Sheffield Teaching Hospitals NHS
NHS Foundation Trust

2003-04

annual report

Contents

Annual Report 2003-04

Sheffield Teaching Hospitals became a National Health Service Trust on the 1st April 2001.

It comprises:

- the Royal Hallamshire Hospital
- the Jessop Wing
- Weston Park Hospital
- the Charles Clifford Dental Hospital
- the Northern General Hospital.

The Trust is one of the largest NHS organisations in the UK and one of the biggest employers in the South Yorkshire region.

Each year our annual Patient Services Plan builds on our vision and priorities with ten objectives we work towards to ensure we provide a quality service to our patients and a good working environment for our staff.

These objectives are:

- Improving waiting times, access, and the process of care
- Clinical service developments
- Leadership and managing trust business
- Staff
- Hospital environment
- Health informatics and information
- Improving the patient experience
- Academic excellence
- Governance
- Partnerships and clinical networks

Progress on our ten objectives for the year April 2003 to March 2004 is detailed in this annual report.

Chairman's Statement

It is my pleasure to introduce the third Annual Report and Accounts for the Sheffield Teaching Hospitals NHS Trust.

Once again the Trust has produced an impressive array of developments and achievements over the last 12 months. These have been accomplished during a year that has seen the hospitals tested by challenging waiting list targets and heavy demand for emergency services.

As always with an annual report we've had the difficult task of highlighting only a few of our achievements. This means that many excellent service developments and worthy achievements are not mentioned in detail so I would like to take this opportunity to thank all staff for their hard work and enthusiasm for continually working to improve the care we provide to our patients.

These are but a few examples from around the Trust of services making a difference to patients and I believe that every member of staff could tell a story of how they have had a positive effect on someone's care.

On a personal note, I have seen the care first hand during the course of the year as a surgical patient myself.

As well as the personal experience of being a patient on our wards, it has also given me a direct insight of our patients' experience.

One way in which we can gauge the success of our services is through the feedback we receive from patients and from outside the organisation. I am very pleased that a number of our teams have received recognition this year. These include a professional development team project inviting patients to share their experiences of cancer with staff to help our training, and the Trust's Cystic Fibrosis Team. Both won categories at the South Yorkshire Health and Social Care Awards. The staff of ward L1 at the Royal Hallamshire Hospital also won the Sheffield Star's "Health Award" for the support they provide to patients and families.

What is most important is that these awards are nominated and voted for by patients who have had first hand experience of our care. We actively seek feedback on the services we provide from the public we serve.

A way in which we are doing this is through our successful application to become a NHS Foundation Trust. The aim of NHS foundation status is to ensure more involvement from the local community, to focus on local health needs, and to promote healthier lifestyles. Almost 7,000 people became members which is a solid start and 7,000 people who have developed a new relationship with their hospitals that did not exist this time last year. We now have in place a governors council made up of patient, public and staff governors who will work at the highest level in the Trust setting the priorities and plans for the future. It's an exciting development and can only help us to further strengthen the services we provide to patients in the future.

We look forward to the coming year in working with the local community, building on our achievements and tackling some of the challenges we face. I hope that all patients will have a positive experience of Sheffield Teaching Hospitals.

David Stone
Chairman

Chief Executive's Report

The past 12 months have again been an extremely successful but challenging year for Sheffield Teaching Hospitals.

It has been a year that has seen us preparing for a period of change in the NHS whilst maintaining our record of making real improvements to the patient services we provide to our local population.

Changes have been made to our services to finalise the initial objectives of the merger. The moves to reconfigure our General Surgery inpatient services were put in place this year. Clinical evidence shows that outcomes for patients are improved when specialist services are centralised with surgeons working together in speciality-based teams.

For the third year running the Trust has achieved three star status in the national NHS performance ratings, which again places us amongst the best in the country. I was delighted that we were shortlisted as one of six Trusts up for the Hospital of the Year award in the Sunday Times. The Trust ranked with one of the lowest mortality rates and highest patient dignity and satisfaction scores in the country.

The results show that patients are getting the treatment they need, efficiently and in surroundings that are clean and comfortable. Our aim is now to keep achieving three stars in the coming years through continual year on year improvements.

Amongst the areas the Trust is looking to further improve are our infection control procedures, and our re-admission rates to hospital, which have been higher than the national average; both these issues are already being tackled.

Three star status has also meant that we were amongst the first Trusts eligible to take forward an application to become a first wave NHS Foundation Trust. Detail on the application can be found elsewhere in this report so I will only add that I truly believe that Foundation Status is the right way forward for a progressive and successful NHS Teaching Trust like ours.

Whilst this year has seen many successes, it has also seen us working under extreme pressure - particularly due to a substantial rise in the number of emergency admissions to the Trust. Staff have worked exceptionally hard to ensure that patients receive the care they need but our aim to also provide specialised hospital services has been challenged by the level of emergency work we have had to do as a priority.

To ensure that this situation does not continue we have put in place several initiatives to reduce the pressure on wards and departments. These include joint proposals with Sheffield Primary Care Trusts to improve community-based services and increase the efficiency and effectiveness of the care process from admission to discharge.

It has been another year where our services have improved in many ways and again, the thanks to this must go to our staff. I hope they are as proud of our successes and record as I am.

Andrew Cash
Chief Executive

The NHS Plan is about putting the patient firmly at the centre of health care by changing systems and processes to ensure they are tailored around the needs of the patient. These are just a few examples amongst many of how this is happening at the Trust.

Key Targets for Three Star Status	Outcome
No one waiting more than 12 months for inpatient treatment	**Achieved**
No one waiting more than 21 weeks for an outpatient appointment	**Achieved**
No patient with suspected cancer waited more than 2 weeks to be seen by the hospital	**Achieved**
Hospital cleanliness reached top criteria	**Achieved**
No patient waiting more than 12 hours in A&E for a bed	**Achieved**
Financial management was satisfactory	**Achieved**
Improving Working Lives	**Achieved**
Outpatient and elective (inpatient and daycase) booking	**Achieved**
Total time in A&E: 4 hours or less	**Achieved**

This table provides a summary of the Trusts increase in activity in 2003/04 in comparison with the previous year. The increase in activity for inpatients and day cases is impressive and has helped us meet our targets on keeping down waiting times. This was achieved against a background of sustained pressure in all wards and departments.

	Target 2003/04	Actual Activity 2003/04	Actual Activity 2002/03	% Activity Increase
Inpatient and day case episodes	161,378	170,422	157,745	**7.5%**
Outpatient attendances	701,389	747,295	745,867	**0.2%**

During 2003/04 our outpatient waiting list decreased significantly while the inpatient waiting list increased slightly, although the number of inpatients waiting 6 months and over also reduced considerably.

	Target	31 March 2004	31 March 2003	% Change
Total inpatient waiting list	12,853	13,057	12,763	**+ 2.2%**
Inpatients waiting 6 months and over	1988	1461	2424	**- 40%**
Outpatients waiting 13 weeks and over	1,264	549	1,257	**- 56%**

Objective 1

improving waiting times, access and the process of care

Improving 999 care for the elderly

Elderly Sheffield residents are benefiting from a unique new scheme, which enables medical treatment for falls and minor injuries to be administered in the comfort of their home without the need to transport them to hospital. The Paramedic Practitioner is a joint initiative between the Trust's Accident and Emergency Department, South Yorkshire Ambulance Service and Social Services. Paramedic Practitioners have undergone a further four-month educational programme (supported by Sheffield Hallam University) to enable them to assess and treat patients who have suffered a minor injury or a fall in their own home.

