about alternative modes of transport available and to promote free ticket offers or ticket discounts that we have negotiated for them. Discounts of up to 10% are now available on monthly travel tickets.

i-Choose, the Trust's salary sacrifice scheme was launched in February 2009. It offers staff the opportunity to select monthly First Bus tickets, brand new cycle and safety accessories and childcare vouchers pre tax and National Insurance. This scheme has proved to be extremely popular and we are already looking for additional benefits that can be offered through it next year.

In January 2009 we established a new innovations fund called the Bright Ideas Fund, with an initial £85,000 investment.

In conjunction with Sheffield City Council, we run monthly Bike Doctor clinics. Bike Doctor, which provides a health and safety check for bicycles, is free to all members of staff. To ensure the safety of cyclists, staff are also offered a two-hour free cycle training session.

A 'Walk to Work Week' is planned for late spring 2009 to encourage staff to leave their cars at home and discover the benefits of a healthier life style.

However, in spite of these initiatives, we recognise that there remains a genuine need for some staff and visitors to travel by car. Consequently, we continue to work closely with Sheffield City Council regarding planning applications to increase the capacity of car parking on all our sites.

During the year the case for significant expansion of car parking on the Northern General Hospital site and latterly the Royal Hallamshire Hospital site was developed and after long delays planning permission subject to conditions was granted for a multi-storey car park at the Northern General Hospital. These conditions are being worked through and a start on this new facility is expected before March 2010.

The solution for a multi-storey car park to ease the congestion around the Royal Hallamshire and Weston Park Hospitals is being explored in the same context and we are hopeful that the planning authorities will continue their support for a new development on Beech Hill Road.

The Trust has reserved capital for these schemes but this is unlikely to be sufficient for both. Alternative funding sources will be explored.

Research and Innovation

The Corporate Strategy for 2008 to 2012 sets out a vision for the Trust to be a provider of world-class health services, and top quality teaching and research.

We want to be at the forefront of international cutting-edge practice in healthcare so that patients have the benefit of the very latest new technologies and therapies. This means developing strong relationships between research, clinical practice and industry so that we are recognised as a centre for innovation and invention.

In 2008/09 we worked hard to support and encourage innovation throughout the organisation and there has been a substantial increase in the number of projects coming to fruition. At the beginning of 2009 there were 15 innovation projects, against a baseline of nine projects in total in March 2008.

The number of innovations generated in the Trust this year is higher than in any other NHS organisation in the Yorkshire and Humber Region.

In January 2009 we established a new innovations fund called the Bright Ideas Fund, with an initial £85,000 investment. This is designed to provide modest amounts of start-up funding for staff to help them work up new ideas.

We have held internal workshops to showcase existing innovations and to encourage more by making staff aware of the help and support that is available and have established a dedicated innovations section of the intranet to help them do so.

The innovative work of staff has been recognised externally during the year. Medipex, the Regional Innovation Hub, awarded one member of staff, Giles Morrison, 'Regional Innovation Fellow' status, while two of our projects won Medipex Innovation Awards.

Three staff are finalists for the 2009 regional awards representing 25% of the total number of finalists in the region.

We have worked hard with help from Medipex to ensure that commercial opportunities arising from innovation are fully exploited. Training and awareness sessions on intellectual property issues have been provided for leaders of some of our major research projects and we have developed seamless and non-bureaucratic partnership arrangements with commercialisation leads at The University of Sheffield. This makes it easier and more straightforward for researchers to identify and realise commercial opportunities.

We established our first 'joint venture' with a commercial partner to prototype, develop and market an operating theatres fluid waste disposal system that will save the NHS money and also provide a greener way of disposing of certain types of clinical waste.

The two spin-off companies in which we have invested, Zilico and ePAQ, are making good progress.

Our interactive computer programme, ePAQ, which was introduced in the Jessop Wing women's hospital, was specifically designed to assist in the assessment of patients with pelvic floor problems. This kind of problem can be embarrassing for patients to discuss and answers given during a clinical consultation are not always reliable enough to provide a truly accurate assessment. Consultant Gynaecologist, Stephen Radley, with colleagues from the Trust's Medical Physics and IT Departments, has overcome the problem by developing an interactive touch-screen assessment questionnaire.

ePAQ or the electronic patient assessment questionnaire, developed in the Trust and now being taken further in a spin-out company with the same name has been specifically designed not to replace the normal consultation but uses the questionnaire to record patients' symptoms, such as incontinence, as well as female-specific problems and sexual issues. Patients can decline to answer any question they are not comfortable with while help pages are available to clarify questions or explain unfamiliar terms if required.

Virtual clinics are now being held, where women, who have been referred to the service by their GP, use the system on-line, via the Internet. With the permission of the patient, the consultant reviews the results then holds a telephone consultation after which treatment or investigations can then be planned as necessary.

We are now developing plans to roll out ePAQ to other clinical areas, including other areas of women's health, musculo-skeletal disorders, drug and alcohol misuse and pre-operative assessment.

Devices for Dignity Healthcare Technology Cooperative

Last year the Trust reported that it had been selected as one of only two in England to pilot a Department of Health initiative to create healthcare technology co-operatives.

One year on, Devices for Dignity (D4D®), which brings together NHS organisations, universities, healthcare industries, patients and the public, to develop technologies for patients with long term conditions, continues to flourish.

D4D currently has eight projects or activities supported through the initial Department of Health grant funding and has since built on this foundation a further twelve projects which are now active, namely research grants being developed. D4D has attracted substantial additional investment from various sources and has exceeded the initial performance indicators of bringing project funding to the pilot by 97%.

Part of the remit of the pilot is to promote long-term sustainability and, to this end, close commercial links have been developed. D4D is currently in collaboration with 37 companies, 12 are actively involved in projects with 12 on standby for projects pending suitable project funding, allocation and expanded infrastructure.

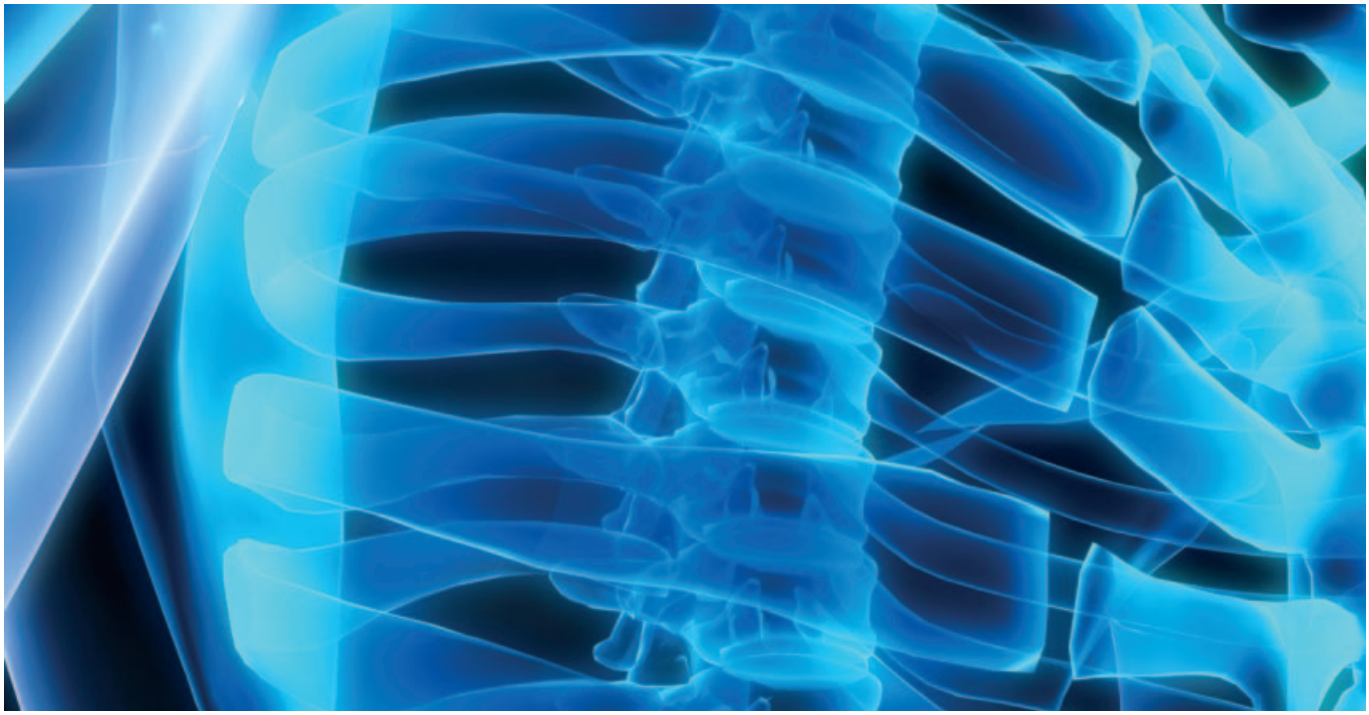
The remainder is awaiting project assignment or is aligned to provide commercial services.

As 'host organisation', we support D4D endeavours to develop new medical devices that address the dignity and independence of patients with long-term conditions. These factors are critical to a patient's feelings of wellbeing and quality of life. These objectives complement the Trust's own broad based research and innovation capabilities and our established record in bringing medical devices to the marketplace.

D4D is supported by five 'node' trusts:

- Barnsley Hospital NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- North Bristol NHS Trust
- Sheffield Children's NHS Foundation Trust
- NHS Sheffield

with academic support from the Universities of Cambridge, Coventry and Sheffield. It is funded by the National Institute of Health Research, the Technology Strategy Board, the Engineering and Physical Sciences Research Council and the Medical Research Council and was the subject of a presentation given as part of an innovations master class led by Lord Darzi and David Nicholson, which was hosted in Sheffield in March 2008.



Bio-medical Research Units

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

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

The individual BRU's are developing their management structures and activity plans and both have begun recruiting research and other staff, a process that will continue into 2009/10.

During the year, the Bone BRU convened the first meetings of its international advisory board, which will advise on project ideas to ensure that only the best are fully developed. Similarly, the Cardiovascular BRU is assessing projects with a view to incorporating them into its work.

In addition, investment in new specialist equipment has begun, including the purchase of an XTREME CT device, one of only two in the UK, which can capture and process very high resolution images of the arms and legs that will be invaluable for research into new bone active agents.

Two new disease specific patient and carer research panels have been recruited to advise the units during the planning stages of new research projects and to assist in the dissemination of study results to the public.

Both units will ultimately be housed in dedicated facilities that will form part of a new Centre for Biomedical Research, being developed on the Northern General Hospital site. As well as the two BRUs, the development will house the Trust's clinical research facility and a large bio repository for the storage of blood/plasma and urine samples. The new centre is due for completion in September 2009.

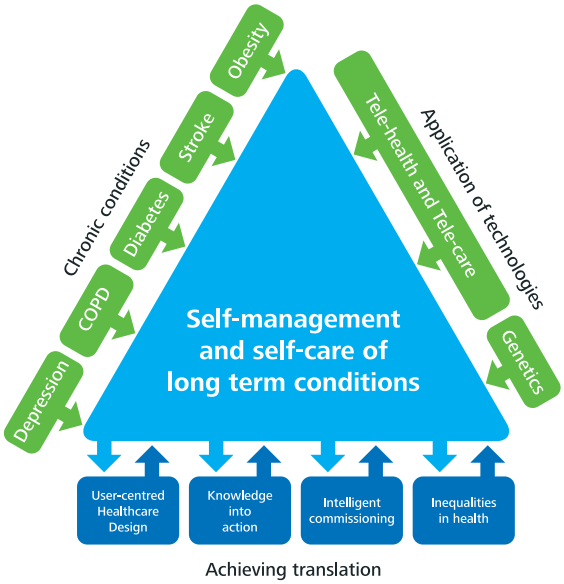
Collaboration for Leadership in Applied Health Research and Care

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

By forging a mutually beneficial, forward-looking partnership between Sheffield's two universities and the region's NHS and 3rd sector organisations, the South Yorkshire Consortium (CLAHRC SY) aims to develop the self-management and self-care of long-term conditions through applied research, health technology innovations and the translation of knowledge into quality patient care.

The success of our application will result in a £20m investment in the health of the region with a further potential investment from NIHR for the flexibility and sustainability of our work of between 20-30% of our annual NIHR budget for the next five years.

CLAHRC SY, which officially came into being on 1 October 2008, will focus on 11 research themes.



Achieving translation

Five of these relate to the self-management of chronic conditions: chronic obstructive airways disease (COPD), stroke, diabetes, obesity and depression. The use of existing, new and emerging technologies form another key area, with two research themes in Tele-health and Tele-care and Genetics. The final, implementation, themes cover inequalities in health, intelligent commissioning, knowledge into action, and user-centred healthcare design.

Since October we have appointed the core team of programme manager, administrator and evaluation lead.

In February 2009 we appointed Mrs Margaret Cox, the out going Chair of the Board of Doncaster and Bassetlaw Hospital NHS Foundation Trust, as Chair of the Consortium's Strategic Board. During the year, CLAHRC SY also hosted the first National Directors meeting in Sheffield and will host the launch of the new NHS Innovation Architecture at the next NHS Research Network meeting in April 2009.

CLAHRC SY will have a major impact on the amount and way that applied research is undertaken and on the design, evaluation and delivery of services across the region. Through this work, we hope to change the care and services provided in South Yorkshire, allowing us to move towards a truly patient centred holistic approach to research and evidence implementation.

NIHR CLAHRC for South Yorkshire

With our partners we have developed an ambitious plan to stimulate and accelerate translational research.

Academic Health Science Centre

The Trust played a leading role in the development of a bid to the Department of Health to develop an Academic Health Science Centre.

An Academic Health Science Centre is designed to align clinical excellence, world-class research and education and training to provide more patients with access to leading edge treatments, more rapidly.

The Trust prompted the development of a productive White Rose Academic Health Science Centre partnership, which includes the Leeds Teaching Hospitals NHS Trust, the Universities of Sheffield, Leeds and York, and the Yorkshire and the Humber Strategic Health Authority. With these partners we developed an ambitious plan to stimulate and accelerate translational research initially in the areas of cancer, cardiovascular disease, musculo-skeletal, dental, neuroscience, and infection and immunology. Researchers and clinicians identified that working together, they could achieve much more, much faster. As part of the application process, the partners designed systems for working together that would deliver these benefits, support innovation and help boost the economy via commercial application. The White Rose proposal was not selected by the Department of Health as part of the first tranche of Academic Health Science Centres. However, the partners are continuing to work together to deliver these benefits.

Clinical Audit and Effectiveness

Each year clinicians and managers in the Trust register between 350 and 400 clinical audit and service review projects with the Clinical Effectiveness Unit.

The Trust's Clinical Effectiveness Unit is one of the largest in the country.

The Trust has an impressive track record for co-ordinating the implementation of national guidance both within the Trust and across the city and our internal prioritisation and review systems for clinical audit and clinical effectiveness projects are robust and well established.

Training and Education

We have a strong commitment to education and to providing clinicians with the opportunity to access training and support for clinical effectiveness activity through our close links with Sheffield Hallam University.

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

National Sentinel Audit of Stroke

Data collection for this bi-annual national audit took place in October and November 2008, with the Trust receiving feedback of results in February 2009. Nine key indicators of stroke care were focussed upon. Overall, Sheffield Teaching Hospitals performed well and our key indicators average score was in the middle half of national scores at 77% compared with 52% in 2004 and 73% in 2006 when 12 indicators were measured. 216 sites nationally were scored on receipt of the complete bundle of 9 indicators. Sheffield Teaching Hospitals achieved 44% with only 15/216 sites achieving a better score. 7/9 factors had improved from 2006 with the remaining 2 targets having changed from previously. We recognise work needs to take place to address the new targets and an action plan is currently under development.

Dr Foster Monitoring Tools

We have continued with the implementation of Dr Foster Real Time Monitoring and Practice and Provider Monitor across the Trust.

These systems enable users to recognise where there is variation in activity or outcomes compared to our peers and to see whether or not that variation is statistically significant. Mechanisms are in place to ensure mortality outcomes are routinely reported to the Clinical Effectiveness and Patient and Healthcare Governance Committees and that any variances are explored in conjunction with the relevant clinical directorates.

Engaged Staff

Taking care of our staff is as important to us as caring for our patients. We want to be a Responsible Employer and to achieve that it is imperative to listen to what staff say and encourage them to be involved in shaping developments.