The Trust met all its targets for inpatient and outpatient waiting times and the number of patients on waiting lists.

- In A&E we achieved our target of 90% of patients being treated, admitted or discharged within four hours of their arrival.
- No patient waited over nine months for their inpatient or day case treatment, in fact 89% of patients were seen within 6months.
- No patient was waiting more than six months for heart surgery by March 2004 and the majority of patients received their operation within 3 months.
- There was a 56% reduction in the number of patients waiting over 13 weeks for an outpatient appointment.
- The target for a maximum wait of two weeks for patients referred by their GP for an urgent appointment for a suspected cancer was achieved for 99% of referrals.

Three ways we've improved the process of care this year:

Assessing the situation

Pre-assessment is a service where a patient attends hospital about two weeks prior to admission for their operation. During this appointment, medical and social histories are taken and diagnostic tests performed. This makes sure that the patient is fit for their impending treatment or surgery and knows what to expect when they come into hospital. Staff are also then aware of any special measures they need to take for individual patients prior to, or during, surgery. Patients not well enough to undergo surgery immediately are given the support required to enable them to safely undergo their surgery at a later date. This helps minimise the number of cancelled operations and makes better use of hospital resources whilst ensuring that surgery is as safe as possible for the patient. New guidelines and training have been developed over the year to increase the effectiveness of pre-assessment.

Admissions unit reduces hospital stays

The Theatre Admission Unit at the Northern General Hospital is a new development that has been open for the past year.

Patients found to have an uncomplicated medical history at their pre-assessment are scheduled to be admitted to the Theatre Admissions Unit (TAU) on the day of their operation rather than spend a night in hospital before their operation. A significant number of these patients can also be discharged home on the same day after recovering. It reduces the time patient has to spend in hospital.

All in a day's work

Extending the use of day case surgery - where a patient does not require an overnight stay - means our facilities and resources are used more effectively and improve convenience of our patients. The Trust is developing day case surgery across all surgical specialities. While providing the highest quality care for the patient, appropriate use of day surgery frees up hospital beds. This in turn helps us to reduce long trolley waits in A&E and reduce waiting times are reduced, leaving the hospital more able to treat patients with more complicated illnesses. Patients benefit from the use of the latest minimally invasive techniques, being able to return home on the day of surgery and therefore decreasing the risk of hospital acquired infections or other complications.

Objective 2

clinical service development

Getting to the heart of the matter

NHS heart services have been transformed in the last few years with major drops in waiting times and new treatment developments. This year was a busy year for the Cardiology Service which provides non-surgical treatment and imaging for coronary heart disease and associated conditions. Approval was given for a £10 million extension to the cardiothoracic centre at the Northern General Hospital which will be complete in 2005. A fifth cardiac surgery theatre opened this year along with two additional progressive care unit beds. There are now six beds in this innovative unit which provides recovery facilities for patients who do not require full intensive care after surgery. It has received national recognition for its role in reducing operation cancellations. Numbers of open-heart operations increased by 14% on the previous year and there was real success in terms of waiting list reduction.

Because of our commitment to provide the best possible healthcare it is essential that we continually develop and modernise the services and how we deliver them.

These are examples of the ways in which services are being continually improved.

New ways of working help stroke patients:

Dysphagia is a condition in which people have swallowing difficulties. It can be very serious. Someone who cannot swallow well may not be able to eat enough of the right foods to stay healthy or maintain an ideal weight. It is often associated with patients who have suffered a stroke. Sheffield Teaching Hospital's Speech and Language Therapy Department have been involved in a project with nurses across the Trust to allow more staff to be involved in care for patients with the condition. Selected nurses are trained in the competencies to allow them to work alongside their Speech and Language Therapists. Patients are now being assessed faster - being seen within 48 hours or less. The project has now been introduced across South Yorkshire allowing more nurses to access the course and receive on-going supervision as they integrate the skills into their own work areas and improve services for their patients.

Stress Testing for Myocardial Perfusion Imaging:

Stress testing for myocardial perfusion imaging is a test widely used in the cardiology service. The blood supply to the heart is investigated and a diagnosis made regarding the best treatment options for each patient.

A citywide modernisation initiative has resulted in radical changes to the service by expanding the roles of NHS staff. A doctor has traditionally led cardiac stress testing but now technologists, nurses and physiologists have gained the extra skills needed to provide the testing. They can consent patients, administer all necessary drugs, and make decisions about the patient's heart rhythms.

Doctors are now free to carry out other essential duties and the timing of sessions is more flexible resulting in efficient use of imaging equipment and staff. It has already resulted in a five month reduction in waiting times at the Northern General Hospital. It's an example of using staff resources more efficiently in the NHS.

Objective 3

leadership and managing trust business

Laying foundations for the future

During the year the Trust took forward its successful application to become one of the first NHS Foundation Trusts in the country. Foundation Trust status rewards successful NHS Trusts with more freedom to develop services. It's about giving more local control to the NHS through less central government control and being able to invest more in patient care, set local health targets, and play a greater role in the economic regeneration of the area served by the hospitals. For the first time ever, patient, public and staff hospital governors were elected whom the trust is now accountable to. Despite membership only being open during a consultation period on the proposals, some 7,000 local people signed up to become members. The governors are elected from the membership and represent the views of their fellow members.

The Trust must have strong leadership at all levels if it is to be successful. These are examples of ways in which leadership and strong strategic management are working to ensure we continue to have a robust and vigorous organisation.

Financial Duties:

The Trust has met all its financial targets for the year under review as demonstrated in the table above.

The Finance Directorate is actively developing mechanisms to ensure that costing information is accurate, complete and effective in informing national requirements and internal decision-making. Benchmarking against other similar units will be developed with action plans to ensure good practice and any necessary corrective action is identified. Corporate Governance documentation has been expanded to include a detailed scheme of delegation for each directorate ensuring that control is exercised throughout the organisation.

Better Payment Practice Code:

The Better Payment Practice Code requires that NHS organisations settle all commercial debts within 30 days. Performance against this target was 91.08% of the total number of bills paid being paid within 30 days. Further details of our performance are given in note 7.1 to the accounts.

Target		Achievement
Break even		£214,000 surplus
Meet the EFL	(£2,702,000)	£2,702,000
Meet the CRL	(£26,770,000)	£26,702,000

Management Costs:

Details of management costs are given in note 6.4 to the accounts.

National Assurance Framework:

The Assurance Framework is designed to identify and prioritise the risks which could prevent the Trust achieving all the aims and objectives. It enables us to evaluate the likelihood of those risks taking place and the impact, and therefore it makes it possible for us to manage risks efficiently, effectively and economically.

This has involved the adoption of principal objectives, based upon the key themes identified in both the Patient Services Plan and the Strategic Direction document and the assessment of the main associated risks. Also taken into consideration have been the key controls on those objectives and where appropriate any relevant action plans. The framework also ensures that the effectiveness of controls to manage the risks are reviewed.

Handling Major Incidents:

The NHS is always a 24 hour service that needs to be ready for any eventuality. Recent world events have highlighted the need for the NHS to have fully tested and updated systems in place to deal with major incidents.

During this year the Trust has developed a new Major Incident Plan, which ensures that it fulfils the principal roles of an acute Trust as listed in Department of Health guidance. The plan defines the response of the entire Trust in the event of a serious incident occurring, and helps staff to feel prepared and to understand their responsibilities.

The Major Incident Plan has been developed with associated organisations including representatives from the South Yorkshire Police, Primary Care trusts, Strategic Health Authority, Social Services and South Yorkshire Ambulance Service.

Objective 4

staff are our greatest asset

Childcare for our staff

As a trust we strive to help our staff balance their work and family commitments. Providing quality and affordable childcare is a key part of this. This year, a new nursery at the Royal Hallamshire Hospital has opened to serve staff at the central campus hospitals and there has been an extension to the nursery at the Northern General Hospital. This has meant the number of childcare places available to staff has more than doubled with nearly 300 places now available every day for children aged 0-4 years. There are also places in school holiday time for children aged 4 to 11 years. Sheffield Teaching Hospitals is now one of the largest providers of childcare in the NHS. An application to fund the refurbishment of the Northern General Hospital nursery has recently been successful and the work will be completed soon.

The biggest resource the Trust has is its staff. This is why we continue to work hard on our continuing programme of recruitment, retention and development of all staff. Highlighted are some of the ways we are continuing to try to meet our staff aspirations.

A diverse workforce

It is important that the hospitals reflect the community which they serve. A lot has been happening in the past year around diversity and equality, with an awareness of these issues now being included in corporate induction. Thirteen members of staff have undertaken courses so that they can deliver diversity and equality courses in our training programmes. A two-day programme entitled Valuing Diversity, Promoting Equality is now mandatory training for Managers and Supervisors. Urdu Language Classes for healthcare staff have been piloted and for staff with little or no prior knowledge of diversity issues a distance-learning workbook entitled 'Respect for People' is available.

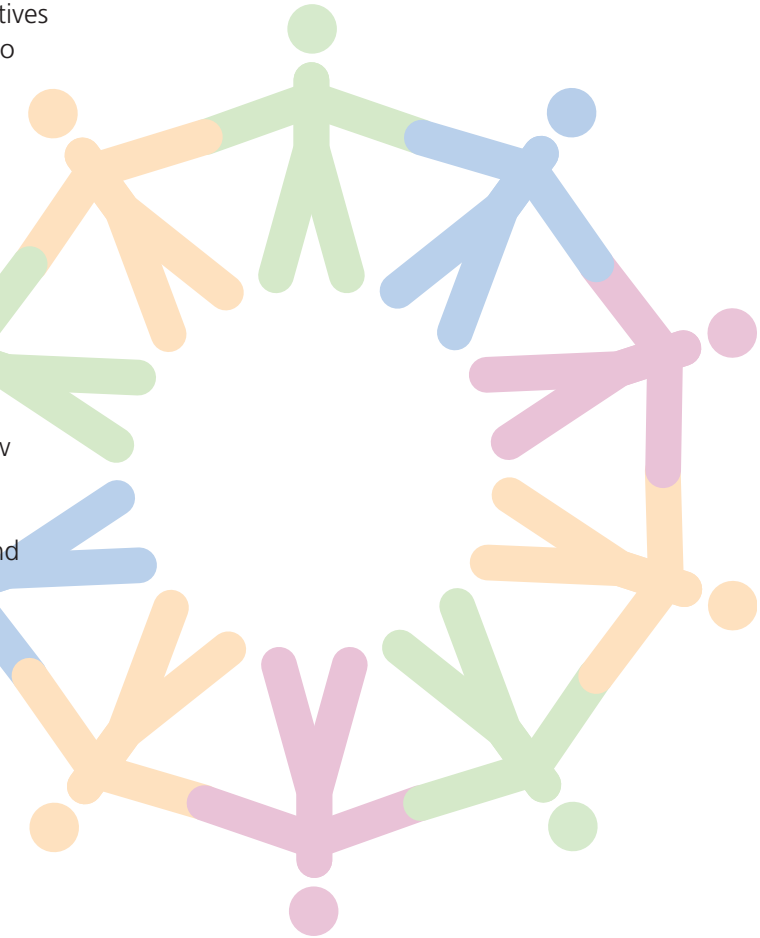
Equality and access for disability

The Trust has again been awarded the 'two ticks' symbol for its work in ensuring equality for people with disabilities. The standards we have to meet include interviewing all disabled job applicants who meet the post's criteria, making every effort to enable employees who become disabled remain in employment and regularly discussing with disabled employees how they can develop their role and use their abilities. As well as fulfilling these objectives there are also several courses available to staff about issues relating to disability.

Valuing our staff

A key part of valuing staff and helping them achieve a good balance between their work and home lives is about communication and ensuring they are aware of what is available to support them. A Staff Charter was adopted and circulated to all staff during the year. It sets out the minimum standards on how staff can expect to be treated during their employment at the Trust. Work is ongoing to ensure that the principles and values outlined in the Staff Charter and the national Improving Working Lives and Investors in People Standards are embedded throughout the hospitals.

Sheffield Teaching Hospitals NHS
NHS Foundation Trust



Objective 5

hospital environment

Security

Security is a vital issue for us and we are committed to providing protection and reassurance to its staff, patients and visitors. With five major hospital sites to look after and well over a million people visiting our public each year, everyone has a role to play in security.

Security services at the Trust have been modernised this year following work from a Trust Board Sub-Committee. Made up of hospital staff from various areas and South Yorkshire Police, the committee put forward a range of recommendations. New staff, state of the art control room facilities and better communication with staff about crime prevention issues have raised the profile of security during the year and are helping ensure the hospitals are a safe place to work and visit.

The hospital environment is important in order that we are able to provide our world-class services in first-rate facilities that are hygienic, comfortable and environmentally responsible.