During 2008/09 the Trust undertook a full survey of its staff and we were pleased to find that 9 out of ten feel they are making

a difference to patients and 82% feel they have an interesting job. Sheffield Teaching Hospitals was in the top 20% of UK Trusts for people being happy in their jobs and 73% of staff use flexible working options which is higher than the national average. 83% of staff said they felt valued by their work colleagues

However, the same survey showed there is still more to be done to actively involve front line staff in how services are developed and to prevent staff suffering verbal and in a small number of cases physical abuse from patients and visitors. This is a growing problem in healthcare. In 2007/08 we recorded 63 incidents of physical assault on staff. 16 of these were reported to the police with 11 resulting in criminal prosecutions.

We take the safety and security of our employees, patients and visitors very seriously. This is reflected in our Security Policy.

The Trust is actively involved with NHS Security Management Services, which is designed to improve professionalism in security throughout the NHS and we have an accredited specialist who operates within the Security Management Professional Accreditation Board's code of professional conduct. We have also continued to make significant capital investment to enhance our CCTV and access control infrastructure.

As part of our commitment, the Trust has invested in two personal safety trainers to provide training in managing violence and aggression. The training is ongoing but to date over 8,500 staff have been trained in conflict resolution skills. During the year a further 170 were trained in physical intervention and breakaway skills aimed at staff working in high-risk areas such as accident and emergency.

Coping with stress

Following a Health and Safety Executive report published in 2008, the Trust set up a 'Wellbeing at Work' steering group to address the issue of stress in the workplace. The aim was to increase awareness and understanding of the organisational causes of work related stress and to develop capacity within the Trust to manage stress proactively.

Since the steering group was established a number of focus groups have been held with staff to discuss issues around stress. The steering group has developed a stress risk assessment tool and identified the support required to implement risk assessment as well as training level 2 support staff. During 2009/10 we will pilot this tool prior to integrating it into risk assessment and governance procedures. We also propose to provide training at executive level and to produce self-help materials for all managers and staff.

Developing Our Staff

We make sure that a wide range of education and training opportunities are available to all staff.

This is done through a comprehensive directory of in-house training, which is delivered throughout the year and covers both mandatory training and ongoing continuing professional development.

The Trust also supports e-learning, giving staff the flexibility to access training at a location convenient to them. Strong links with Sheffield Hallam University and The University of Sheffield ensure that staff have access to higher-level education specific to their roles. This is centrally funded by the Strategic Health Authority and we work closely with our partner organisations to ensure modules are relevant to service needs.

In partnership with Sheffield College, we have introduced a Healthcare Assistant (HCA) Certificate programme.

During the year we raised the achievement rate of learners on the Hospital Apprentices in Care Scheme. The scheme itself is now seen as an example of good practice, with Skills for Health using it as a case study model. Through the appointment of peripatetic assessors we also increased achievement levels in National Vocational Qualifications.

In partnership with Sheffield College, we introduced a Health Care Assistant (HCA) Certificate programme during the autumn. It prepares newly recruited HCAs to care for patients and supports adult learners with numeracy and literacy skills in line with the Governments Skills Pledge, which the Trust signed last year.

As part of the Trust's support for flexible learning and reflecting our commitment to equality and diversity, we are currently developing e-learning packages around ensuring equality and diversity, customer service and care values and are working closely with the Disability Steering Group and the Visually Impaired User Group to achieve this.

Looking forward to 2009/10, we will be introducing a new development programme for our Health Care Assistants. Starting in April, it will address activities of daily living as well as essence of care and NSF frameworks. It is also proposed to make changes to the Newly Qualified Staff Development programme to ensure that learning is based on the six core dimensions of the Knowledge and Skills Framework. The new course, which will be known as the Foundation Development Programme will also include an element of medicines management. An e-learning package is currently under development to support it.

Providing Opportunities

The Trust employed over 30 people into entry-level jobs through its Employability scheme during 2008/09. This scheme draws from a diverse recruitment base of the unemployed, single parents and those who have recently been made redundant. It works with local communities in the north and south of Sheffield to provide the workforce of the future. The scheme, which is supported by the Sheffield Work and Skills Board, is considered a pathfinder project providing entry into health sector employment. We have also been re-awarded the 'Two Ticks' Positive about Disability symbol for our work in the recruitment and retention of staff with disabilities.

Our leaders conference inspired staff to put quality at the heart of everything they do.

Leadership

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

The year's Leaders Conference focused on one of the supporting pillars of the 2008-2012 Corporate Strategy: delivering a consistently high quality patient experience. It set out to inspire and inform the 270 staff that attended so that they can continue to make real improvements to the quality of our patients' experience.

Providing Benefits

We continue to negotiate benefits for staff from a wide range of suppliers.

Many of these like membership of 'Liftshare' the national care share team are covered in detail in the Travel and Transport section.

Recognising Excellence

Once again we celebrated the dedication and achievement of individuals and teams from across the Trust at the annual Thank You Awards, now in their sixth year.

Presented in October 2008 they continue to highlight the way in which our staff are willing to work over and above the call of duty to ensure that the needs of our patients are met and are the focus of everything that we do. The winners and highly commended nominees illustrate the very best in commitment, innovation, leadership and team working.

Meeting the challenge of the European Working Time Directive

We are now counting down to the introduction of the European Working Time Directive (EWTD 2009), which comes into force on 1 August 2009.

As England's largest NHS Foundation Trust, this new legislation has always represented a challenge since it reduces the maximum average hours of work for all training grade doctors from 58 to 48 hours a week. That challenge has been made greater by the complex nature of the Trust.

To ensure that we comply, we have built on the work outlined in last year's Annual Report and Accounts.

The detailed audits covering the current working hours of training grade doctors, workload and activity in those directorates most likely to be effected and the financial implications for the Trust have enabled us to produce summary reports for each directorate. The resultant EWTD 2009 action plans for individual directorates have now been implemented.

The changes required by the Directive must be implemented if we are to continue lawfully to employ training grade doctors after the August deadline. Further directorate meetings and targeted activity exercises are planned for the preceding months and the integrated EWTD 2009 project plan will continue to be updated quarterly enabling us to monitor our progress.

Celebrating Foundation Trust Status

Sheffield Teaching Hospitals is the largest NHS Foundation Trust in England. Now entering our fifth year since gaining Foundation Trust status, we continue to achieve financial balance and to improve the services and the quality of the care we provide for our patients.

One of our key strengths remains the involvement of people who live locally or who have received treatment at one of our hospitals in our Governors' Council. The Council is made up of 37 Foundation Trust Governors who oversee and advise on the Trust's strategic direction and help to make sure that we are accountable to the people we serve. It holds the Board of Directors to account and seeks to ensure the continued success of the Trust through effective management, partnership working and maintaining the values and principles of the NHS.

Formal meetings of the Governors' Council are held four times a year. The Trust's Executive Directors also attend council meetings facilitating the sharing of information and specialist knowledge to support the Council's functions. This enables Governors to become involved in discussions and strategic planning at an early stage. Governors also make valuable contributions to specific projects by providing relevant expertise or offering a different perspective.

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

The Council appoints the Trust's Non-Executive Directors, including the Chair and determines their remuneration. Originally these functions were carried out through appointments and Remuneration Committees. However, in 2007 a Nominations Committee was established to undertake both functions.

During 2008/09 the Nominations Committee made one appointment to the Board, that of Iain Thompson. The Council also approves the appointment or removal of the Trust's auditors following a recommendation from a nominated sub-group of the Board of Directors.

The Governors' Council

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

During 2008/09 each Council meeting was attended by at least one member from every elected constituency while attendance for the Council as a whole varied between 44 and 61.6 per cent.

At the end of March 2009, membership of the full Governors' Council was as shown opposite:

Sheffield Teaching Hospitals NHS Foundation Trust Governors' Council		
Constituency	**Elected Governor**	**Expiration of term of office**
Patient	Joe Abson	1 July 2010
Patient	Susan Coldwell	9 June 2009
Patient	John Holden	9 June 2009
Patient	John Laxton	30 June 2011
Patient	Clare Rawding	9 June 2009
Patient	Graham Thompson	30 June 2011
Patient	Christina Wakefield	30 June 2011
Public - North Sheffield	Georgina Bishop	30 June 2011
Public - North Sheffield	George Clark	30 June 2011
Public - North Sheffield	Kaye Meegan	16 October 2009
Public - S/West Sheffield	Charlie Khan	30 June 2010
Public - S/West Sheffield	Philip Seager	30 June 2011
Public - S/West Sheffield	Susan Wilson	9 June 2009
Public - West Sheffield	Anne Eckford	30 June 2010
Public - West Sheffield	John Warner	30 June 2011
Public - West Sheffield	Beryl Wilson	9 June 2009
Public - S/East Sheffield	Richard Chapman	30 June 2010
Public - S/East Sheffield	Elaine Hill	9 June 2009
Public - S/East Sheffield	John Hulse	9 June 2009
Staff - Medical & Dental	Mike Collins	9 June 2009
Staff - Nursing	Rose Bollands	9 June 2009
Staff - Allied Health Professionals, Scientists & Technicians	Stephen Westby	9 June 2009
Staff - Managerial, Administrative & Clerical	Mark Hattersley	9 June 2009
Staff - Ancillary, Works & Maintenance	Dave Weston	9 June 2009 (retired June 08)

The Governors have an important role to play in shaping our services.

Organisation	Partner Governer
NHS Sheffield	Jeremy Wight
Sheffield City Council	To be confirmed To be confirmed
NHS Yorkshire & the Humber SHA	To be confirmed
The University of Sheffield	Dominic Shellard
Sheffield Hallam University	Rhiannon Billingsley
Sheffield College	Heather MacDonald
South Yorkshire Police	Paul Broadbent
Sheffield Care Trust	Martin Rosling
Sheffield First Partnership	Jack Scott
Voluntary Action Sheffield	To be confirmed
Outside Sheffield Primary Care Trust	Christine Boswell

The Governors have an important role to play in shaping our services. They do this not only by contributing to Council meetings, but also through their involvement in specific activities and membership of a range of different groups and committees. Individual Governors sit on over 26 such groups, many directly related to patient and user involvement, covering the whole gamut of the Trust's work, as well as attending one-off events throughout the year.

Governors gain additional insight into particular aspects of our work through presentations from staff, which this year covered infection prevention and control, Neurocare, hotel services and the work of the Patient Partnership Department. They have also undertaken an extensive programme of visits to see departments of the Trust at work, including:

- Central Food Processing Unit
- Medical Engineering
- Critical Care New Building
- Ophthalmology
- Sir Robert Hadfield Wing
- Dermatology Service
- Charles Clifford Dental Hospital
- Jessop Wing

These visits provide them with the opportunity to talk directly to patients and staff, helping them to develop an understanding of both public expectations and the complexities of the services we provide and placing them in a unique position to make a valuable contribution to the work and future development of the Trust.

Foundation Trust Membership

Public Constituency	3,824
Patient Constituency	3,457
Staff Constituency	13,786

As well as providing people with the opportunity to become involved in the development of their local hospitals, members receive a free copy of 'Good Health', a quarterly newspaper providing health information and news about hospital services.

We also run a series of exclusive members' events including lectures on topics of interest to the general public. Over 300 people attended the 2008/9 lecture series, which included:


goodhealth

Trust of the Year

		Attendance
Bugs, Bites and All Things Tropical	May 2008	70
Heart to Heart	August 2008	70
About Cancer	November 2008	110
Trying for a Baby?	January 2009	80

Healthcare Governance and Healthcare Standards

We want to make sure that our patients receive the highest quality care possible and are always working to achieve this.

We look at our internal systems and learn from national assessments which examine the services we provide and how we handle our resources. (See also Clinical Audit and Effectiveness).

Annual Health Check

The Trust was named as one of the top 10% of UK hospitals for the second year running in the official NHS annual health check ratings for 2007/08, published in October.

The Annual Health Check, carried out by the Healthcare Commission, uses a complex set of standards to assess trusts and provide patients with a detailed view of how NHS organisations are performing.

Each Trust receives two ratings on a four-point scale of 'excellent', 'good', 'fair' or 'weak'. One rating covers the quality of services, measured against the Government's core standards and national targets; the other relates to the use of resources, measured against how well trusts manage their finances. Areas assessed include safety, quality of care, waiting times, cleanliness of the hospitals, prevention of hospital-acquired infections such as MRSA and how responsive a trust is to patients.

We were one of only 42 out of 391 trusts nationally to achieve a double rating of excellent and only one of 12 to have done so in consecutive years.

Self-Assessment

As part of the Annual Health Check process for 2008/09, the Trust self-assessed against the Standard for Better Health Core Standards and declared that it is compliant with the 24 standards.

Hospital of the Year

In November 2008, the Trust was named Hospital of the Year for the second time in three years in the independent Good Hospital Guide published by Dr Foster. The Guide looks at 10 indicators.

Trust's must 'pass' at least eight of these to be short listed while Teaching Trusts must pass at least nine.
Areas covered are:

- Hospital mortality
- Care of stroke patients
- Care of patients with fractured hips
- Patient satisfaction with their overall care
- Waiting times
- Care of patients needing hip and knee replacements (three indicators)
- Hospital acquired infection
- Efficiency - excess bed days
- Re-admission rates.

Information Governance Assurance

The Trust has an on-going programme of work to ensure that person identifiable information (PID) is safe and secure when it is transferred within and outside the organisation. We are working to implement the Connecting for Health national solution to encrypt all Trust laptops and removable media.

However, one personal data related incident was reported during the year, which was classified as a Serious Untoward Incident, Level 2.

See table below.

NHS Litigation Authority

The NHS Litigation Authority (NHSLA) administers a scheme called the Clinical Negligence Scheme for Trusts covering NHS organisations against the cost of litigation.

Trusts pay a sum to the NHSLA for their general work in return for this cover, with those providing maternity services paying an additional amount. Trusts must also be assessed against a series of standards covering general and maternity services as applicable.

Summary of Other Personal Data Related Incidents in 2008/09

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	Nil
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	1
III	Insecure disposal of inadequately electronic equipment, devices or paper documents.	Nil
IV	Unauthorised disclosure	Nil
V	Other	Nil

General Scheme

The general scheme assessment now incorporates 50 risk management standards, which were introduced some years ago, covering a wide range of topics including:

- Producing policies
- Consent
- Patient information
- Moving and handling
- Resuscitation
- Infection control
- Hand hygiene
- Stress
- Doctors training
- Incident management
- Complaints

These standards are assessed at three levels:

1 Having a compliant policy

2 Proving the Trust is working to the policy

3 Monitoring the effectiveness of the policy

Successful assessment (passing over 40 standards) at a level, as well as demonstrating good practice results in a 10% reduction in payments so ultimately it is possible to attract a reduction of up to 30%.

The Trust was last assessed in late March 2008 and passed at level 1. We will be reassessed in February 2010 and are currently working hard to collate evidence to enable us to be assessed at level 2.

Maternity Services

Our maternity services were last assessed in February 2008 and again, the Trust passed at level 1. The NHSLA has now also converted this scheme into one based on risk management standards, although these differ from the standards applicable to the general scheme.

The new standards were piloted in 2008/09 and although the Trust applied to be a pilot site, we were unsuccessful. Therefore, our maternity services will be reassessed during 2009/10. However, they will have to be assessed at level 1 as the scheme only allow trusts to be assessed at the same level when moving from one set of standards to another.

In 2007 the Trust developed a Clinical Assurance Toolkit (CAT) to ensure a consistent, coordinated approach to the quality of care.

Complaints Management

Following a national review of the management of complaints within the NHS, the Trust has established a complaints management group. It is implementing key changes to ensure complaints are managed effectively and lessons are learnt from them.

A risk assessment process is being introduced to cover all new concerns and their management. A more personal approach is being adopted. In future, whenever possible, complainants will be contacted personally to discuss their concerns in detail and agree a plan of action. There will be increased use of independent clinical reviews in instances where a clinical issue requires an independent opinion. A restructuring of key roles will also enable us to bring together complaints, informal concerns and patient feedback from surveys or patient and public involvement projects to provide an overview of the whole patient experience.

e-CAT

In 2007 the Trust developed a Clinical Assurance Toolkit (CAT) to ensure a consistent, coordinated approach for assessing quality of care, giving wards and departments a coordinated, comprehensive and up to date range of standards that provide accurate and timely feedback. Initially paper based, during 2008/09 the toolkit was developed as an electronic version (e-CAT). It includes updates which reflect new initiatives both at a local and a national level along with feedback from users and outcomes from the first two years.

Quality Report

Quality Report

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

We know how important it is to patients and their familes to know that when they have to come into hospital they are going to receive the best possible care, be safe and cared for in a clean, welcoming and infection free environment. That is why we are continually implementing quality improvement initiatives that further enhance the safety, experience and clinical outcomes for all our patients.