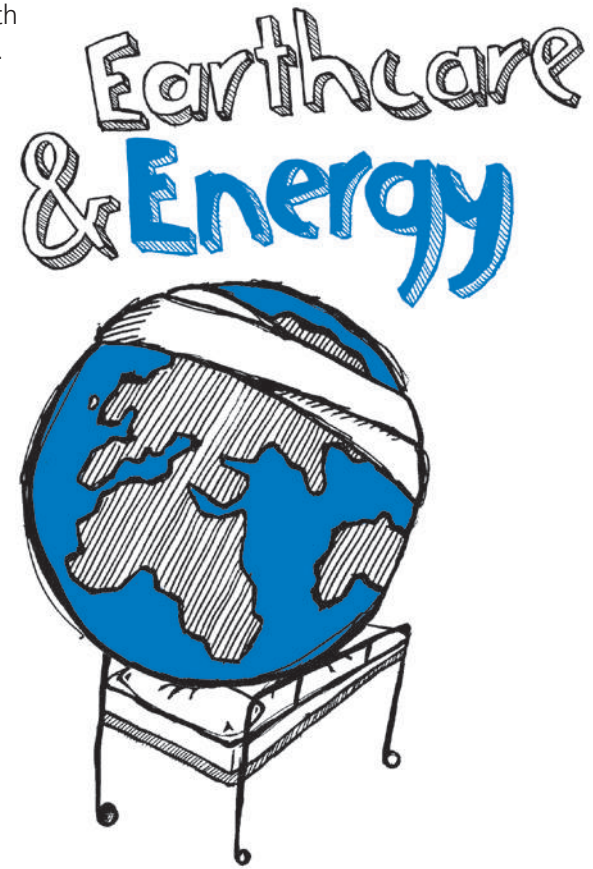
Saving money by saving energy

As a major user of energy, the Trust spends around £5million per year on energy and water each year and an estimated £500,000 of this is wasted. In conjunction with the Carbon Trust (a Government Agency which supports organisations in using energy more efficiently), Sheffield Teaching Hospitals has launched a campaign called 'Earthcare' designed to reduce the energy and water costs of Trust by £500,000 in the next three years. The Trust is the first public sector organisation in the country to secure funding for the entire project from the Carbon Trust. The idea of the campaign is to raise awareness of how simple measures, such as switching off electrical items when not in use, can save energy and money when adopted across our 12,000 plus employees. As a major user of energy we have a responsibility for better environmental management and also to ensure that the maximum use is made of our financial resources. Money saved can be put to use in patient care.

Investing in new buildings and facilities:

The Trust spent some £36.4million on capital developments this year. The key focus of expenditure was to support initiatives on health and safety and fire code compliance and infrastructure improvements, new and replacement medical equipment, waiting list activity and new service developments associated with the Trust's Service Development Strategy.

The 2003/04 capital expenditure is analysed as follows overleaf.



	£000	£000
Medical Equipment	5,127	
Endoscopy - 26 flexible scopes and 3 stack systems (NGH)		824
51 Renal Dialysis Machines (NGH)		529
5 Ultrasound Scanners (3 NGH and 2 RHH)		427
14 Critical Care Ventilators (7 NGH and 7 RHH)		404
Other		2,943
Statutory Compliance	4,086	
Firecode		1,970
Washer Disinfectors (2 NGH and 11 RHH)		504
Other (e.g. Health & Safety, Disability Discrimination, Legionella etc)		1,612
Information Technology	2,426	
Cardiac Imaging Digital Archive System (NGH)		620
Theatre Computer System		352
Outpatient Result Reporting		293
Other		1,161
Infrastructure	10,899	
Medical School Refurbishment (RHH)		8964
Security Equipment/Systems		243
Other		1,692
Service Development	13,840	
WPH Site Redevelopment (includes £2184k re medical equipment)		3,867
Vascular Angiography Facilities (NGH) (includes £1620k re medical equipment)		2,343
Additional Orthopaedic Theatre Capacity (NGH)		1,479
RHH Nursery Facilities		812
CSSD Cabinet Washers (NGH)		473
Office Accommodation Clocktower & Nurses Home (NGH)		448
Dermatology Outpatients Capacity Expansion (RHH)		414
Centralisation Metabolic Bone Facilities (NGH)		295
Occupational Health Accommodation (NGH)		278
Stereotactic Radiosurgery Expansion (RHH)		257
Replacement Dental Surgeries (CCDH)		240
Car Parking (NGH)		230
MRI Scanner (WPH)		195
Modifications to Urology OPD (RHH)		179
Other smaller schemes		2,330
Total Expenditure	**36,378**	

The total capital income included £9.7m from donations and other contributions towards capital expenditure. The capital income is analysed as follows:

	£000
Resources available from the Department of Health	26,770
Sheffield University investment in Medical School Refurbishment	8,912
Other Donations/Contributions	764
Total Income	**36,446**

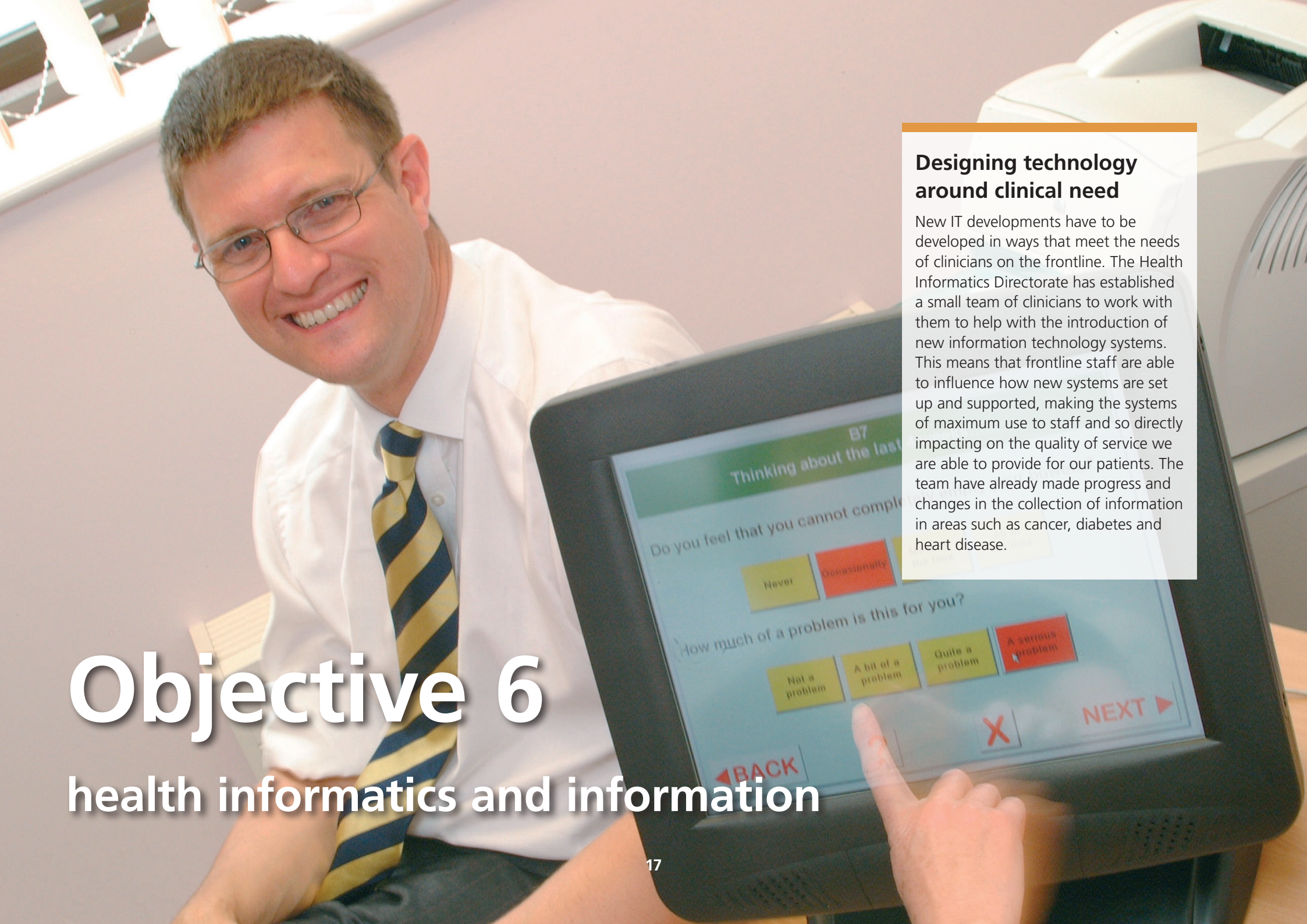
Some of the Service Developments that have been funded this year

Vascular Angiography: Vascular angiography is a special type of x-ray which maps the arteries and veins of the body showing areas in need of treatment. The old Angiography suite has been redesigned and state of the art equipment installed to give a more efficient working environment and as reassuring as possible surroundings for patients. This development cost over £2.7 million and the Trust received a 50% contribution from the South Yorkshire Strategic Health Authority.