This is reflected in the last three years' Healthcare Commission Annual Health Check in which Sheffield Teaching Hospitals was placed in the top 10% of UK hospitals for 'excellent' quality of services and financial management.

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

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

Andrew Cash OBE
Chief Executive

3rd June 2009

A quality service

Does Sheffield Hospitals provide a 'quality' service for patients?

Sheffield Teaching Hospitals puts quality at the heart of everything we do and for the 3rd year running we have achieved the highest possible rating of 'excellent' in the Healthcare Commission's Annual Health Check for both the quality of services and financial management. This is one of the key indicators which shows how the quality of care is provided.

We were also named 'Trust of the Year' for the second time by Dr Foster Intelligence. This award is independently assessed and only awarded to an organisation which demonstrates excellence in the things which really matter to patients including safety, quality of care, waiting times, cleanliness of the hospitals, prevention of healthcare acquired infections such as MRSA and how responsive a trust is to its patients.

With the help of over 13,500 dedicated staff we have continued to make significant improvements in key quality measures including screening for infections like MRSA before a patient comes Into hospital and improving stroke care by introducing a new care pathway with a single point of access to provide 'gold standard' care.

We do, however, still face some challenges, including reducing the number of patients whose discharge is delayed unnecessarily and addressing the issue of mixed sex accommodation in a minority of our facilities.

Embedding the drive for 'Quality' into daily practice

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

You said… We did

We are now able to gather patients' views about their care or facilities while they are still in hospital or receiving treatment by using a simple handheld electronic device. This will mean we can respond more quickly to areas where standards are not as high as we might expect. The results from the monitoring will be fed back to the ward or department involved as well as the Board. If areas for improvement are identified, actions will be put in place to rectify the problem and publicly displayed on the ward/department under a heading of You said… We did.

Celebrating success

We are encouraging a culture in our hospitals where staff feel recognised and rewarded, but where poor performance is also challenged and managed appropriately. We have introduced a performance management process which includes a visible celebration of success in quality improvement: publicly-displayed posters celebrating 'quality champions', Quality and Patient Satisfaction awards and the opportunity for high performing teams to present good quality performance to the Board.

How we have prioritised our quality improvement initiatives

After taking into account the views of our patients, clinical advice and best practice we have decided that our top four quality priorities for 2009/10 are:

Priority 1 To keep our patients safe from infections such as MRSA and *Clostridium Difficile*.

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

Priority 3 Improve survival rates by offering the 'gold standard' heart attack (primary angioplasty) treatment to all South Yorkshire patients.

Priority 4 Increase the number of patients who would recommend our hospitals to a friend/relative.

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

- **The impact** it would have on improving safety, clinical outcomes and our patients' overall experience of their care.
- **The feasibility** of implementing the priority, for example do we have the resources required to deliver the change.

We also factored in areas of further improvement from inspection reports and patient feedback.

Our selected priorities and proposed initiatives

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

Priority 1

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

Our stringent cleaning and infection prevention measures have meant the chances of patients acquiring an infection like MRSA while in our hospitals is well below most other large teaching hospitals.

This commitment was recently recognised through a Healthcare Innovations award which will enable us to spend £150k on new innovations to combat infection.

Despite this good performance we are never complacent and believe that we can introduce further measures to reach our aim of having zero preventable healthcare associated infections like MRSA and *Clostridium Difficile.*

Our aim

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

Current performance

Over the past four years there has been a 77% reduction in the number of MRSA bacteraemias.

There has also been dramatic progress in reducing cases of *Clostridium Difficile* infection by over 60% compared to the same time in the previous year.

What have we done so far?

During 2008/2009 the Trust introduced a number of initiatives which have contributed to the continued reduction in the rate of MRSA bacteraemia and the dramatic reductions in the rate of *Clostridium Difficile*:

- The introduction of an enhanced care ward - Robert Hadfield 4 - where all patients suspected of having *Clostridium Difficile* are isolated and cared for which limits the chances of further patients also becoming infected.
- *Clostridium Difficile* testing is now available 7 days a week which enables quicker diagnosis and treatment.
- We have introduced even higher standards of hand hygiene and cleanliness.
- Introduced commode cleanliness audits. This means we check regularly that our commodes have been cleaned to a very high standard.
- The extension of the use of hydrogen peroxide vapour (HPV) technology which enables us to deep clean whole rooms and the equipment within them.
- We have spent millions of pounds on upgrading our wards and carrying out deep cleaning programmes.
- We now carry out a root cause analysis of how and why a patient has contracted an MRSA Infection. We also undertake regular Infection Prevention and Control reviews.

New initiatives for 2009/10

Over the course of 2009/ 2010 the Trust will introduce further measures to improve practice and achieve:

- Further reductions in the rate of MRSA bacteraemias to keep our patients as safe as possible and maintain the Trust's position as the best performing Teaching Hospital.
- Further reductions in the rate of *Clostridium Difficile* infection to keep our patients as safe as possible and become the best performing Teaching Hospital.
- Exceed Government requirements. (NHS Operating Framework 2009/10) by screening all emergency patients as well as those coming into hospital for planned procedures.

Priority 2

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

To achieve this in 2009/10 we will

- Revise our Ward Accreditation scheme to encompass the recommendations of the Healthcare Commission Hygiene Code review. The Ward accreditation scheme is an annual check that wards and departments are achieving high standards on infection control and cleanliness.
- Expand the commode cleanliness audit to include deep cleaning using advanced ultrasonic cleaners.
- Ensure we prevent infection coming into our hospitals by screening all patients for MRSA before they are admitted to our wards.

  If patients are found to be carrying the bacteria we will offer a course of treatment which when complete will enable the patient to continue their care.
- Extended testing for norovirus which is the winter diarrhoea and sickness bug.
- The introduction of a computer based learning programme to ensure our staff have training in good infection prevention and control.

Board Sponsor
Hilary Scholefield, Chief Nurse

Implementation Lead
Dr Christine Bates
Director of Infection Prevention and Control

Program Manager
Richard Parker, Deputy Chief Nurse

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

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

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

- Wrong site surgery.
- Instrument left in the patient after surgery.
- Incorrect chemotherapy.

Current performance

Sheffield Teaching Hospitals did not record any Never Events during 2008/09 but recognises that when treating over a million patients a year safety incidents can occur and wherever possible should be prevented.

Aim

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

What have we done so far?

- Safety guidance is provided by the National Patient Safety Agency and we always try to apply the guidance in full and then audit to ensure that the procedures are still effective, e.g. safe use of epidural equipment.
- Appointed an Associate Medical Director with a specific remit for patient and healthcare governance and patient safety.
- Each of our different Directorates are notified of any under performance in key areas of patient safety by a special performance report called a performance 'dashboard'.
- We have introduced a Clinical Assessment Tool (CAT) which is a way to highlight key performance in clinical areas.
- We have a Healthcare Governance Framework to provide assurance that Patient Safety is prioritised

Other safety initiatives that have already started, or will have done so by May 2009 are:

- Preventing blood clots in the legs and lungs
- Looking at serious infections in patients with a reduced immune system at Weston Park Cancer Hospital.
- Introduction of a maternity early warning scoring system to aid the detection of mothers who are becoming unwell.

New initiatives for 2009/10

- Set up a Patient Safety Board
- Implement the 'Safer Surgery Checklist' to help prevent a 'never event' involving wrong site Surgery.
- Audit of Practice relating to current safety guidance associated with prevention of 'never events'.
- Take part in the National Patient Safety First Campaign.

Board Sponsor

Dr Mike Richmond, Medical Director

Implementation Lead

Dr Des Breen, Associated Medical Director

Programme Manager

Chris Morley
Head of Patient & Healthcare Governance

Priority 3

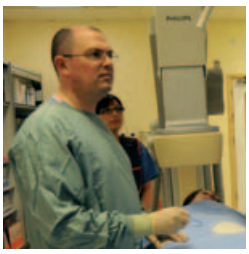
Improve survival rates by offering the 'gold standard' heart attack (primary angioplasty) treatment to all South Yorkshire patients.

Description of Issue and Rationale for Prioritising

Primary coronary angioplasty is acknowledged to be the best treatment for patients presenting with a certain type of heart attack, and early treatment is essential if patients are to gain maximum benefit from the technique. National guidance on the treatment of heart attack has set a target of three years by which time all patients in the UK should have access to this treatment. Whilst the cardiology service at the Northern General Hospital (NGH) has provided primary angioplasty for Sheffield residents since June 2008, other patients in South Yorkshire, North Derbyshire, North Nottinghamshire and South Humberside do not yet have access to this form of treatment. We intend to expand this service to enable patients from these areas to have this treatment.

Aim

To expand the primary coronary angioplasty service at the Northern General Hospital, offering treatment for all patients in South Yorkshire, North Derbyshire, North Nottinghamshire and South Humberside by the end of 2011.



Priority 4

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

Current status

Approximately 23 Sheffield patients per month have been treated by primary angioplasty since the establishment of the service in June 2008.

New initiatives in 2009-10

- Primary angioplasty will be made available to patients from Rotherham (estimated demand 150 patients/year) in Spring 2009.
- Expand capacity to meet the predicted demand for primary angioplasty.
- Modification of ambulance protocols to allow rapid transfer of patients from the whole catchment area directly to the Northern General Hospital catheter laboratory where primary angioplasty is carried out.

New initiatives to be implemented in 2011

- Rolling out of the service to include all eligible patients from Doncaster and Bassetlaw, Barnsley and Chesterfield.
- Agree protocols to support this service with the Yorkshire and East Midlands Ambulance Services.
- Establish joint protocols with other local Hospitals to allow patients to return to their local hospital the morning after their angioplasty procedure.

Board Sponsor

Dr Mike Richmond

Implementation Lead

Dr Julian Gunn, Consultant Cardiologist and Clinical Lead for Primary Angioplasty

Programme Manager

Mrs Marie McKenniff, Group General Manager, South Yorkshire Regional Services.

As well as excellent clinical outcomes we want to ensure our patients have as good an experience as possible of being treated in our hospitals. This can include everything from the welcome they receive to the food they eat and even how easy it is to park.

We want our patients to feel they have been well looked after, and as a result are inclined to recommend our hospitals to their families and friends.

Aim/Goal

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

Current Performance

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

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

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

The figures are extremely good, and also show an improvement of almost 4% from 07/08.

Again recognising the views expressed in the national staff survey and other feedback mechanisms we have identified areas where we feel we can further improve our patients' experience of being cared for in our hospitals.

What have we done so far?

- Ongoing patient experience monitoring has been introduced, which asks for patient views throughout their care.
- Implementation of Yorkshire and the Humber Strategic Health Authority Patient Recorded Experience measures (PREMs).

PREMs will provide feedback on key aspects of patient experience. Measures will be both generic - such as overall satisfaction or treating patients with respect - and service specific.

A panel of service users and clinicians will be involved in the development of the experience measures, which will then be tested with patients, staff and others. Initially, PREMs will be developed and piloted in maternity services.

A number of options are being considered for collecting patient views through PREMs, including bedside technology, discharge lounge surveys, bedside interviews and postal surveys

- A ward refurbishment programme is underway.
- We have implemented Patient Reported Outcome Measures (PROMs). PROMs are measures of health status, from the patients' perspective. From April 2009, PROMs questionnaires are being given to all patients, asking them to assess their health status before and after the following procedures:
  - Unilateral hip and knee replacements
  - Groin hernia surgery
  - Varicose vein surgery
  - Outcomes data will be produced nationally and will enable comparison across providers. Comparative outcomes will be made public.

  There are a number of potential benefits to the routine collection of PROMs data including:
  - enabling clinicians, managers and patients to benchmark performance
  - supporting patients and GPs to make treatment choices
  - strengthening audit and research
  - assessing the appropriateness of referrals

  PROMs is being considered for roll out to other procedures from 2010-2011.
- We have brought together our complaints, Patient Advisory Liaison Service and patient/public engagement teams to provide a focus on the overall patient experience and closer links to clinical services.
- We have introduced a Mystery Shopping programme, initially concentrating on reception areas and first impressions of our patients.

Identified areas of improvement

- The time patients can wait to be admitted to a bed continues to be a major bottleneck in reducing the time patients wait in A&E.
- The time taken to receive medications to take home once discharge has been agreed.
- Mixed sex accommodation in respect of co-located bathroom/washing facilities.

New initiatives to be implemented in 2010-11

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

- Implementing the Releasing Time to Care programme across all wards in our hospitals to enable nurses to spend more of their time on patient care.
- Remove unnecessary administration and bottlenecks to speed up discharge and improve bed availability.
- Introduction of Information Prescriptions to give patients comprehensive information on issues affecting them.
- Enhanced privacy and dignity measures in areas where male and female patients may be cared for together.

Board Sponsor

Hilary Scholefield, Chief Nurse

Implementation Lead and Programme Manager

Sue Butler, Head of Patient Partnership

Quality overview

The table below shows how Sheffield Teaching Hospitals NHS Foundation Trust has performed against key national standards and targets over the past two years.

This gives you an indication of the quality of the care you can expect when treated in our hospitals.

If you would like any further information please do not hesitate to contact us by email at qualitycounts@sth.nhs.uk or in writing to: Chief Nurse, Sheffield Teaching Hospitals NHS Foundation Trust, 8 Beech Hill Road, Sheffield, S10 2SB.

	2007-08	2008-09
Never Events 'Never Events' are serious, largely preventable patient safety incidents that should not occur if available preventable measures have been implemented. For example: wrong site surgery. The data source for this indicator is the National Patient Safety Agency.	Zero	Zero
Hospital Standard mortality rates Mortality, or death, rates are calculated using the number of deaths at a hospital trust compared with the number of patients who would be expected to die, taking into account age, complexity of illness, deprivation and sex. The baseline for England is set at 100 and a lower figure indicates fewer patients died than expected; a higher one means more patients died. Sheffield Teaching Hospitals death rate is significantly below the national average. The data source for this indicator is: Hospital Episode Statistics (HES)	90.8	Not currently available
% of patients who were readmitted to hospital after surgery. The data source for this indicator is Hospital Episode Statistics (HES)	4.02%	4.04%
% of hip replacements we do in the trust that are revisions. The data source for this indicator is Hospital Episode Statistics (HES)	25.3%	24.5%
% of patients that would recommend our hospitals to a relative/ friend The data source for this indicator is the National Inpatient Survey.	68.6% responded "Yes, definitely" 22.5% responded "Yes, probably" (total 91.1%)	71% responded "Yes, definitely" 23.8% responded "Yes probably" (total 94.8%)
% of patients who felt they were treated with respect and dignity The data source for this indicator is the National Inpatient Survey.	82% responded "Yes, always"	82% responded "Yes, always"
% of patients who spent less than 4 hours waiting in A&E. The target is 98%. The data source for this indicator is: a local data collection system that feeds the national Quarterly Monitoring Accident and Emergency return.	97.80%	97.80%
The trust has fully met the Healthcare Commission core standards. The data source for this indicator is local systems	We met all of the 24 standards.	Data not available until the Annual Healthcheck is published in October 2009.

	2007-08	2008-09
Performance against existing NHS national targets and new NHS national targets.	2007/08 - We fully achieved 21 of the 24 targets. The three targets we underachieved were: 1 The number of patients whose operation was cancelled on the day and who were not re-admitted within 28 days. 2 Percentage of patients who received thrombolysis treatment within the recommended time of 60 minutes. 3 Achieving a 5% reduction in the number of nights patients with a long term condition spent in hospital through improved care in primary care or a community setting.	
Clostridium difficile year on year reduction. There has been a 39.9% in year reduction in the Health Community which includes cases of *Clostridium difficile* in the community not just in hospital.	787 cases	473 cases
Reducing the number of MRSA blood stream infections to less than half the 2003/4 levels The 2003/4 level was 103 All of the figures are entered onto MESS (Mandatory Electronic Surveillance System) and reported via the HCAI Data Capture System, Administered by the Health Protection Agency (HPA).	36 cases	24 cases
% of patients needing to be admitted to hospital who waited less than 18 weeks from referral to hospital to treatment. The data source for this indicator is the national returns we fill out from our local systems.	89%	91.10%
% of patients who do not need to be admitted to hospital who waited less than 18 weeks from GP referral to hospital treatment. The data source for this indicator is the national returns we fill out from our local systems.	93%	96.80%
% of patients who waited less than 31 days from diagnosis to receiving their treatment for cancer. The data source for this indicator is the Exeter national cancer waiting times database.	100%	99.8%
% of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer. The data source for this indicator is the Exeter national cancer waiting times database.	95%	95%
% of patients who received thrombolysis treatment within the recommended time of 60 minutes. The data source for this information is MINAP audit.	67.20%	Not available until October 2009.
% of patients who waited less than 2 weeks from GP referral to their first outpatient appointment for urgent suspected cancer diagnosis. The data source for this indicator is the Exeter national cancer waiting times database.	100%	100%

Response to regulators

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

Sheffield Teaching Hospitals NHS Foundation Trust's recent declaration to the Healthcare Commission indicated our compliance with all of the core standards.

Our latest Healthcare Commission inspection report commented that the Trust performed strongly and is considered relatively low risk, placing us in the top 3% of all Trusts in the UK.

We also achieved a green clinical governance rating from Monitor, the body which regulates NHS Foundation Trusts.

The Trust scored three green rating (positive) and one amber rating in the Hygiene Code inspection. The amber rating was because a small number of mattresses were found to have marks under the protective covers.

We immediately took action to remove the mattresses and they were replaced by the manufacturer because the covers were faulty. They were permeable to liquids when they should not have been. The amber rating also referred to keeping clean linen on trolleys rather than in a cupboard on the ward which has also been rectified.

The Healthcare Commission was satisfied that we took immediate action on all these points and no further work was required in these areas.

We have also taken action to respond to some areas of further improvement in the Accident and Emergency department which were raised by the Healthcare Commission through their annual patient survey. They were:

- shorter waiting time for patients to receive painkillers
- Better display of waiting times.

While there have been improvements in these areas, more work needs to be done.

Response to feedback from Members and Governors

Some examples of feedback from the public (considering comments from our Patient Representatives, Hospital Members and Hospital Governors) included:

- High patient satisfaction - witnessed from a number of observations and experiences.
- Concern over signage to some parts of the hospital sites particularly affecting more elderly patients.
- Concern over the delay to patient discharge due to the long period of time taken to provide medicines needed to take home.
- Request for enhanced measures to be put in place (additional curtains /blinds/ obscure glass) in areas where patient and public facilities adjoin each other.
- Request to review the design of patient gowns to protect patient dignity.

We are considering the appropriate initiatives to deal with these concerns, and will continue to ask the necessary questions of our patients and their representatives to identify any other areas that may require improvement.

Director of Finance Report

Director of Finance Report

For 2008/09 the Trust has again achieved an Income and Expenditure Account (I&E) surplus, although at £1.46m it is a relatively modest one of just 0.2% of turnover. However, the surplus still reflects continued financial stability for the Trust and has been achieved after investment in a number of important areas, such as infection prevention and control initiatives and other quality developments.

The Trust's income grew significantly again in 2008/09 as shown below:

	£m	% increase over 2007/08
Income from Patient Service Activities	600.7	5.4
Total Income	**731.5**	**5.7**

After adjusting for inflation and nationally determined NHS cost pressures, real terms income growth is much smaller. Growth in income from patient services activities was significantly lower than in previous years, largely due to the loss of £12.8m of transitional funding received in 2007/08 as part of the introduction of the Payment by Results (PbR) funding system. The high level of activity in 2008/09 was the main reason for the real terms activity growth.

Income losses associated with the introduction of the PbR system and new national Research and Development (R&D) funding arrangements, national efficiency targets (3% in 2008/09), and modest levels of internally funded investments resulted in the Trust having to deliver almost £90m of efficiency savings over the 3 years to 2008/09. This has been a major challenge for the Trust and has necessitated considerable management focus to drive such large efficiency improvements whilst maintaining and improving the quality and safety of services. The small surplus in 2008/09 shows that the 3 year plan, promoted by the Trust's Adding Value Programme, has been successful but pressure points remain in a number of key Clinical Directorates where it has not proved possible to address historic budget deficits and deliver further major efficiency gains.

Pay costs rose by 5.0% in 2008/09 which reflects pay awards, additional costs from the introduction of the national Agenda for Change (AfC) pay system and expansion in a small number of services, e.g. the new Northern General Hospital Critical Care Unit. Other significant cost increases in 2008/09 were in respect of drugs (13.6%), clinical supplies and services (4.5%) premises (17.2%) and purchase of healthcare from non-NHS bodies (22.7%). The increase in premises costs reflects the major pressure on energy prices during 2008/09 and the increase in the healthcare from non-NHS bodies costs reflects areas where the Trust's capacity was insufficient to deliver access targets.

Total capital expenditure for the year was £36.9m. Slippage due to planning and operational pressures resulted in a £5.2m under spend against available resources but these resources will be carried forward to undertake the planned schemes in 2009/10.

The key focus of expenditure was again to invest in new and replacement medical equipment, undertake significant initiatives in information technology advances, support new developments associated with the Trust's service development plans, address statutory compliance needs and improve the infrastructure to reduce risk and enhance the patient experience.

The 2008/09 capital expenditure is analysed as follows:

	£000	£000
Medical Equipment	**8,156**	
Ultrasound machines		1,410
Patient monitors		960
Defibrillators		803
Anaesthetic machines		674
Digital X-ray equipment		550
MRI & Spectroscopy system		495
Renal Dialysis machines		377
Diathermy machines		233
Other		2,654
Statutory Compliance	**381**	
Road Safety improvements		110
Infection Control equipment/facilities		101
Other (eg Fire Compliance, Disability Discrimination, Security etc)		170
Information Technology	**3,164**	
Picture Archiving and Communications System		1,607
VMware Upgrade Programme		300
Single Patient Record		204
Other		1,053
Infrastructure	**6,899**	
Ward Refurbishments		2,264
Replacement Chillers & Energy Strategy schemes		1,887
Lift Refurbishments		1,506
Other		1,242
Service Development	**18,338**	
Charles Clifford Dental Hospital Expansion		3,655
NGH Clinical Research Facility & Biomedical Research Units		2,383
Expansion Haematology/Bone Marrow Transplant Facilities		1,552
Miscellaneous Office/Consultant Accommodation		1,367
Radiopharmacy Facilities		1,187
Reconfiguration Vickers 1		1,107
BME Accommodation		990
Reconfiguration RHH Pharmacy		860
NGH Critical Care Expansion		656
Expansion NGH Endoscopy Facilities		525
GP Collaborative Accommodation		489
RHH Theatre Admissions Unit		442
Other smaller schemes		3,125
Total Expenditure	**36,938**	

Total capital income available to the Trust for the year was £42.2m. The capital income is analysed as follows:

	£000
Resources available from the Department of Health/Internally Generated	40,527
Sale proceeds from disposed assets	378
Other Donations/Contributions	1,279
Total Income	**42,184**

In April 2008 the Trust completed the draw-down of the £18.3m loan from the Department of Health's Foundation Trust Financing Facility which was secured to fund the new Northern General Hospital Critical Care Unit. Interest payments (£0.85m in 2008/09), and other costs associated with the Unit, have to be funded from the income which it earns from treating patients. Principal repayments (£0.78m in 2008/09) have to be funded from the Trust's internally generated resources, thereby reducing funding available for other capital investments.

Cash balances at 31 March 2009 were £45.2m, down £9.6m over the year. Of this around £19m relates to capital, pay reform (largely AfC) and R&D commitments and around £11.5m relates to I&E surpluses over the last 3 years which will be used to increase capital investment in the coming years. This leaves a £15m uncommitted balance which the Trust believes is the minimum required to maintain a satisfactory working capital position and provide a degree of financial resilience. It equates to just over one week of expenditure for the Trust.

Overall the Trust had net assets employed of £517.5m at 31 March 2009 and had net current assets of £26.9m. The latter figure will be reduced to around £15m when the capital and pay reform commitments referred to above are met.

On Monitor's financial risk rating of one to five, where one represents very high risk and five very low risk, the Trust was assessed as a four rating at both plan and outturn stages. It was at all times compliant with the Prudential Borrowing Limit set by Monitor and income from private patients, at 0.64% of patient related income, was well within the Statutory Cap of 0.9%.

Overall, therefore, the Trust's 2008/09 financial results are satisfactory, particularly when set alongside the very challenging efficiency targets and the excellent service achievements in the year. Whilst the future always looks more uncertain, there are particular issues for 2009/10 and beyond which suggest even greater financial challenges ahead.

These include:

- The need for further significant efficiency gains in 2009/10 to delver the 3% national efficiency requirement and corporate targets.
- A further increase in the national efficiency target from 2010/11 and much lower levels of NHS funding growth from 2011/12 as the impact on public finances of the general economic downturn is seen.
- Considerable uncertainty over the impact on the Trust's income from the introduction and development of new PbR tariffs from 2009/10 based on Version 4 of Healthcare Resource Groups.
- Instability in non-pay prices as a result of general economic factors.
- A national direction to make greater elements of the Trust's income conditional on meeting quality targets.
- Uncertainty over the level of Education and Training funding from 2010/11 following the national review of the MPET (Multi Professional Education and Training) Levy.
- Demanding service, quality and regulatory standards.
- A potentially more challenging competitive environment arising from national initiatives on plurality of provision, patient choice, movement of activity to community settings and a greater tendency to put services out to competitive tender.
- The difficulty of managing expectation at all levels when growth in NHS funding is much reduced following several years of very significant investment.

Overall, therefore, the future financial climate for the Trust appears very challenging. The sustainability and success of the Trust will therefore be heavily reliant on its ability to adapt quickly to the changing environment resulting from the general economic downturn. This will necessitate excellent cost control, skilled negotiation to attract appropriate levels of funding and the ability to deliver high levels of efficiency gain alongside high levels of quality and patient safety.

The Trust has a relatively good track record in this latter area given the three years to-date of its Adding Value Programme. However, the Trust will need to build on this foundation and ensure engagement and focus at all levels of the organisation if the future challenges are to be met successfully.

Neil Priestley
Director of Finance

3rd June 2009

Public Interest Disclosure

The Board of Directors comprises the chairman, six non-executive directors and six executive directors.

Together they bring a wide range of different skills and experience to the Trust, enabling it to achieve balance and completeness at the highest level.

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

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

The Board of Directors can be contacted by writing to:

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

Senior Independent Director

In January 2007 the Board of Directors agreed the requirement for a senior independent director to act with 'independence of mind' and provide a channel through which foundation trust members and governors are able to express concerns, other than the normal route of the chairman, chief executive or finance director. Mr Vic Powell was subsequently appointed in April 2007 from the six non-executive directors then sitting on the Board and remains in this role.

The Chairman

David Stone OBE

Chairman

During March, the Chairman, Mr David Stone OBE was reappointed for a further four years. He has been Chairman of the Board since the formation of the Trust in 2001 and steered the Trust to Foundation Trust status in 2004. He was previously Chairman of Weston Park Hospital and Central Sheffield University Hospitals NHS Trusts and was Chair of the UK University Hospitals Chairs Group from 2005-2008.

Other Interests:

- Trustee, Weston Park Cancer Care Appeal
- Trustee, Freshgate Foundation
- Trustee, Sheffield Botanical Gardens Trust
- Guardian, Sheffield Assay Office
- Honorary Consul, Republic of Finland
- Chairman, Cutlers Hall Preservation Trust

The Executive Directors

Andrew Cash OBE

Chief Executive

Andrew Cash joined the NHS as a fast track graduate management trainee and has been a chief executive for over 20 years. He has worked at local, regional and national level. He has worked by invite at the Department of Health Whitehall on a number of occasions. He is a visiting Professor in Leadership Development at the Universities of York and Sheffield.

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

Other Interests:

- Visiting Professor, University of York's Centre for Leadership and Development, Department of Health Studies
- Non-executive Director, Medilink (Yorkshire & The Humber) Ltd
- Professor (Visiting Chair), University of Sheffield Leadership Centre
- Brother - Northern Regional Chairman of Building Design Partnership

Professor Chris Welsh

Chief Operating Officer

Professor Chris Welsh trained as a vascular surgeon and was appointed to a consultant post at the Northern General Hospital in 1984. Before becoming Medical Director in 2001 and then Chief Operating Officer in April 2008, Professor Welsh held the post of Regional Postgraduate Dean for the NHS Trent Region for six years. He was seconded to the post of Acting Chief Executive for one year from July 2006. Professor Chris Welsh also holds the post of Medical Director, NHS Yorkshire and the Humber.

Other Interests:

- In private medical practice based at Claremont Hospital
- Part owner and Director of C. L. Welsh and Company Ltd

Hilary Scholefield

Chief Nurse

Hilary Scholefield joined the Trust in March 2006 as Chief Nurse. Hilary began her nursing career at the Northern General Hospital, where she undertook her training and worked as staff nurse, then sister in both the cardiothoracic and critical care areas. Before her appointment as Chief Nurse, Mrs Scholefield held the post of Chief Nurse at the University Hospitals Coventry and Warwickshire NHS Trust. She chairs the National Association of UK University Hospitals Nurse Directors' Group.

Other Interests:

- Member, NIHR Advisory Board
- Member, Centre of Excellence Advisory Board, Next Stage Review
- Visiting Professor, Faculty of Health and Well-Being, Sheffield Hallam University
- Member, Advisory Panel to NHS Chief Executive and Minister for Health, High Quality for All
- Member, National Quality Board
- Member, NETSCC SDO NHS Evaluations Panel

Chris Linacre

Director of Service Development

Chris Linacre joined the NHS in 1971 and has worked in hospital management and specialist personnel management in Sheffield since that time. He has held posts as Director of Organisational Development at the Royal Hallamshire Hospital and General Manager of Lodge Moor and King Edward Hospitals prior to becoming Director of Corporate Strategy for the former Central Sheffield University Hospitals NHS Trust when it was established in 1992. He has held the post of Director of Service Development since Sheffield teaching Hospitals was formed in April 2001.

Other Interests:

- Non-executive Director, Medipex Ltd
- Non-executive Director, EPAQ Ltd (a company in which the Trust has a shareholding)
- Non-executive Director, Zilico (formerly called Aperio Diagnostic - a company in which the Trust has a shareholding)

Neil Priestley

Director of Finance

Neil Priestley was appointed to the post of Director of Finance of the newly merged Sheffield Teaching Hospitals in February 2001. He had previously held the post of Head of Finance at the NHS Executive Trent Regional Office, from where he had been seconded to the Northern General Hospital as acting Director of Finance prior to the Trust merger. Mr Priestley is a Fellow of the Chartered Association of Certified Accountants.

Other Interests: None

Mike Richmond

Medical Director

Dr Mike Richmond was initially appointed as a consultant anaesthetist and honorary senior lecturer to the Jessop Hospital for Women in February 1988 having trained in Sheffield, Oxford and the Royal Air force. He has 12 years experience as a clinical director originally on the central campus, but most recently to the Critical Care, Anaesthesia and Operating Services Group.

Dr Richmond has had a long involvement with the Royal College of Anaesthetists, acting as a final fellowship examiner for the past 10 years. He was appointed as the Trust's Medical Director in Aril 2008

Other interests:

- Undertakes private practice at Thornbury Hospital

John Watts

Director of Human Resources

John Watts has a 30-year career in NHS personnel and executive management and has held senior posts in NHS organisations around the country. Prior to joining the team at Sheffield Teaching Hospitals, Mr Watts was Director of Human Resources at the Northern General Hospital.

Other Interests: None

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

Phil Brennan

Director of Estates Management

Phil Brennan was appointed as Estates Director in March 2008, following a period in an acting position. Phil is a chartered engineer and has worked in both the private and public sectors. He joined the NHS in 1981 and has worked in Sheffield's acute sector ever since. He became Deputy Director Estates, responsible for operational services, in 2001, taking on responsibility for capital projects (engineering design) in 2003.

Other Interests: None

Julie Phelan

Communications Director

(Since June 2008)

Julie Phelan spent her early career as a journalist in both print and broadcast media before moving into public sector communication in local government and health. She was previously Head of Communications at Sandwell and West Birmingham Hospitals NHS Trust, Head of Communications for Birmingham Women's Hospital and Director of Communications for Worcestershire Acute Hospitals and Worcester Health Authority. Before joining the Trust in June 2008, Julie was Director of Communications for University Hospitals Coventry and Warwickshire NHS Trust a post she had held for five years.

Other Interests: None

Neil Riley

Trust Secretary

Neil Riley is a graduate of Queens College, Oxford and in 1981 joined the National Health Service as a management trainee. He has subsequently worked in a number of NHS settings across the country and in 1995 was appointed as Chief Executive of Weston Park Hospital.

In 2002 Mr Riley was appointed to the post of Assistant Chief Executive at Sheffield Teaching Hospitals NHS Trust and most recently, was appointed to the post of Trust Secretary for Sheffield Teaching Hospitals NHS Foundation Trust.