Extending the Urology Outpatients Department: Work started at the Royal Hallamshire Hospital to extend this department to create much needed additional accommodation and outpatient capacity.

Vickers Corridor Replacement: The process to replace the Victorian medical wards at the Northern General Hospital with a new medical ward block is now at the final stage. The Trust has selected the preferred bidder - Kajima Europe - that will be our partner organisation working on the £30million development. The work on the new 168 bed ward block will begin in 2004 and be complete within two-years.

Linear Accelerator Suite: Work commenced at Weston Park Hospital to house two new linear accelerators; this will bring the total number of accelerators available for the treatment of patients with cancer in South Yorkshire and North Derbyshire to seven.



Objective 6

health informatics and information

Designing technology around clinical need

New IT developments have to be developed in ways that meet the needs of clinicians on the frontline. The Health Informatics Directorate has established a small team of clinicians to work with them to help with the introduction of new information technology systems. This means that frontline staff are able to influence how new systems are set up and supported, making the systems of maximum use to staff and so directly impacting on the quality of service we are able to provide for our patients. The team have already made progress and changes in the collection of information in areas such as cancer, diabetes and heart disease.

Without a comprehensive and up to date information system much of the work of the Trust cannot function in the efficient way in which staff and patients rightly expect. These are some of the developments that have taken place this year.

A new image for heart services

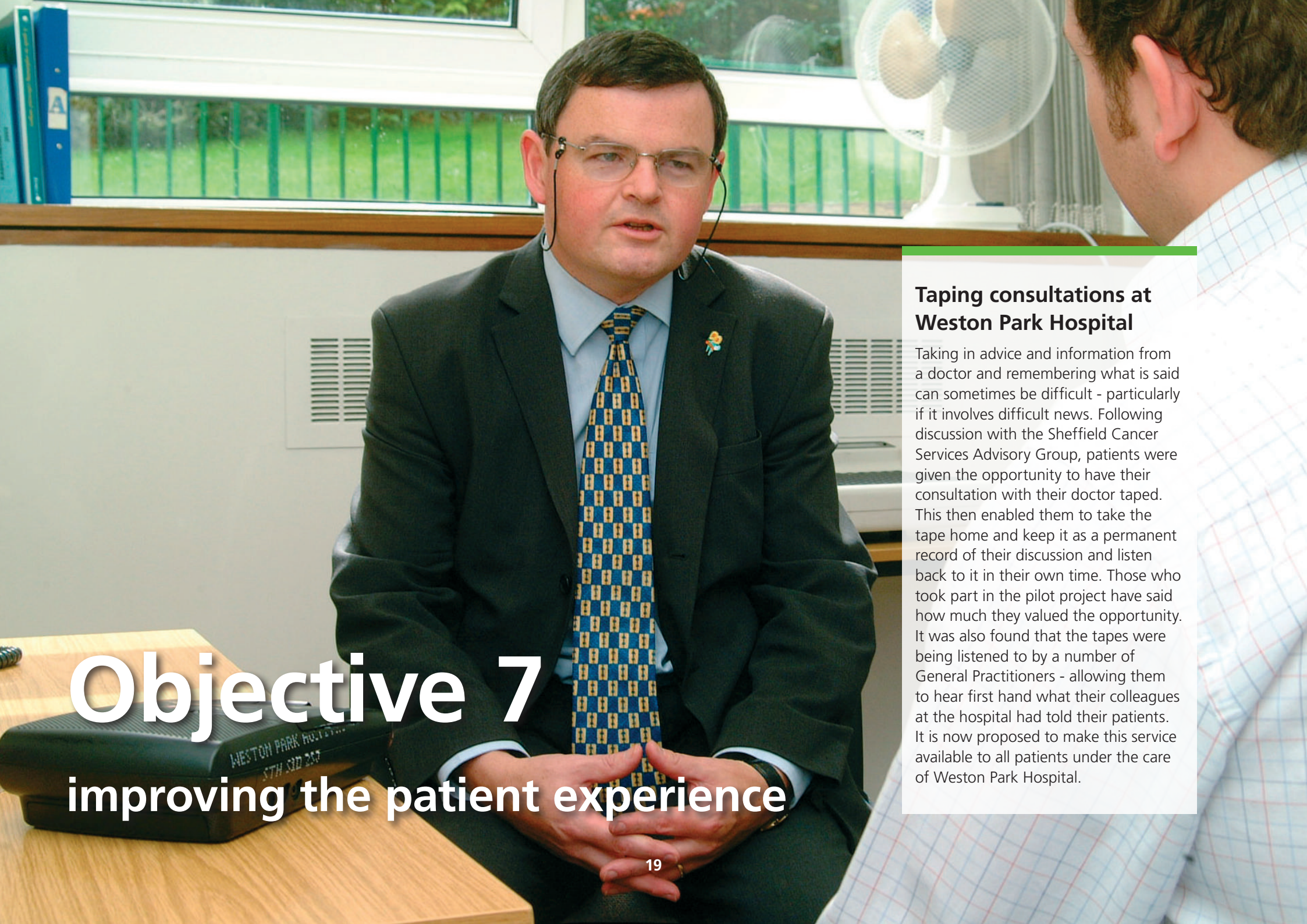
Major improvements continue to be made in medical imaging in Cardiac Services, with the acquisition of a huge electronic storage system at the Northern General Hospital. When fully functioning, it will be 50,000 times more powerful than a modern personal computer. It will hold the images of the 4,300 angiograms carried out each year at the Chesterman Unit. An angiogram is an image of the heart's blood supply. Another 8,600 ultrasound images of the heart carried out annually can also be stored. Images, whether taken by other hospitals or within the Trust itself are stored in a safe and reliable way so that they can be quickly retrieved and made available electronically to consultants across South Yorkshire. This could directly benefit nearly 15,000 patients a year with speedy viewing and sharing of heart images.

Staff Development, Skills and Knowledge

Information technology will continue to become ever more important in the delivery of quality healthcare. For example it will be used to transmit tests results immediately to a patients GP or Consultant and used in actually carrying out some tests and treatments. We need make certain that trust's staff are able to fully utilise new technologies of the future, allowing them to continue delivering an efficient and effective service to our patients. The Informatics Directorate has been actively engaging and encouraging staff to participate in training and development programmes. Over 100 members of staff in the Trust have completed the European Computer Driving Licence Qualification. This course is a basic introduction to computer skills so they can get the most out of information technology in the workplace. Other short courses aimed at getting 'non-computer users' engaged and prepared for the future, have included over 700 'Computers don't byte' training sessions in the past year.