Other Interests:

- Visiting Professor, Faculty of Health and Well Being, Sheffield Hallam University from 1 May 2005 to 31 July 2009
- Associate, PACT consultancy (from 5 July 2005)
- Vice Chairman, FTN Company Secretary Network (from 1 January 2008)

The Non-Executive Directors

John Donnelly

John Donnelly was a Chief Superintendent with South Yorkshire Police and Commander for the district that covers the Trust's hospitals. He joined the police as a cadet in 1966 and, in time, headed up the Force's Research and Development, Community Relations, and Police Traffic Departments. He retired from the police service in 2005.

Other Interests:

- Trustee, Sheffield Hospitals Charitable Trust
- Chair, General Medical Council Fitness to Practice Panel

Vickie Ferres

Vickie Ferres is Chief Executive of Age Concern in Doncaster, a position she has held since 1983. A Sheffield resident, Vickie has extensive experience in working with elderly people and understanding the health and social care issues that affect them. She was formerly a Non-executive Director at the Northern General Hospital NHS Trust.

Other Interests:

- Chief Executive, Age Concern Doncaster

Shirley Harrison

Shirley Harrison's professional career has been in marketing and public relations, both as a practitioner and an academic. She was formerly the Director of Public Relations at Sheffield City Council. She is a former chair of the Human Fertilisation and Embryology Authority and of the South Yorkshire Probation Board and is the current chair of the Human Tissue Authority.

Other Interests:

- Chair, Human Tissue Authority (HTA)

Sheffield Teaching Hospitals NHS Foundation Trust is the Corporate Licence Holder for three licences issued by the HTA: Licence number 12182 (Research) Licence number 12427 (Pathology) Licence number 11030 (Tissue Bank). Should any matter concerning these licences or regulatory activity in relation to them come before the Board, Ms. Harrison will declare her interest at the time and not take any part in the proceedings.

- Member, Organ Donation Task Force (unpaid)
- Member, North Trent Consumer Research Panel (unpaid)
- Member (co-opted), NCRI Consumer Liaison Group (unpaid)
- Lay peer reviewer, NHS SDO R&D Programme
- Director, Harrison Research and Consultancy Ltd

Jane Norbron

Jane Norbron has held senior management posts at Marks and Spencer, Meadowhall and has expertise in both human resources and commercial management. She is currently a business consultant and performance coach and has a special interest in helping more women achieve senior management positions.

Other Interests:

- Company Director, Jane Norbron Limited - Acts as Business Consultant and Performance Coach
- Involved with the organisation International Women of Excellence (Registered Charity) (unpaid) - promotes the appointment of women to senior positions
- Accredited management assessment centre for the Institute for the Motor Institute (Sector Skills Council)

Vic Powell

Victor Powell is an accountant by profession and worked for KPMG in Sheffield throughout his professional career. He was involved in the management of the North-East Region in general and the Sheffield office in particular where he was Business Unit Managing Partner for nine years until his retirement.

Other Interests:

- Member, Department of Health Foundation Trust Finance Facility

Iain Thompson

(Since May 2008)

Iain Thompson has held senior supply chain positions in the flour milling and brewing industries. He returned to Sheffield in 2003 following early retirement and joined the Board of Directors in May 2008.

Other Interest: None

Professor Anthony Weetman

Tony Weetman is Pro Vice Chancellor of the Faculty of Medicine, Dentistry and Health and the Sir Arthur Hall Professor of Medicine at the University of Sheffield. He is also an Honorary Consultant Physician in the Trust (from 1991) and was formerly a Non-executive Director at the Northern General Hospital NHS Trust.

Other Interests:

- Medical Advisor, British Thyroid Foundation
- Sees private patients at Thornbury Hospital

Appointments

Non-executive directors are appointed via an open advertisement and formal interview process, which the NHS Appointments Commission manages on behalf of the Trust. The final appointment of Non-Executive Directors, including that of the chair, is made by the Nomination Committee of the Governors' Council, which also determines their remuneration.

Terms of Office

Non-executive directors' are appointed for four years. Their terms of office are as follows:

Name	Position	Term of Office Commenced	Term of Office Ends
David Stone	Chairman	Reappointment commenced 1 July 2008	30 June 2012
John Donnelly	Non-executive director	Reappointment commenced 1 July 2006	30 June 2010
Vickie Ferres	Non-executive director	Reappointment commenced 1 July 2005	30 June 2009
Shirley Harrison	Non-executive director	Appointment commenced 1 November 2007	30 October 2011
Jane Norbron	Non-executive director	Appointment commenced 1 July 2007	30 June 2011
Vic Powell	Non-executive director	Reappointed commenced 1 July 2007	30 June 2011
Iain Thompson	Non-executive director	Appointment commenced 1 May 2008	30 April 2012
Anthony Weetman	Non-executive director	Reappointment commenced 1 July 2005	30 June 2009

Development of the Board

In June 2008 the Board held a development time out, facilitated by PricewaterhouseCoopers, designed to strengthen its work in light of the Trust's new corporate strategy for 2008 – 2012.

An action plan was agreed and a six-monthly review of progress has subsequently been undertaken, which demonstrated that good progress has been made in delivering the plan.

Meetings of the Board

The Board of Directors meets every month. The majority of these, including any extraordinary meetings, are held privately with only the Board of Directors, associated employees, and employees of the Trust making presentations to the Board, in attendance. The Trust did introduce a quarterly meeting of the Board open to both staff and the general public and focusing on themes of particular interest to the public. However, due to the extremely low attendance rate this practice was discontinued with the last such meeting being held in May 2007.

The individual attendance by Directors is noted at each meeting and reviewed by the chairman. Attendance may be affected by sickness or annual leave. Individual attendance for 2008/09 is as follows:

Attendance at Board Meetings

Board Members	Attendance Rate (Out of 13 meetings unless otherwise stated)
David Stone OBE, Chairman	11
Andrew Cash OBE, Chief Executive	13
Chris Linacre, Director of Service Development, Deputy Chief Executive	13
Neil Priestley, Director of Finance	13
Mike Richmond, Medical Director	10
Hilary Scholefield, Chief Nurse	12
John Watts, Director of Human Resources	12
Professor Chris Welsh, Chief Operating Officer STHFT, Medical Director Yorks & Humber SHA	9
Phil Brennan, Director of Estates Management	13
Julie Phelan, Communications Director (Appointed June 2008)	10/10
Neil Riley, Trust Secretary	13
John Donnelly, Non-executive Director	11
Vickie Ferres, Non-executive Director	13
Shirley Harrison, Non-executive Director	11
Jane Norbron, Non-executive Director	12
Vic Powell, Non-executive Director	13
Iain Thompson, Non-executive Director (Appointed May 2008)	10/12
Professor Anthony Weetman, Non-executive Director, University Representative	10

Committees of the Board

The Management Audit Committee (MAC) is appointed by the Board of Directors and consists of more than three non-executive directors of the Trust. The chief executive, director of finance, the chief internal auditor and a representative from the external auditor normally attend meetings.

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

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

Attendance at Management Audit Committee

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

Attendance at Finance Committee

Board Members	Attendance Rate (Out of eleven meetings unless otherwise stated)
David Stone, Chairman	9
Andrew Cash, Chief Executive	7
John Donnelly, Non-executive Director	9
Chris Linacre, Director of Service Development. (stopped attending after meeting 3 and Chris Welsh, Chief Operating Officer attended instead)	3 (4)
Vic Powell, Non-executive Director	11
Neil Priestley, Director of Finance	11
John Watts, Director of Human Resources	7
Chris Welsh, Chief Operating Officer STHFT, Medical Director Yorks & Humber SHA	6 (7)

Attendance at Human Resources Committee

Board Members	Attendance Rate (Out of five meetings unless otherwise stated)
Vickie Ferres, Non-executive Director	5
Jane Norbron, Non-executive Director	5
John Watts, Director of Human Resources	5

Attendance at Healthcare Governance Committee

Board Members	Attendance Rate (Out of twelve meetings unless otherwise stated)
Phil Brennan, Director of Estates Management	9
Vickie Ferres, Non-executive Director	12
Chris Linacre, Director of Service Development	1
Mike Richmond, Medical Director	6/11
Neil Riley, Trust Secretary	10
Hilary Scholefield, Chief Nurse	10
Iain Thompson, Non-executive Director	8/10
John Watts, Director of Human Resources	5
Professor Anthony Weetman, Non-Executive Director, University Representative	8
Chris Welsh, Chief Operating Officer STHFT, Medical Director Yorks & Humber SHA	3

Attendance at Remuneration Committee

Board Members	Attendance Rate (Out of one meeting unless otherwise stated)
David Stone, Chairman	1
Andrew Cash, Chief Executive	Part
John Donnelly, Non-executive Director	1
Vickie Ferres, Non-executive Director	1
Jane Norbron, Non-executive Director	1
Vic Powell, Non-executive Director	1
Neil Priestley, Director of Finance	Part
Neil Riley, Trust Secretary	Part
Iain Thompson, Non-executive Director	0
John Watts, Director of Human Resources	0
Professor Anthony Weetman, Non-executive Director	1

Governance code

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

During 2007/08 the Trust undertook a formal review of its insurance liabilities. Having identified a gap in the arrangements, we took out cover from 1 April 2008.

The Board does not believe that the re-appointment of executive directors at no more than five years is required, given the existence of robust annual appraisal arrangements for directors.

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

Remuneration

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

Countering fraud and corruption

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

Discrimination and equal opportunities

The Trust is committed to promoting equality and eliminating discrimination in all its forms, whether affecting staff or people using its services. The Trust's schemes and action plans relating to disability, race and gender equality can be accessed via the website at www.sth.nhs.uk. (See also Working with Our Communityand Engaged Staff)

Communication and consulting with staff

The Trust holds bi-monthly Joint Negotiating Consultative Committee (JNCC) meetings consisting of representatives of the recognised trade unions and the Trust Executive Group. The meetings play an important role in facilitating high-level discussion on strategic issues concerning the Trust including strategy, finance and policy. The Joint Consultative Committee (JCC) has a more operational remit where the trade unions bring issues raised by their members to the table for further discussion and resolution. The Trust employs a staff side chair to coordinate discussions with all the trade unions and management.

The Trust has a number of central communications mechanisms, which aim to inform staff about Trust business. The Link magazine is a quarterly publication, the content of which is largely driven by staff in the organisation. The weekly CEO web broadcasts give a timely update on key issues or developments. The monthly Team Brief provides a template for managers to use in their own local staff briefings and the weekly Communications Update is an informal single page publication disseminated by email.

Health and safety

The Trust was fined £18k for a breach in Health and Safety at Work Act following the tragic death of one of our patients in 2004. The Trust received 7 improvement notices from the Health and Safety Executive of which only one remained at year end and is expected to be resolved by the end of April 2009. The Trust remains committed to ensuring that it protects the health and safety of its patients, staff, and visitors. During 2008/09 the Trust had a routine management audit by the Health and Safety Executive and using the information from this audit to help inform improvements to safety within the Trust.

Occupational Health

Sheffield Occupational Health Service currently provides occupational health advice and support to 33,000 employees of 16 major employers, in mainly health and higher education arenas. SOHS offers the full range of services including:

- Pre-employment health screening
- On commencement health interviews
- Management referrals and sickness absence reviews
- Health surveillance
- Immunisation programmes
- Blood and body fluid exposure incident management and post exposure prophylaxis
- Infection control advice/screening
- Investigation of workplace hazards and possible occupational ill health
- Advice to workforce and managers on occupational health issues

Services are provided from two locations, the Northern General hospital, Silverwood site and the Royal Hallamshire hospital, Claremont Place site.

Consultation, communication and involvement

The Trust is committed to delivering high quality services that are patient-focused. To help to ensure that it does so, it works closely with, consults and involves other organisations, local groups, patients and the public as appropriate.

During the year an extensive internal and external consultation was undertaken regarding the Trust's corporate strategy 2009-2012. This took place over a six-month period and involved staff and major stakeholders including commissioners, the Strategic Health Authority, Foundation Trusts in the North Trent Network, the Universities, City Council and MPs.

For further details of the Trust's activities in relation to working with other organisations, groups, patients and the public (see also Customer Service and Working With Our Community).

Remuneration Report

Remuneration committee

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

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

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

Remuneration of chairman and non-executive directors

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

Remuneration of senior managers

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

Assessment of performance

All executive and non-executive directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to the following 31 March. During the year regular reviews take place to discuss progress, and there is an end of year review to assess achievements and performance. The executive directors are assessed by the chief executive; following this there is a meeting between the chairman and each executive director to discuss their performance.

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

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

Performance pay

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

Duration of contracts

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

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

Name	Designated	Expiry date
Mr DR Stone	Chairman	30 June 2012
Mr VGW Powell	Non-executive Director Senior Independent Director	30 June 2011
Mr J Donnelly	Non-executive Director	30 June 2010
Ms V Ferres	Non-executive Director	30 June 2009
Mrs S Harrison	Non-executive Director	31 October 2011
Mrs J Norbron	Non-executive Director	30 June 2011
Mr I Thompson	Non-executive Director	30 April 2012
Professor AP Weetman	Non-executive Director	30 June 2009

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

Early termination liability

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

Other Information:

Please refer to the notes in the 08/09 Accounts contained on pages 100-101 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Increases in Pension at age 60 during 08/09
- Value of the cash equivalent transfer value at the beginning of the year
- Increase in the cash equivalent transfer value during 08/09.

Andrew Cash OBE
Chief Executive

3rd June 2009

Independent Auditor's Report

Independent Auditor's Report

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

I have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2009 under the National Health Service Act 2006. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

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

Respective responsibilities of the Accounting Officer and auditor

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

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

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

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2008/09. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements.

This other information comprises the Chairman's Statement, Management Commentary, Quality Report, Celebrating foundation trust status, the sections on Healthcare Governance and healthcare standards, public interest disclosures and the un¬audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

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

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

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

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Directors' Report and Finance Director's Report, included in the annual report, is consistent with the financial statements.

Certificate

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

Mr D Murray
Engagement Lead Audit Commission

1st Floor
Kernel House
Killingbeck Drive
Killingbeck
Leeds, LS14 6UF

5th June 2009

Statement of Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Sheffield Teaching Hospitals NHS Foundation Trust

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

Under the 2006 Act, Monitor has directed the Sheffield Teaching Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS foundation trust Financial Reporting Manual and in particular to:

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

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

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

Andrew Cash OBE
Chief Executive

3rd June 2009

Foreword to the Accounts

These accounts for the year ended 31 March 2009 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Andrew Cash OBE
Chief Executive
3rd June 2009

Income and Expenditure Account for the 12 Months Ended 31 March 2009

	NOTE	**2008/09** **£000**	2007/08 £000
Income from activities	3	**600,655**	570,006
Other operating income	4	**130,863**	121,925
Operating expenses	5-7	**(717,513)**	(673,828)
OPERATING SURPLUS		**14,005**	18,103
Surplus on sale of fixed assets	8	**18**	0
SURPLUS BEFORE INTEREST		**14,023**	18,103
Finance Income	9	**2,417**	3,170
Finance Costs - interest expense	9	**(851)**	(146)
Other finance costs - unwinding of discount	17	**(55)**	(58)
SURPLUS FOR THE YEAR		**15,534**	21,069
Public Dividend Capital dividends payable		**(14,077)**	(14,167)
RETAINED SURPLUS FOR THE YEAR		**1,457**	6,902

The notes on pages 94-115 form part of these accounts.

All income and expenditure is derived from continuing operations.

Andrew Cash OBE
Chief Executive
3rd June 2009

Balance Sheet as at 31 March 2009

	NOTE	**31 March 2009 £000**	31 March 2008 £000
FIXED ASSETS			
Intangible assets	10	**3,269**	2,835
Tangible assets	11	**515,772**	514,732
Investments	12	**0**	0
		519,041	517,567
CURRENT ASSETS			
Stocks	13	**9,638**	8,287
Debtors	14	**35,777**	35,826
Investment	15	**0**	0
Cash	19.3	**45,212**	54,794
		90,627	98,907
CREDITORS: Amounts falling due within one year	16	**(63,696)**	(69,025)
NET CURRENT ASSETS		**26,931**	29,882
TOTAL ASSETS LESS CURRENT LIABILITIES		**545,972**	547,449
CREDITORS: Amounts falling due after more than one year	16	**(18,365)**	(9,039)
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(10,062)**	(23,727)
TOTAL ASSETS EMPLOYED		**517,545**	514,683
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital	18.2	**320,207**	314,279
Revaluation reserve	18.3	**121,070**	130,998
Donated asset reserve	18.3	**41,563**	42,855
Income and expenditure reserve	18.3	**34,705**	26,551
TOTAL TAXPAYERS' EQUITY		**517,545**	514,683

Andrew Cash OBE
Chief Executive
3rd June 2009

Statement of Total Recognised Gains and Losses for the 12 Months Ended 31 March 2009

	2008/09 £000	2007/08 £000
Surplus for the year before dividend payments	**15,534**	21,069
Unrealised (loss) surplus on fixed asset revaluations/indexation	**(3,081)**	59,868
Increases in the donated asset reserve due to receipt of donated assets	**1,279**	2,064
Reductions in the donated asset reserve due to depreciation, impairment, and / or disposal of donated assets	**(2,662)**	(2616)
Other recognised gains and losses	**(59)**	(57)
Total gains and losses recognised since last annual report	**11,011**	80,328

Cash Flow Statement for the 12 Months Ended 31 March 2009

	NOTE	**2008/09** **£000**	2007/08 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	19.1	**25,193**	56,033
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**2,582**	3,035
Interest Paid		**(997)**	0
Net cash inflow from returns on investments and servicing of finance		**1,585**	3,035
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(37,857)**	(45,094)
Receipts from sale of tangible fixed assets		**378**	0
(Payments) to acquire intangible assets		**(2,862)**	(525)
Net cash (outflow) from capital expenditure		**(40,341)**	(45,619)
DIVIDENDS PAID		**(14,077)**	(14,167)
Net cash (outflow) before management of liquid resources and financing		**(27,640)**	(718)
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of current asset investments		**(90,000)**	(150,000)
Sale of current asset investments		**90,000**	150,000
Net cash flow from management of liquid resources		**0**	0
Net cash (outflow) inflow before financing		**(27,640)**	(718)
FINANCING			
Public dividend capital received		**5,928**	9,160
Loans received from Foundation Trust Financing Facility		**11,000**	7,300
Loans repaid to Foundation Trust Financing Facility		**(780)**	0
Other capital receipts		**1,910**	1,484
Net cash inflow from financing		**18,058**	17,944
(Decrease) / increase in cash		**(9,582)**	17,226

Notes to the accounts

1 Introduction

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor, the body responsible for overseeing Foundation Trust activities. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual 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. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation Trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a) the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b) if a termination, the former activities have ceased permanently;

c) the sale or termination has a material effect on the nature and focus of the reporting trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the Trust's continuing operations

d) the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all of these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided.

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

Partially completed spells for patient episodes are accounted for as required under FRS 5. An asset in the form of a debtor is therefore recognised together with the corresponding income adjustments.

The NHS Foundation Trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology from 2004/05. To manage the financial impact of this change on the NHS Foundation Trust and its commissioners the Department of Health has implemented transitional gain and clawback arrangements. These are on a sliding scale, as the change is phased in over the four year period to 2008/09. Under these arrangements the Trust received income protection of £0 from the Department of Health during 2008/09 (2007-08 £12,755,000).

1.4 Expenditure

Expenditure is accounted for applying the accruals convention.

1.5 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence or their useful economic lives.

1.6 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have a broadly simultaneous purchase date, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting up of a new building, ward or unit irrespective of their individual or collective cost
- Digital Hearing aids were capitalised in accordance with the direction of the Secretary of State in 2003/04 and the first quarter of 2004/05, and will be written down over 5 years.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any

costs such as installation directly attributable to bringing them into working condition. They are restated to current value periodically. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation is also carried out

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last estate valuations were undertaken in 2007/08 as at the prospective valuation date of 1 April 2007 and were applied on 1 April 2007. Ad-hoc revaluations are carried out in year, as required when material or operational changes occur to specific premises.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three yearly valuation or when they are brought into use.

Residual interests in off balance sheet private finance initiative properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in fair value of the residual as estimated at the start of the contract and at the balance sheet date.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

Fixed asset impairments resulting from losses of economic benefits are charged to the Income and Expenditure Account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

The economic life of buildings is based on the assessment of the District Valuer. The economic life of equipment ranges between 5 and 10 years.

1.7 Donated fixed assets

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

1.8 Government Grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants, as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for the asset.

1.9 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) 'How to Account for PFI transactions' which provides definitive guidance for the application of note F to FRS 5.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI obligations are recorded as an operating expense. Where the trust has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Income and Expenditure Account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it, which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.10 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production.

1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;

- its resulting in a product or service which will eventually be brought into use;
- adequate resources exist to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project.

It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. The trust is unable to disclose the total amount of research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.12 Contingencies

Contingent assets (that is assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the trust's control) are not recognised as assets, but are recognised in note 22 where an inflow of economic benefit is probable.

Contingent liabilities are provided where the transfer of economic benefit is probable. Otherwise they are not recognised, but are disclosed in note 22, unless the transfer of economic benefits is remote. Contingent liabilities are defined as

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

1.13 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 17.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2008/09 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

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 the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising.

The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS Employers, General Practices, and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period. The total employer contributions payable in the 12 months to 31 March 2009 were £42,461,059 (31 March 2008 £39,070,454).

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

The Scheme is subject to a full actuarial investigation every four years, the main purpose of which is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and Scheme members. The last such published investigation, on the conclusions of which Scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the Scheme liabilities for FRS 17 purposes.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary Report, which forms part of the NHS Pension Scheme (England and Wales) resource account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office. The last such FRS 17 valuation, dated 23 December 2008, relates to the 07/08 liability, which is reported as £212.5 billion in the NHS Pensions Accounts.

The conclusion of the 2004 actuarial investigation was the the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for the one-off effects of pay modernisation, but before taking into account any of the Scheme changes which had come into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effect from 1 April 2008, employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the Scheme's liabilities. Up to 31 March 2008 employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. From 1 April 2008, employees will pay contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

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

1.15 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.16 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure account.

1.18 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 26 to the accounts.

1.19 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The asset and liability are recognised at the inception of the lease, and are de-recognised when the obligation is discharged, cancelled or expires. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.20 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS trust, along with any further sums subsequently authorised by the Secretary of State.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.21 Losses and Special Payments

Losses and Special Payments are charged to the relevant functional headings on a cash basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 Corporation Tax

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

1.23 Cash, Bank and Overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS Foundation Trust's cash book. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see Third Party Assets above). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'Interest Receivable' and 'Interest Payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.24 Financial Instruments and Financial Liabilities

Recognition

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

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

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

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

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

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

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

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

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.The Trust's loans and receivables comprise cash at bank and in hand and

NHS and trade debtors, accrued debt and provisions for impaired debt. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or,when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the balance sheet date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised in reserves are included in the income and expenditure account.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the income and expenditure account.

Determination of fair value

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

Impairment of financial assets

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

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

1.25 Move to International Financial Reporting Standards (IFRS)

With effect from Financial Year 2009/10, the Trust's accounts will be prepared under International Financial Reporting Standards (IFRS).

This will involve the restatement of the 2008/09 figures in these accounts as comparatives in the 2009/10 accounts.

It is not yet possible to quantify the effect of any restatement that may be neccessitated under the move to IFRS.

2 Segmental Analysis

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

3 Income

3.1 Income from Activities

	2008/09	2007/08
	£'000	£'000
Elective income	**137,040**	128,345
Non Elective income	**160,931**	152,688
Outpatient income	**98,632**	88,099
Other NHS Clinical income	**190,464**	175,359
A&E Income	**9,750**	9,269
PBR transitional relief	**0**	12,755
Private Patient Income	**3,838**	3,491
TOTAL	**600,655**	570,006

3.2 Private patient income

	2008/09	2007/08	Base year (2002-03)
	£'000	£'000	£'000
Private Patient Income	**3,838**	3,491	2,774
Total patient related income	**600,655**	570,006	367,782
Proportion (as percentage)	**0.64%**	0.61%	0.75%

Section 15 of the 2003 Act requires that the Trust's proportion of private patient income in relation to its total patient related income does not exceed that same percentage whilst the Trust was an NHS Trust in 2002/03. This requirement has been met.

3.3 Income from Activities

	Total	
	2008/09	2007/08
	£'000	£'000
Strategic Health Authorities	**898**	0
Primary Care Trusts	**567,776**	527,357
Local Authorities	**113**	268
Department of Health	**23,864**	35,608
NHS Other	**1,131**	1,007
Non NHS: Private patients	**3,025**	2,312
Non NHS: Overseas patients (non-reciprocal)	**813**	1,179
NHS injury scheme (was Road Traffic Act Scheme)	**2,972**	2,206
Non NHS: Other	**63**	69
TOTAL	**600,655**	570,006

4 Other Operating Income

	Total	
	2008/09	2007/08
	£'000	£'000
Research and Development	**8,328**	8,170
Education and Training	**64,424**	56,792
Transfers from the donated asset reserve in respect of depreciation, impairment, and disposal of donated assets	**2,662**	2,616
Non patient care services to other bodies	**42,010**	41,083
Other	**13,439**	13,264
TOTAL	**130,863**	121,925

Other Operating Income 'Other' consists of sundry income from the provision of various facilities to staff, patients and public on STH sites.

The largest individual components relate to the provision of car-parking, catering, and nursery facilities.

5 Operating Expenses

5.1 Operating expenses comprise:

	2008/09	2007/08
	Total	Total
	£'000	£'000
Services from other NHS Foundation Trusts	**6,095**	4,152
Services from other NHS Trusts	**5,311**	6,865
Services from other NHS bodies	**6,491**	6,142
Purchase of healthcare from non NHS bodies	**10,529**	8,581
Executive Directors' costs	**1,346**	1,180
Non-Executive Directors' costs	**180**	157
Staff costs	**452,725**	431,288
Drugs costs	**69,771**	61,408
Supplies and services - clinical	**66,659**	63,782
Supplies and services - general	**6,933**	7,657
Establishment	**7,346**	6,781
Research and Development	**2,984**	866
Transport	**752**	726
Premises	**31,492**	26,866
Bad debts	**3,139**	371
Depreciation and amortisation	**30,614**	29,446
Fixed asset impairments	**1,569**	4,526
Fixed asset impairments reversals	**(398)**	(747)
Audit fees	**87**	89
Other auditors' remuneration	**1**	0
Clinical negligence	**5,127**	5,794
Other	**8,760**	7,898
TOTAL	**717,513**	673,828

	2008-09	2007/08
	£'000	£'000
Limitation on Auditors' liability	**Unlimited**	10,000

5.2 Operating leases

5.2/1 Operating expenses include:

	2008/09	2007/08
	£'000	£'000
Other operating lease rentals	**1,714**	1,823
TOTAL	**1,714**	1,823

5.2/2 Annual commitments under non -cancellable operating leases are

	2008/09	2007/08
	Land and buildings	Land and buildings
	£'000	£'000
Operating leases which expire:		
Within 1 year	**60**	13
Between 1 and 5 years	**70**	183
After 5 years	**134**	132
TOTAL	**264**	328

	2008/09	2007/08
	Other leases	Other leases
	£'000	£'000
Operating leases which expire:		
Within 1 year	**149**	65
Between 1 and 5 years	**842**	744
After 5 years	**189**	466
TOTAL	**1,180**	1,275

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

	To 31 March 2009			To 31 March 2008		
Name and Title	**Salary (bands of £5000)** £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mr A J Cash, Chief Executive (in 2007/08, Chief Executive from 1 July 2007)	**210-215**	-	-	155-160	45-50	-
Mr J Watts, Director of Human Resources	**125-130**	-	-	125-130	-	-
Mr N Priestley, Director of Finance	**145-150**	-	-	140-145	-	-
Mr M Richmond, Medical Director, with effect from 28 April 2008	**145-150**		-	n/a	n/a	n/a
Mr G Davies, Acting Medical Director (until 30 June 2007)	**n/a**	n/a	n/a	35-40	5-10	-
Mrs H Scholefield, Chief Nurse	**125-130**	-	-	125-130	-	-
Mr C Welsh, Medical Director (until 28 April 2008), Chief Operating Officer with effect from that same date.	**120-125**	40-45	-	160-165	-	-
Mr C C Linacre, Director of Service Development	**135-140**	-	-	135-140	-	-
Mr C Suddes, Non-Executive Director (until 31 December 2007)	**n/a**	n/a	n/a	10-15	-	-
Mr I Thompson, Non Executive Director	**10-15**	-	-	n/a	n/a	n/a
Mr J P Donnelly, Non Executive Director	**15-20**	-	-	10-15	-	-
Ms V R Ferres, Non Executive Director	**15-20**	-	-	10-15	-	-
Mr V G W Powell, Non Executive Director	**15-20**	-	-	10-15	-	-
Mrs J Norbron, Non Executive Director (appointed 1 July 2007)	**15-20**	-	-	10-15	-	-
Ms S Harrison Non Executive Director (appointed 1 November 2007)	**15-20**			5-10		
Professor A P Weetman, Non Executive Director	**15-20**	-	-	10-15	-	-
Ms O V Bright, Non Executive Director (until 30 June 2007)	**n/a**	n/a	n/a	0-5	-	-
Mr D Stone, Chairman	**55-60**	-	-	50-55	-	-

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	**Real increase in pension and related lump sum at age 60 (bands of £2500)** £000	Total accrued pension and related lump sum at age 60 at 31 March 2009 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mr A J Cash, Chief Executive	**10-12.5**	335-337.5	1,772	1,295	312	29,800
Mr J Watts, Director of Human Resources	**5-7.5**	237.5-240	n/a	n/a	n/a	18,000
Mr N Priestley, Director of Finance	**7.5-10**	187.5-190	817	604	139	20,700
Mr M Richmond, Medical Director, with effect from 28 April 2008	**52.5-55**	192.5-195	992	532	290	23,500
Mrs H Scholefield, Chief Nurse	**7.5-10**	185-187.5	754	565	123	18,000
Mr C Welsh, Medical Director (until 28 April 2008), Chief Operating Officer with effect from that same date.	**7.5-10**	295-297.5	n/a	n/a	n/a	17,200
Mr C C Linacre, Director of Service Development	**2.5-5**	255-257.5	1,620	1,165	298	19,100

As Non-Executive members do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

There are no CETV amounts for those Directors aged sixty or over at the Balance Sheet date. This is because these directors are not permitted to transfer benefits, hence no valued is disclosed under this note.

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

6 Staff costs and numbers

6.1 Staff costs

	2008/09	2007/08
	Total	Total
	£'000	£'000
Salaries and wages	**378,277**	362,527
Social Security Costs	**27,457**	25,602
Employer contributions to NHSPA	**42,461**	39,070
Other pension costs	**48**	30
Agency/contract staff	**5,828**	5,239
TOTAL	**454,071**	432,468

The above figure of £454,071k is net of the amount of £1,339k (12 months to 31.3.2008 £1,160k) in respect of capitalised salary costs included in fixed asset additions (note 11.1).

6.2 Average number of persons employed

	2008/09			2007/08		
	Total			Total		
	Number	**Permanently employed**	**Other**	Number	Permanently employed	Other
Medical and dental	**1,548**	**1,515**	**33**	1,471	1430	41
Administration and estates	**2,387**	**2,298**	**89**	2,438	2260	178
Healthcare assistants and other support staff	**1,374**	**1,292**	**82**	1,277	1277	0
Nursing, midwifery and health visiting staff	**4,957**	**4,723**	**234**	4,785	4,564	221
Scientific, therapeutic and technical staff	**1,905**	**1,886**	**19**	1,886	1,873	13
TOTAL	**12,171**	**11,714**	**457**	11,857	11,404	453

6.3 Employee benefits

	2008/09	2007/08
	£000	£000
None	**0**	0
TOTAL	**0**	0

6.4 Early Retirements Due to Ill Health

	2008/09	**2008/09**	2007/08	2007/08
	£'000	**Number**	£'000	Number
Number of early retirements agreed on the grounds of ill health		**18**		18
Cost of early retirements agreed on grounds of ill health	**771**		683	

As explained in note 1.14, these costs were borne by the NHS Pensions Agency.