Developing the hospital infrastructure to support modern NHS Services

Major work programmes have been undertaken in the past 12 months to upgrade and modernise the technical networks and telecommunication systems within the Trust. Because of this work preparing for new information technologies we have secured early adopter status for the first wave of new system deployment as part of the National Programme for IT. New technologies introduced over the past year have included hand held 'blackberry' devices which enable individuals to 'stay in touch' through electronic messaging, whilst working away from the Trust. There is a new automated call cascade system to contact staff in the event of them being required to help with major incidents, and an electronic telephone directory. All these developments aid communications and help to provide an effective service to our patients.



Objective 7

improving the patient experience

Taping consultations at Weston Park Hospital

Taking in advice and information from a doctor and remembering what is said can sometimes be difficult - particularly if it involves difficult news. Following discussion with the Sheffield Cancer Services Advisory Group, patients were given the opportunity to have their consultation with their doctor taped. This then enabled them to take the tape home and keep it as a permanent record of their discussion and listen back to it in their own time. Those who took part in the pilot project have said how much they valued the opportunity. It was also found that the tapes were being listened to by a number of General Practitioners - allowing them to hear first hand what their colleagues at the hospital had told their patients. It is now proposed to make this service available to all patients under the care of Weston Park Hospital.

Enormous effort goes into continually trying to improve our patients' experiences. These are only a small example of the developments that have taken place this year.

Complaints lead to improvements:

With almost one million patients coming to the hospitals each year there are going to be some cases where there is a problem or some conflict. That's why a complaints system is vital. During the year the Trust received 825 complaints of which 86% were responded to within our target time of 20 working days. Eight requests for independent review were received, with two proceeding to this stage. A Complaint Response Audit Group has been established consisting of members of Trust staff and lay people from the Patient's Council. There are quarterly meetings which assess the quality of responses to complainants against the audit standards and discuss areas for improvement and good practice in general.

Some of the improvements that have been made to services as a result of learning from complaints include:

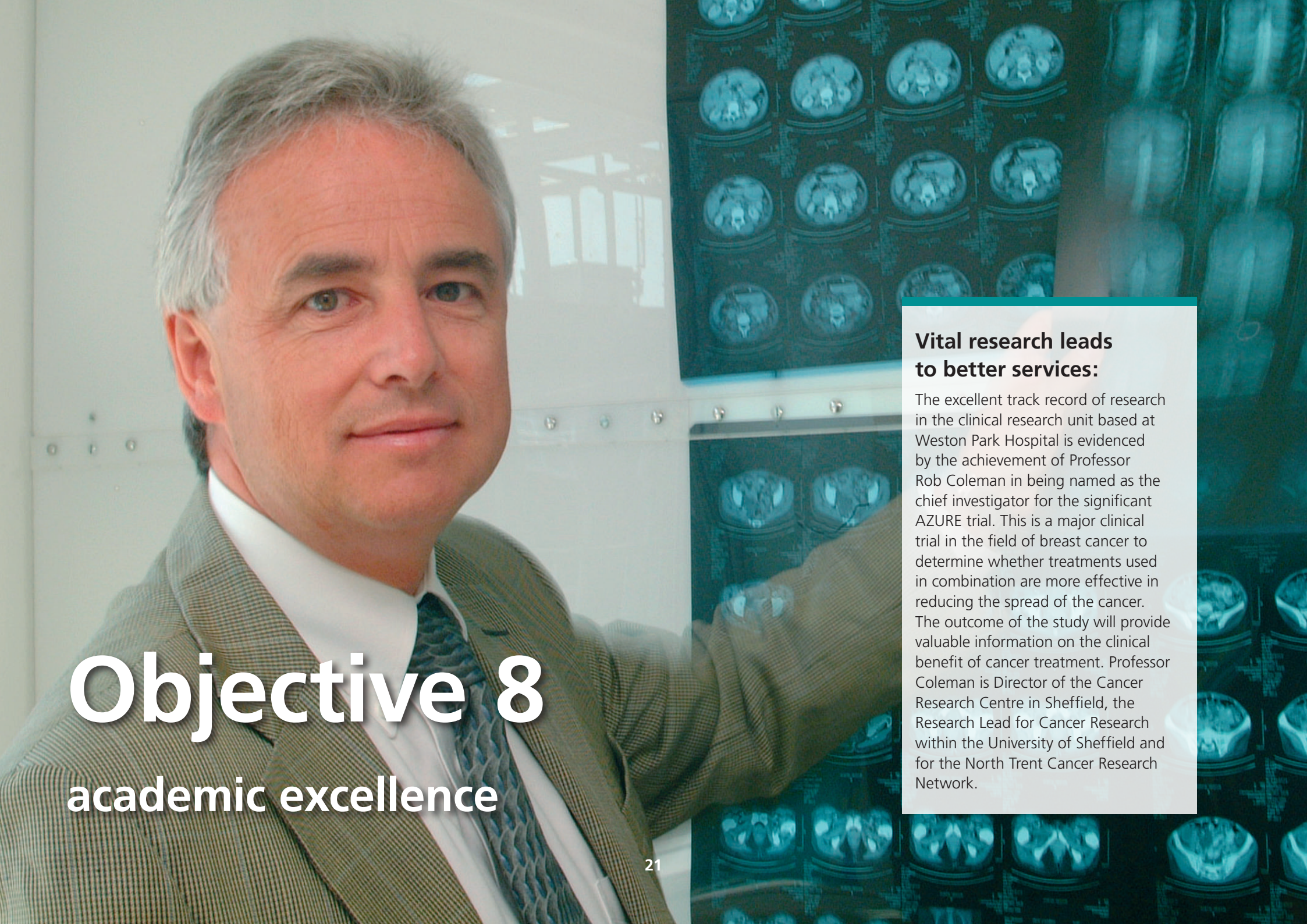
- In the endoscopy suite at the Royal Hallamshire Hospital there is now a private interview room for patients to receive the results of investigations.
- The reporting of pressure sores by ward staff has improved to ensure better communication with patients and their families.
- The process of sending interim discharge letters from Weston Park Hospital to General Practitioners has been changed to improve communication and to better keep GPs informed of progress in treatments.

What our patients tell us

The best way to assess how our services are meeting patient need is to ask people who have used them. Almost 1,000 patients who used Outpatient and A&E services gave feedback on their experiences as part of a national patient survey conducted by the independent Commission for Health Improvement.

Responses were sought in several key areas including waiting, quality of care, relationships with staff and standard of the hospital environment.

The results shows that people attending outpatients have confidence and trust in the health professionals who treat them and receive clear information on their condition or treatment. The majority feel they were also properly involved in decisions about their healthcare. Patients who have used the A&E services felt that they were treated with respect and dignity and results on waiting times were comparable to the average in other hospitals.