7 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:

	2008/09	2007/08
Number of non NHS invoices paid	**156,697**	141,269
Number of non NHS invoices paid within 30 days	**147,762**	135,251
Percentage of invoices paid within 30 days	**94.30%**	95.74%

	£'000	£'000
Value of non NHS invoices paid	**257,682**	231,542
Value of non NHS invoices paid within 30days	**239,800**	215,982
Percentage of invoices paid within 30 days	**93.06%**	93.28%

Amounts included within Interest Payable (Note 9) 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

8 Profit on Disposal of Fixed Assets

Profit/loss on the disposal of fixed assets is made up as follows:	**2008/09**	2007/08
	Total	Total
	£000	£000
Profit on disposal of other tangible fixed assets	**18**	0
TOTAL	**18**	0

9.1 Finance Income

	2008/09	2007/08
	£000	£000
Interest on loans and receivables	**2,417**	3,170
TOTAL	**2,417**	3,170
Interest on impaired financial asset included in finance income	**0**	0

9.2. Finance costs - interest expense

	2008/09	2007/08
	£000	£000
Loans from the Foundation Trust Financing Facility	**851**	146
TOTAL	**851**	146

10.1 Intangible fixed assets:

	Total	Software licences
	£'000	£'000
Gross cost at 1 April 2008	**3890**	3890
Reclassifications	**798**	798
Additions - purchased	**355**	355
Disposals	**(53)**	(53)
Gross cost at 31 March 2009	**4990**	4990
Amortisation at 1 April 2008	**1055**	1055
Provided during the year	**719**	719
Disposals	**(53)**	(53)
Amortisation at 31 March 2009	**1721**	1721
Net book value		
- Purchased at 1 April 2008	**2826**	2826
- Donated at 1 April 2008	**9**	9
Total at 1 April 2008	**2835**	2835
Net book value		
- Purchased at 31 March 2009	**3265**	3265
- Donated at 31 March 2009	**4**	4
Total at 31 March 2009	**3269**	3269

11 Tangible Fixed Assets

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Total	Land	Buildings exc dwellings	Dwellings	Assets under constr & poa	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2008	**619,967**	28,731	427,960	2,598	17,568	103,046	975	18,083	21,006
Additions - purchased	**35,065**	0	2,165	0	28,878	3,104	133	531	254
Additions - donated	**1,280**	0	27	0	758	444	0	0	51
Impairments	**(1,308)**	0	(448)	0	(860)	0	0	0	0
Reclassifications	**(798)**	0	20,113	0	(27,077)	3,877	0	1,518	771
Other revaluations	**(5,593)**	64	(5,771)	114	0	0	0	0	0
Disposals	**(5,278)**	(96)	0	(264)	0	(3,565)	(61)	(998)	(294)
Cost or valuation at 31 March 09	**643,335**	28,699	444,046	2,448	19,267	106,906	1,047	19,134	21,788
Depreciation at 1 April 2008	**105,235**	0	17,231	114	0	61,244	742	10,998	14,906
Provided during the year	**29,895**	0	18,820	113	0	7,677	60	1,978	1,247
Impairments	**261**	0	0	0	0	258	0	3	0
Reversal of impairments	**(398)**	0	(398)	0	0	0	0	0	0
Reclassifications	**0**	0	0	0	0	23	0	1	(24)
Other revaluations	**(2,512)**	0	(2,499)	(13)	0	0	0	0	0
Disposals	**(4,918)**	0	0	0	0	(3,565)	(61)	(998)	(294)
Depreciation at 31 March 2009	**127,563**	0	33,154	214	0	65,637	741	11,982	15,835
Net book value									
- Purchased at 1 April 2008	**471,887**	27,237	373,850	2,309	17,119	38,358	202	7,069	5,743
- Donated at 1 April 2008	**42,845**	1,494	36,879	175	449	3,444	31	16	357
TOTAL at 1 April 2008	**514,732**	28,731	410,729	2,484	17,568	41,802	233	7,085	6,100
Net book value									
- Purchased at 31 March 2009	**474,212**	27,205	375,077	2,068	19,130	37,770	284	7,128	5,550
- Donated at 31 March 2009	**41,560**	1,494	35,815	166	137	3,499	22	24	403
TOTAL at 31 March 2009	**515,772**	28,699	410,892	2,234	19,267	41,269	306	7,152	5,953

11.2 Analysis of tangible fixed assets:

Net book value									
- Protected assets at 31 March 09	**441,825**	28,699	410,892	2,234	0	0	0	0	0
- Unprotected assets at 31 March 09	**73,947**	0	0	0	19,267	41,269	306	7,152	5,953
TOTAL at 31 March 2009	**515,772**	28,699	410,892	2,234	19,267	41,269	306	7,152	5,953

11.3 Assets held at open market value

There were no assets held at open market value at the Balance Sheet date or at 31 March 2008

11.4 Net book value of assets held under finance leases and hire purchase contracts at the Balance Sheet date:

No assets were held under finance leases or hire purchase contracts at the Balance Sheet Date or at 31 March 2008.

11.5 The net book value of land, buildings and dwellings at 31 March 2009 comprises

	31 March 2009			31 March 2008		
	Total	Protected	Unprotected	Total	Protected	Unprotected
	£,000	£,000	£,000	£,000	£,000	£,000
Freehold	**441,825**	441,825	0	441,944	441,944	0
Long leasehold	**0**	0	0	0	0	0
Short leasehold	**0**	0	0	0	0	0
TOTAL	**441,825**	441,825	0	441,944	441,944	0

11.6 Impairment of assets

	2008/09	2007/08
	£,000	£,000
Loss or damage from normal operations	**261**	204
Loss as a result of catastrophe	**0**	0
Abandonment of assets in course of construction	**860**	855
Unforeseen obsolescence	**0**	0
Over specification of assets	**0**	0
Other	**0**	0
Changes in market price	**50**	3,467
TOTAL	**1,171**	4,526

12 Fixed asset investments

The Trust has holdings in Zilico (formerly Aperio) Diagnostics and Epaq , companies commercially developing intellectual property. The Trust holding in these companies carry a minimal value at the balance sheet date (31.03.2009)

The Trust owns 40% (45.95% 31 March 2008) of the share capital of Epaq, and 22.22% (32.37%, 31 March 2008) of the share capital of Zilico.

13 Stocks

	31 March 2009	31 March 2008
	£'000	£'000
Raw materials and consumables	**9,638**	8,287
TOTAL	**9,638**	8,287

14.1. Debtors

	31 March 2009	31 March 2008
	Total	Total
	£'000	£'000
Amounts falling due within one year:		
NHS debtors	**22,394**	18,236
Provision for irrecoverable debts	**(3,797)**	(1,303)
Prepayments	**814**	750
Accrued income	**17**	181
Other debtors	**12,694**	15,036
Sub Total	**32,122**	32,900
Amounts falling due after more than one year:		
NHS debtors	**258**	268
Other debtors	**3,397**	2,658
Sub Total	**3,655**	2,926
TOTAL	**35,777**	35,826

14.2 Provision for impairment of debtors

	2008/09	2007/08 restated*
	£'000	£'000
At 1 April 2008	**1,303**	1,144
Increase in provision	**3,419**	560
Utilised	**(650)**	(229)
Unused amounts reversed	**(275)**	(172)
At 31 March 2009	**3,797**	1,303

14.3 Analysis of impaired debtors

Ageing of impaired debtors	2008/09 £'000	2007/08 £'000
Up to three months	**2**	128
In three to six months	**366**	171
Over six months	**3,429**	1,004
TOTAL	**3,797**	1,303
Ageing of non-impaired debtors past their due date		
Up to three months	**6,158**	3,470
In three to six months	**1,147**	1,019
Over six months	**1,665**	2,807
TOTAL	**8,970**	7,296

*Published 2007/2008 limited analysis of impaired debtors to NHS only. Current year 2008/09 accounts extend this analysis to both NHS and Non-NHS impaired debtors.

15 Current asset investments

	2008/09 Total £'000	2007/08 Total £'000
Additions	**90,000**	150,000
Disposals	**(90,000)**	(150,000)
Cost or valuation at 31 March 2009	**0**	0

16 Creditors

16.1 Creditors at the balance sheet date are made up of:

Amounts falling due within one year:	31 March 2009 Total £'000	31 March 2008 Total £'000
Loans	**780**	311
NHS creditors	**6,761**	8,240
Non - NHS trade creditors - revenue - other	**9,290**	13,071
Non - NHS trade creditors - capital	**10,017**	14,078
Tax and social security costs	**9,759**	9,272
Other creditors	**5,637**	5,363
Accruals and Deferred income	**21,452**	18,690
TOTAL	**63,696**	69,025

Amounts falling due after one year:	31 March 2009 Total £'000	31 March 2008 Total £'000
Loans	**16,740**	6,989
Accruals and deferred income	**1,625**	2,050
TOTAL	**18,365**	9,039

Other creditors include £5,599k (31 March 2008, £4,976k) outstanding pensions contributions at 31 March 2009.

16.2/1 Loans

	31 March 2009 £'000	31 March 2008 £'000
Payments of loan principal falling due:		
- within one year	**780**	311
- between one to two years	**780**	311
- between two and five years	**2,338**	933
- after five years	**13,622**	5,745
TOTAL	**17,520**	7,300

16.2/2 of which:

	£'000	£'000
- wholly repayable within 5 years	**3,898**	1,555
- wholly repayable after 5 years by instalments	**13,622**	5,745
TOTAL	**17,520**	7,300
Of which, wholly repayable after 5 years	**13,622**	5,745

Note 16.3 Prudential Borrowing Limit

	2008/09	2007/08
	£'000	£'000
Total long term borrowing limit set by Monitor	**157,700**	150,700
Working capital facility agreed by Monitor	**46,000**	46,000
TOTAL PRUDENTIAL BORROWING LIMIT	**203,700**	196,700
Long term borrowing at 1.April 2008	**7,300**	0
Net actual long term borrowing/repayment in year	**10,220**	7,300
Long term borrowing at 31 March 2009	**17,520**	7,300
Working capital facilty at 1 April 2008	**0**	0
Net actual borrowing/repayment in year	**0**	0
Net Working capital facility at 31 March 2009	**0**	0

	2008/09		2007/08	
	Limit	**actual**	Limit	actual
Minimum Dividend Cover	**>1**	**3.36**	>1	3.83
Maximum Debt/ Assets Ratio	**25%**	**2.87%**	25%	1.2%
Minimum Interest Cover	**>3**	**56.53**	>3	372.3
Minimum Debt Service Cover	**>2**	**29.52**	>2	372.3
Maximum Debt Service to Revenue	**<3%**	**0.22%**	<3%	0.02%

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust's Prudential Borrowing Code & Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The financial ratios for 2008/09 (2007/08) as published in the Pudential Borrowing Code are shown above with the actual level of achievement for the period.

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

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

17 Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Agenda For Change	Other	**31 March 2009 Total**	31 March 2008 Total
	£'000	£'000	£'000	£'000	**£'000**	£'000
At start of period	2,499	551	15,345	5,332	**23,727**	23,740
Arising during the year	169	620	3,009	1,419	**5,217**	11,890
Utilised during the year	(162)	(592)	(12,645)	(2,951)	**(16,350)**	(11,226)
Reversed unused	(26)	(102)	0	(2,459)	**(2,587)**	(735)
Unwinding of discount	55	0	0	0	**55**	58
At 31 March 2009	**2,535**	**477**	**5,709**	**1,341**	**10,062**	23,727
Expected timing of cashflows						
Within one year	160	477	5,709	1,341	**7,687**	21,384
Between one and five years	609	0	0		**609**	590
After five years	1,766	0	0		**1,766**	1,753

Pensions relating to other staff represents the liability relating to staff retiring before April 95 (£622k) and Injury benefit Liabilities (£1,913k).

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

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

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

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

There is also a case brought by the Health and Safety Executive (£33k arising and utilised) under this heading.

Agenda for Change provision relates to amounts that may become due to members of staff if they accept the new rates of pay under Agenda For Change. Consultation with individual members of staff on this issue is proceeding.

Other provisions relate to:

- Costs likely to be incurred under the trust workforce reduction scheme (£773k).
- Costs likely to be incurred due to Carbon Trading scheme (£54k)
- Costs likely to be incurred due to Non Consultant Career Grade Medical Staff Pay Award (£514k)

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

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

Of the above total provision and related payments , some £275,574 has been covered by 'back-to-back' income arrangements with the Trust's major Purchasers (31/3/08 £286,797).

£38,081,454 is included in the provisions of the NHS Litigation Authority at 31/03/2009 in respect of clinical negligence liabilities of the Trust (31/3/2008 £34,255,112) - see note 1.13

18 Reserves

18.1 Movement in taxpayers' equity:

	31 March 2009	31 March 2008
	£'000	£'000
Taxpayers' equity at start of period	**514,683**	439,362
Surplus for the financial year	**15,534**	21,069
Public dividend capital dividend	**(14,077)**	(14,167)
Surplus from revaluations of fixed assets and current asset investments	**(3,231)**	55,693
New public dividend capital received	**5,928**	9,160
Transfers from donated asset reserve	**(1,292)**	3,566
Closing Government Funds	**517,545**	514,683

18.2 Movements in public dividend capital

	31 March 2009	31 March 2008
	£'000	£'000
Public Dividend Capital at start of period	**314,279**	305,119
New Public Dividend Capital received	**5,928**	9,160
Public Dividend Capital at 31 March 2009	**320,207**	314,279

18.3 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Available for sale investments reserve	Income and Expenditure Reserve	**2008/09 Total**
	£'000	£'000	£'000	£'000	**£'000**
At start of period	130,998	42,855	0	26,551	**200,404**
Transfer from the Income and Expenditure Account	0	0	0	1,457	**1,457**
Surplus/(deficit) on revaluations of fixed assets and current asset investments	(3,172)	91	0	0	**(3,081)**
Transfer of realised profits (losses) to the Income and Expenditure Reserve	(6,756)	0	0	6,697	**(59)***
Receipt of donated assets	0	1,279	0	0	**1,279**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	0	(2,662)	0	0	**(2,662)**
At 31 March 2009	121,070	41,563	0	34,705	**197,338**

* Note that £59k was transferred from Revaluation Reserve to the Government Grant Reserve in respect of realised surpluses.

19 Notes to the Cash Flow Statement

19.1 Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09	2007/08
	£000	£'000
Total operating surplus	**14,005**	18,103
Depreciation and amortisation charge	**30,614**	29,446
Fixed asset impairments	**1,569**	4,526
Reversal of fixed asset impairment	**(398)**	(747)
Transfer from donated asset reserve	**(2,662)**	(2,616)
(Increase) in stocks	**(1,351)**	(383)
(Increase) in debtors	**(732)**	(3,785)
(Decrease) / increase in creditors	**(2,133)**	11,705
(Decrease) in provisions	**(13,719)**	(216)
Net cash inflow from operating activities	**25,193**	56,033

19.2 Reconciliation of net cash flow to movement in net funds

	2008/09	2007/08
	£000	£'000
Increase in cash in the period	**(9,582)**	17,226
Change in net debt resulting from cashflows	**(9,582)**	17,226
Net funds at start of period	**54,794**	37,568
Net funds at 31 March 2009	**45,212**	54,794

19.3 Analysis of changes in net funds

	At 1st April 2008	Cash changes in year	**At 31st March 2009**
	£'000	£'000	**£'000**
OPG cash at bank	54,558	(9,916)	**44,642**
Commercial cash at bank and in hand	236	334	**570**
	54,794	(9,582)	**45,212**

	At 1st April 2008		**At 31st March 2009**
Third party assets held by the NHS Foundation Trust (note 26)	18		**9**

20 Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £12.0million (31 March 2008, £7.6million).

The major components of these commitments are as follows:

Scheme	**£'000**
NGH Clinical research Facility	**3,960**
RHH Theatre Admissions Unit	**2,286**
Refurbishment of Radiopharmacy Facilities	**2,172**
RHH Ward Refurbishment Programme	**472**
Other Builiding & Engineering work	**1,418**
Equipment	**1,674**
TOTAL	**11,982**

21 Post Balance Sheet Events

There were no material Post Balance Sheet events.

22 Contingencies

	2008/09	2007/08
	£000	£000
Gross value	**(248)**	(264)
Amounts recoverable (if any)	**0**	0
Net contingent liability	**(248)**	(264)

Contingencies represent the consequences of losing all current third party legal claim cases (see note 17).

23 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.

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

These entities are listed opposite:

	2008/09		2007/08	
	Income	Expenditure	Income	Expenditure
	£'000	£'000	£'000	£'000
Sheffield PCT	325,401		320,912	
Bassetlaw PCT	9,500		10,173	
Derby County PCT	31,397		35,853	
Barnsley PCT	111,471		75,139	
Rotherham PCT	27,531		29,838	
Doncaster PCT	22,474		25,404	
Leicestershire County and Rutland	11,928		1,172	
Yorkshire and The Humber Strategic Health Authority	63,035		57,541	
Yorkshire Ambulance Service		3,793		3,968
NHS Litigation Authority		5,582		5,794
National Blood Authority		1,379		1,493
NHS Blood and Transplant Agency		5,198		5,054
National Health Service Logistics Authority		11,125		9,323
Doncaster and Bassetlaw NHS Foundation Trust		5,150		4,000
Sheffield Care Trust		3,130		1,616

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

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

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

Of the Trust's total debtors of £35,777k at 31 March 2009, (note 14.1) £22,652k was receivable from NHS bodies. This sum comprises, in the main, monies due from Commissioners in respect of health care services invoiced, but not paid for, at the Balance Sheet date.

The remainder of the balance comprises income from NHS Trusts in respect of clinical support services provided.

£3,930k was receivable from the University of Sheffield at 31 March 2009 in respect of clinical and estates support services provided.

Professor C Welsh and Professor A P Weetman have clinical commitments at Thornbury Private Hospital, which is sited in Sheffield. During the year the Trust purchased healthcare from this hospital in the sum of £3,845k (2007/2008 £2,259k.)

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at the above hospitals. This amounted to £5,342k (2007/2008 £4,376k) during the year. Certain of the Trust's clinical employees have an interest in this company.

Creditors falling due within one year of £63,696k (note 16.1) include £6,761k owing to NHS bodies. This sum includes monies owing to the Department of Health in respect of pension contributions, and to other NHS Trusts for clinical support services received.

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

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

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

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in the year from this Charity amounted to £2.6m (2007/08, £1.7m). The Trust has also received revenue and capital payments from a number of other charitable funds.

Certain of the trustees of the charitable trusts from whom the Trust has received grants are members of the NHS Foundation Trust Board.

24 Private Finance Transactions

24.1 PFI schemes deemed to be off-balance sheet

	2008/09	2007/08
	£000	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**2,562**	2,457
Amortisation of PFI deferred asset	**0**	0
Net charge to operating expenses	**2,562**	2,457

The Trust is committed to make the payment of £2,800k (at 2008/09 prices) during the next financial year.

Future annual payments will be increased by the Retail Prices Index on 1 April in each year.

	£000
Estimated capital value of the PFI scheme	24,040
Contract Start date:	December 2004
Contract Handover Date	March 2007
Length of project (years)	32
Number of years to end of project	28
Contract end date	December 2036

The PFI scheme is a scheme to build a new medical ward block on the Northern General Hospital Site (Sir Robert Hadfield Block).

The residual interest projected value at December 2036 is based on a projection from a professional valuer.

There are no deferred assets associated with this scheme.

Detail;	£,000
- value of deferred asset	0
- value of residual interest	12,457

24.2 'Service' element of PFI schemes deemed to be on-balance sheet

There are no PFI schemes deemed to be on-balance sheet.

25 Financial Instruments

25.1 Financial assets

	Loans and receivables	Assets at fair value through the I&E *	Held to maturity	Available-for-sale	**Total**
	£000	£000	£000	£000	**£000**
Fixed asset investments	0	0	0	0	**0**
NHS Debtors	22652	0	0	0	**22652**
Provision for irrecoverable debts	(3797)	0	0	0	**(3797)**
Accrued income	17	0	0	0	**17**
Other debtors	10340	0	0	0	**10340**
Cash at bank and in hand	45212	0	0	0	**45212**
Total at 31 March 2009	74424	0	0	0	**74424**
Fixed asset investments	0	0	0	0	**0**
NHS Debtors	18504	0	0	0	**18504**
Provision for irrecoverable debts	(1303)	0	0	0	**(1303)**
Accrued income	181	0	0	0	**181**
Other debtors	12344	0	0	0	**12344**
Cash at bank and in hand	54794	0	0	0	**54794**
Total at 31 March 2008 (restated*)	84520	0	0	0	**84520**

25.2 Financial liabilities by category

	Other financial liabilities	Liabilities at fair value through the I&E	**Total**
Liabilities as per balance sheet	£000	£000	**£000**
Loans	17,520	0	**17,520**
NHS Creditors	6,759	0	**6,759**
Other creditors	9,330	0	**9,330**
Accruals	11,571	0	**11,571**
Capital creditors	10,017	0	**10,017**
Provisions under contract	10,062	0	**10,062**
Total at 31 March 2009	**65,259**	**0**	**65,259**
Bank overdrafts	0	0	**0**
Loans	7,300	0	**7,300**
NHS Creditors	13,187	0	**13,187**
Other creditors	13,071	0	**13,071**
Accruals	11,398	0	**11,398**
Capital creditors	14,078	0	**14,078**
Provisions under contract	23,727	0	**23,727**
Total at 31 March 2008 (restated*)	**82,761**	**0**	**82,761**

25.3 Fair values of financial assets at 31 March 2009

	Book Value	Fair value
	£000	£000
Debtors over 1 year -	258	258
Investments	0	0
Other	0	0
TOTAL *	258	258

25.4 Fair values of financial liabilities at 31 March 2009

	Book Value	**Fair value**
	£000	**£000**
Provisions under contract	**10,062**	**10,062**
Loans	**16,740**	**16,740**
TOTAL	**26,802**	**26,802**

Financial Instruments comprise assets of £74,424k and liabilities of £65,259k. The assets comprise cash of £45,212k, provisions for impaired debts of (£3,797k), accrued income of £17k, NHS debtors of £22,652k and Other Debtors of £10,340k. The cash is held in the Paymaster General Account(£44,642k) and three other accounts with commercial high street banks (£570k). The credit risk to this asset is that the commercial banks may default on payment, either temporarily or permanently. Since they are all credit rated as 'A1' (Standard & Poor's) this risk is considered immaterial. The PGO is a Department of HM Government and is considered to have a zero credit risk. The cleared balance these accounts attracts interest calculated with reference to the Bank Of England's base rate.Note that the relative holdings of cash in the PGO/Commercial accounts will vary in the course of the year. The accrued debtor represents interest due from the Bank of England's PGO account for the month of March 09, and as such the risks of default are minimal.

The NHS debtors represent sums due from other NHS bodies in respect of goods and services provided to them, either under a formally negotiated contract, e.g. with PCT's for patient activity or via a more informal request for such things as pharmacy drugs and laboratory tests. The risk associated with the NHS debts is that the NHS body may dispute aspects of the charges and delay or default on payment. Other debtors similarly represent sums due for goods and services from organisations and individuals outside the NHS. The risk associated with this entry is that an organisation may fail financially, or an individual default on payment. Where this risk is believed to be significant a provision for impaired debtors is created. Provision for impaired debtors represents the reduction in value of all debts, both NHS and other debts, caused by difficulties in obtaining payment from the debtor to whom the invoice was sent, either as a result of a dispute as to terms, or refusal to pay. There is a possibility that the debtor may actually pay the debt so provided, and this represents the main uncertainty around the value of this entry.

Liabilities consist of loans (£17,520k), NHS Creditors (£6,759k), Other creditors (£9,330k), Accruals (£11,571k), Capital Creditors (£10,017k) and Provisions (£10,062k). NHS Creditors, Capital Creditors and Other Creditors represent amounts payable to organisations within or outside the NHS for goods and services provided to the trust. An invoice will have been received in each case, defining the amount due. The main risk is associated with these entries is that specific elements of the contract may not have been performed to the satisfaction of the trust, and that there may therefore be delays in payments or disputes as to the sum actually due. The Accruals entry similarly represents amounts payable for goods and services purchased by the trust, but in this case an invoice has not been received. In addition to the previous comments concerning risks re creditors, there is in this case the added uncertainty due to the estimated nature of the accrual, and the actual invoice could vary to some extent in value and timing. The loan represents principal sums payable to the Government's NHS Financing Facility over the 23 years to September 2031 for the constuction of a critical care unit on the Northern General site. Since the lender is part of the UK government the risk of lender default is considered nil. The loan is contracted at 4.8%per annum fixed interest rate.

The main risk is that the trust would fail to cover the repayments, but since trust income is running at £732m p.a. and the total interest and principal payable over the 23 years of the loan is only £28.8m this risk is considered negligible. The provisions entry relates to a number of separate headings. Details of these can be found under the provisions note 17.

The fair value of the long term NHS debtor is stated at book value. The debt is derived from a back to back agreement with PCTs re certain Injury benefit cases and has been calculated using discounting at the approved treasury rate of 2.2% (see provisions below)

The fair value of provisions is stated at book value - discounted cash flow techniques have been used to deep discount the liabilty where appropriate at the approved treasury rate of 2.2%.Note that the fair value of the loan from Foundation Trust Financing Facility is stated at book value - the terms of the loan agreement specify that the borrower (STH) may not transfer its obligations, hence there is no commercial value to the loan.

* The scope of financial instruments has been expanded for 2008/2009 to accord with national Foundation Trust definitions. Financial Instruments now comprise the bulk of those debtors, creditors and provisions contained in the accounts.

26 Third Party Assets

The Trust held £9,345 (31 March 2008, £17,570) at bank and in hand at 31 March 2009 which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

27 Losses and Special Payments

There were 457 (530 in the year to 31 March 2008) cases of losses and special payments totalling £766k (12 months to 31 March 2007, £412k) approved during the financial year.

There were no cases (12 months to 31. March 2008- no cases) of individual losses exceeding £100,000.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the accounts which are prepared on an accruals basis.

28 Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £14,077k (12 months to 31 March 2008 £14,167k) bear to the average net relevant assets during the twelve month period of £424,305k (12 months to 31 March 2008 £399,124k), that is 3.3% (2007-08 - 3.5%).

This is calculated as follows:

	31 March 2009	31 March 2008
	£'000	£'000
Total Capital and Reserves	**517,545**	514,683
Less - Donated Asset Reserve	**(41,563)**	(42,855)
Less - Cash held at Office of the Paymaster General	**(44,642)**	(54,558)
Ner Relevant Assets	**431,340**	417,270
Average Net Relevant Assets	**424,305**	399,124
Dividend paid per Cash Flow statement	**14,077**	14,167
Percentage	**3.3%**	3.5%

The Trust's actual rate of return in 2008/2009 of 3.3% (12 months to 31.3.2008 3.5%) is not materially different from its forecast rate of 3.5%.

Statement on Internal Control

Statement on Internal Control

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

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

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

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

Operationally, risk management is delegated to the Trust Executive Group which reports through the Chief Executive to the Board of Directors. Executive Directors are responsible for specific categories of risk, (as detailed in the Risk Management Strategy and Policy).

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

The Risk Management Strategy and Policy indicates the level of training for all grades of staff commensurate with their responsibility for risk management. Training is determined by the personal development process at an individual level and by training needs analyses at a strategic level. Advice on generic and specific risk management training, either internally or externally delivered, is available to staff and managers via the Training and Organisational Development Department.

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

The Patient and Healthcare Governance Team provide support and expert advice and guidance.

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

The risk and control framework

The Risk Management Strategy and Policy was approved by the Board in July 2006. It is maintained by the Department of Patient and Healthcare Governance and is regularly reviewed. It has been widely promoted across the organisation and is available to all staff on the Trust intranet.

The strategy and policy sets out the organisation's approach to risk which aims to strike a balance between innovation, opportunity and risk, seeking to enhance performance and quality whilst minimising adverse consequence. It clarifies accountability arrangements and individual and collective roles and responsibilities for risk management at all levels across the organisation. It outlines the structures and processes for effective risk management within the Trust. It also provides instructions on how to register risks on the Trust's electronic Risk Register, (Datix Risk Management System).

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

There are robust and effective systems, procedures and practices to identify, manage and control information risks. Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Committee which is accountable to the Healthcare Governance Committee, a committee of the Board. The Information Governance Committee is chaired by the Medical Director who is also the Caldicott Guardian. The Director of Service Development acts as the Board's Senior Information Risk Owner.

The Information Governance Strategy (approved by the Board in April 2005) outlines a framework which brings together all the statutory requirements, standards and best practice in information governance.

Underpinning the strategy is the Information Governance Policy (approved by the Board in June 2005) and a risk-based Annual Plan which is used to drive continuous improvement in information governance. The development of the Annual Plan is informed by the results from the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Framework Programme.

In relation to the provision of information, the Trust has complied with the cost allocation and charging arrangements set out in HM Treasury and Office of Public Sector Information guidance.

The Trust has an ongoing programme of work to ensure person identifiable information is safe and secure when it is transferred within and outside the organisation. Work is underway to implement Connecting for Health national solution to encrypt all Trust laptops and removable media.

The Trust reported a serious data security incident (Category 2) in the past year.
I have taken advice and have concluded that this does not constitute a significant control issue. The Trust undertook a thorough investigation and contacted all the affected patients and explained what had happened. The patients we contacted are content with the action taken by the Trust. I am assured that the controls in place were sufficient to manage the risk to a reasonable level.

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

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

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

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

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

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

The Trust is also represented on various national forums such as Foundation Trust Network, NHS Confederation and Association of UK University Hospitals and is able to help influence national policies

The Trust is fully compliant with the core standards for better health.

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.

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

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plans for improving productivity and efficiency in order to offset income losses, meet the national efficiency target applied to all NHS providers and fund local investment proposals. The financial plans reflect organisational-wide plans and initiatives but are also translated into Directorate budgets and productivity and efficiency plans. Financial planning at all levels is influenced by income assumed from national tariffs and local prices agreed with Commissioners.

Financial plans are approved by the Board, supported by its Finance Committee. An Annual Plan is submitted to Monitor, reflecting financial, service and governance aspects, each of which is ascribed a risk rating by Monitor. This plan incorporates projections for the following two years, which facilitates forward planning by the Trust.

The in-year use of resources is monitored by the Board and its committees via a series of detailed monthly reports, covering finance, activity, capacity, human resource management and risk. These documents are a consolidation of detailed reports that are provided at Directorate and Department level to allow active management of resources on an operational level. Quarterly monitoring returns are submitted to Monitor from which a risk rating is again attributed to the financial, service and governance aspects.

The Trust's Adding Value Programme continues to drive enhanced productivity and efficiency through targeting areas for improvement and developing capability and capacity to deliver the required change. A key principle of the programme is to seek improvements to patient care alongside productivity and efficiency gains. The development of information and performance management systems are also key elements of the Programme.

The Trust employs a number of approaches to ensure best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service re-design leading to improvements in the quality of services and patient experience as well as financial performance. External consultants are commissioned to undertake reviews where the Trust believes economy, efficiency and effectiveness can be improved. In its drive for service improvement, the Trust works closely the NHS Institute for Innovation and Improvement.
As mentioned below, the Board receives assurance on the use of resources from a number of external agencies for example, Monitor's Financial and Governance risk rating and the Healthcare Commission's Annual Healthcheck. Such reviews are reported to the Board of Directors or its committees.

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

The Trust also makes use of both Internal and External Audit functions to ensure the controls are operating effectively and to advise on areas for improvement. In addition to financially related audits the Internal Audit programme covers governance and risk issues.

Individual recommendations and overall conclusions are risk assessed thereby assisting prioritised action plans which are agreed with management for implementation. All action plans agreed are monitored and implementation is reviewed regularly and reported to Management Audit Committee as appropriate.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Management Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The Management Audit Committee continues to receive and monitor the Assurance Framework and relevant audit reports. It plays a central role in performance managing the action plans to address the recommendations from D or E grade audits.

The Trust is committed to continuous improvement of its risk management and assurance systems and processes to ensure improved effectiveness and efficiency. The past year has seen further development and consolidation of the reconfigured governance arrangements in the Trust, following a review by external consultants in 2006.

My review is also informed by:

- Opinion and reports by Internal Audit who work to a risk-based plan. Of specific value have been internal audit reviews of Risk Management, the Board Assurance Framework, Emergency Planning, Sudden and Unexpected Incidents and Standards for Better Health.
- Opinion and reports by our external auditors (Audit Commission) and specifically the annual audit letter.
- Quarterly performance management reports by Monitor.
- DH reports such as Performance Indicators and Cleaner Hospitals Visit.
- Healthcare Commission reports such as the Hygiene Code Visit.
- The Board of Directors' declaration of full compliance against Core Standards for Better Health and supporting "third party" comments from South Yorkshire Joint Health Scrutiny Committee, Yorkshire and Humber Strategic Health Authority, Governors Council, Sheffield Safeguarding Children's Board and Sheffield Local Involvement Network.
- Achievement of Improving Working Lives - Practice Plus.
- NHSLA assessments against Risk Management Standards and CNST for Maternity.
- Information Governance Assurance Framework and the Information Governance Toolkit
- Results of national Patient Surveys and the National Staff Survey.
- Investigation reports and action plans following Sudden Unexpected Incidents.
- User feedback such as PALs reports, complaints and claims.
- Governors' Council reports.
- Clinical Audit reports.

Conclusion

As Accounting Officer and based on the review process outlined above, I am assured that there are no significant internal control issues.

Andrew Cash OBE
Chief Executive

3rd June 2009

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

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

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