Objective 8

academic excellence

Vital research leads to better services:

The excellent track record of research in the clinical research unit based at Weston Park Hospital is evidenced by the achievement of Professor Rob Coleman in being named as the chief investigator for the significant AZURE trial. This is a major clinical trial in the field of breast cancer to determine whether treatments used in combination are more effective in reducing the spread of the cancer. The outcome of the study will provide valuable information on the clinical benefit of cancer treatment. Professor Coleman is Director of the Cancer Research Centre in Sheffield, the Research Lead for Cancer Research within the University of Sheffield and for the North Trent Cancer Research Network.

Clinical research is a vital part of our work. We believe that the local population will benefit from the improved quality of service available to them through good research.

The Trust has continued to work closely with the University of Sheffield with the development of a Clinical Research Facility located within the Royal Hallamshire Hospital well underway. There are an impressive number of important research studies in progress, and once again there have been many publications in notable academic journals over the past year.

Leading the way in bone disease:

Professor Richard Eastell, Research and Development Director, has won the prestigious Society for Endocrinology Medal 2004 and the Kohn Foundation Award 2004 for his commitment to osteoporosis that has helped revolutionise the treatment and diagnosis of this condition. The work of Professor Eastell and his colleagues at has resulted in Sheffield being home to the UK's leading centre for metabolic bone diagnosis and research and the largest bone density screening service in the country.

The President of the National Osteoporosis Society, Camilla Parker Bowles, officially opened the new Metabolic Bone Unit - located at the Northern General Hospital - in March 2004.

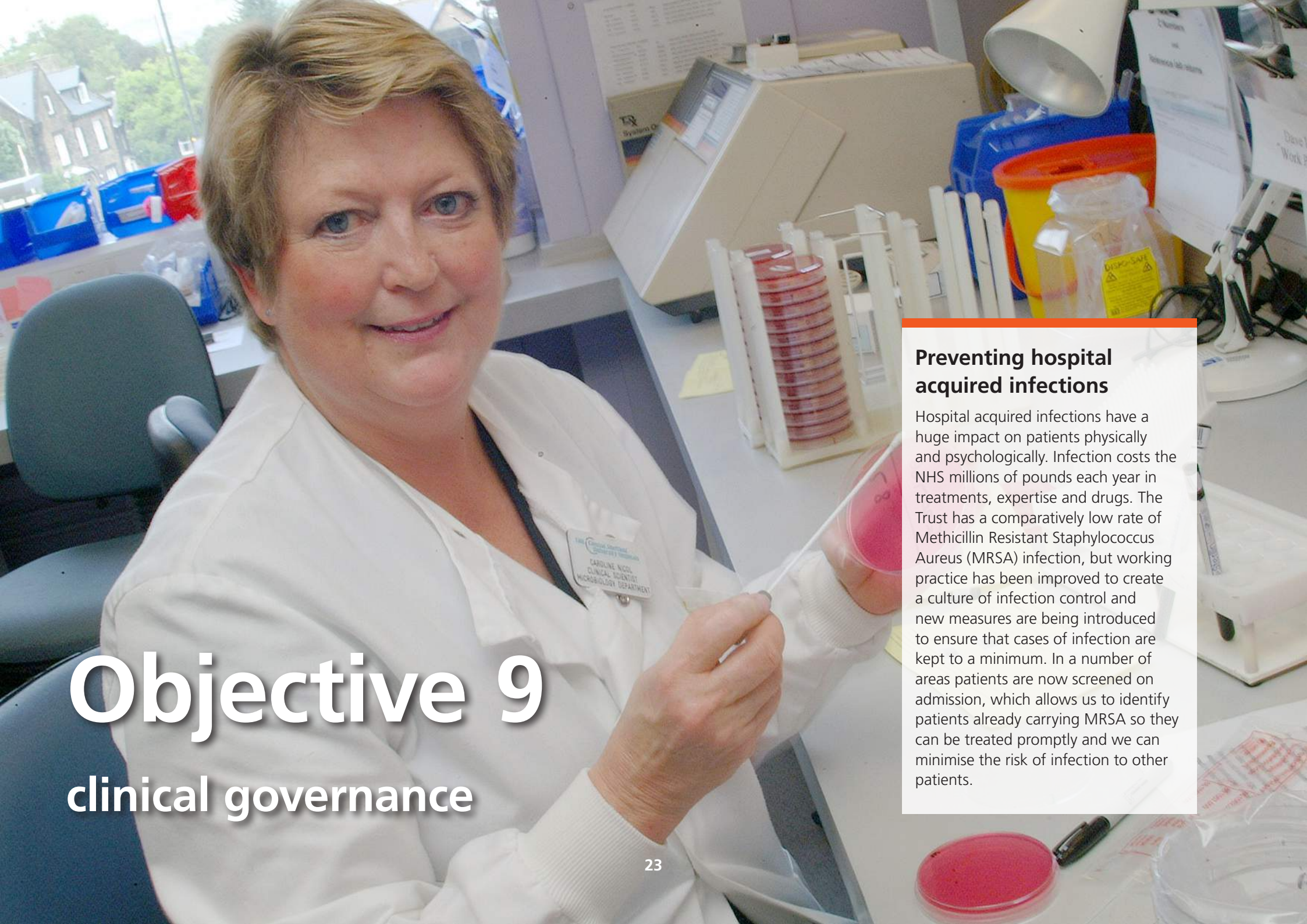
Looking at exercise on the NHS:

A major new research study which aims to find out exactly what factors make patients with chronic lung disease take up and keep up a programme of regular exercise is taking place. Results from the study will be used to help the NHS decide how to run exercise programmes across the country in the future. Simple exercise is proven to help these patients improve their quality of life, but many do not take up programmes.

The research includes looking at taking NHS exercise programmes into the community closer rather than basing them in hospital. It is supported by Sheffield City Council's Leisure Services Department whose community facilities are being used in the study.

Pulmonary Vascular Disease Unit:

Sheffield Teaching Hospitals is one of only 4 UK centres that provide treatment for the lung condition pulmonary hypertension and research into treatments. Developments have included the establishment of an educational programme to raise awareness of pulmonary hypertension and improve access to investigations and treatment. This has resulted in an increasing number of referrals of patients. The increase in activity and investment in the service has allowed the Trust to recruit more staff to the service. The service is committed to increasing patient involvement and 160 attendees took part in a successful patient conference in February 2004.



Objective 9

clinical governance

Preventing hospital acquired infections

Hospital acquired infections have a huge impact on patients physically and psychologically. Infection costs the NHS millions of pounds each year in treatments, expertise and drugs. The Trust has a comparatively low rate of Methicillin Resistant Staphylococcus Aureus (MRSA) infection, but working practice has been improved to create a culture of infection control and new measures are being introduced to ensure that cases of infection are kept to a minimum. In a number of areas patients are now screened on admission, which allows us to identify patients already carrying MRSA so they can be treated promptly and we can minimise the risk of infection to other patients.

Clinical Governance is the system by which the Trust makes sure that the correct procedures are in place to ensure that patients receive the highest standards of treatment.

The Trust also ensures that non-clinical issues are subjected to scrutiny to identify and manage potential risks. Our Clinical Governance infrastructure continues to develop to support an integrated systematic approach to quality improvement based on patient needs.

Independent assessment leads to action:

The Trust was visited by the Commission for Health Improvement (CHI) in 2003 as part of their visit programme to all NHS Trusts in the country. Their clinical governance review of the Trust was very positive and highlighted areas of excellence and areas for development.

This year, an action plan was implemented to address the key areas identified for further development. Among the work in this has been the development of a clinical effectiveness strategy and mandatory training strategy. Clinical effectiveness is the way the Trust ensures the approaches and treatments used are based on the best available evidence. The risk management procedures of the Trust were re-accredited with an overall score of 91%, with a special mention for our corporate induction programme and infection control initiatives.

Safety in medicines:

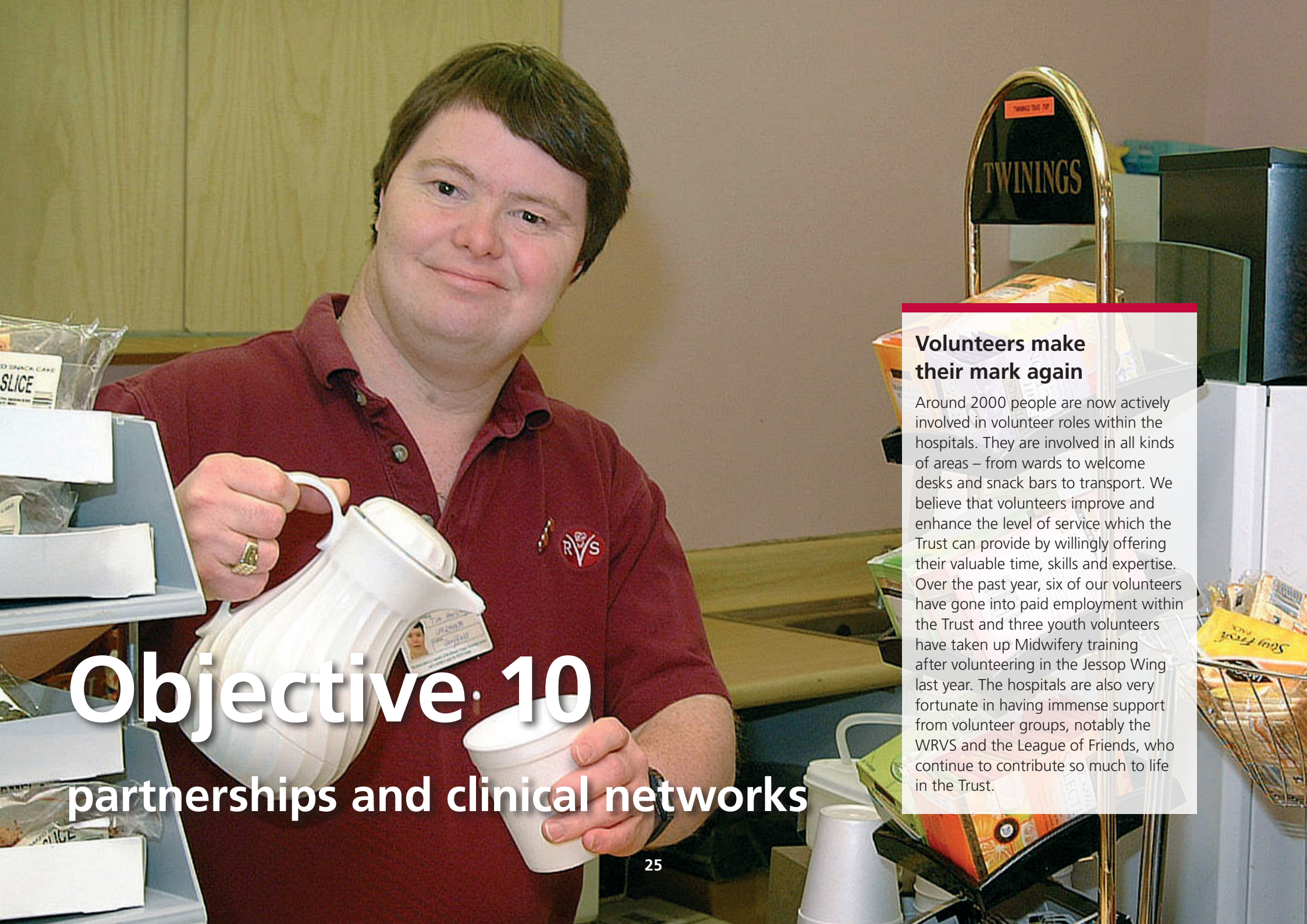
Each month the Trusts pharmacies process and dispense over 107,500 individual drugs at an average monthly cost of £2,412,600. To minimise the risk of medication errors, the Trust has recently established a Medicines Safety Committee. Its focus is to promote continued improvement in medicine management systems. The group will review local medication incident reports, recommend appropriate actions to address concerns, and monitor the use of unlicensed medicines within the Trust. The Trust has established a new post of Director of Prescribing to oversee this work - believed to be the first such appointment in the NHS.

Accounting to local people:

The NHS needs to be accountable to its local population. Scrutiny through the Local Authority is one way in which this can happen. Since May 2003 senior officers from Sheffield City Council, the Trust and the wider Health community have worked closely to develop the Health Scrutiny function in Sheffield. The primary aim of Health Scrutiny is to encourage improvement in the health of local people and to ensure that the needs of local people are considered. In addition, there is duty on local NHS bodies to consult the Health Scrutiny Board - made up of local councillors - on any significant service change proposals. The Trust has submitted to the Board its proposals to apply for NHS Foundation Status and to reconfigure General Surgical inpatient services and received useful feedback and advice which have strengthened its proposals.

Audit

During 2003/04 the external audit service was provided by The Audit Commission. The fees paid for the statutory audit are detailed in note 5.1 to the accounts



Objective 10

partnerships and clinical networks

Volunteers make their mark again

Around 2000 people are now actively involved in volunteer roles within the hospitals. They are involved in all kinds of areas – from wards to welcome desks and snack bars to transport. We believe that volunteers improve and enhance the level of service which the Trust can provide by willingly offering their valuable time, skills and expertise. Over the past year, six of our volunteers have gone into paid employment within the Trust and three youth volunteers have taken up Midwifery training after volunteering in the Jessop Wing last year. The hospitals are also very fortunate in having immense support from volunteer groups, notably the WRVS and the League of Friends, who continue to contribute so much to life in the Trust.

Collaborative working and planning with organisations at all operational levels means that the Trusts services are developed to best meet the needs of the populations it serves.

These are some of the new partnerships and developments with whom the Trust is involved.

Working with the Modernisation Agency to look at Endoscopy:

We have worked to make innovative changes to Endoscopy services across the Northern General and Royal Hallamshire Hospitals in partnership with the NHS Modernisation Agency.

There has been a marked reduction in waiting times and patients are offered the choice of site and date for their procedure. Patients are also reminded of their appointment by text/telephone 48 hours prior to the appointment. The impact of this measure has been an impressive reduction in the non-attendance rate.

Improvement Partnership for Hospitals Programme:

Our modernisation team are now involved in the Improvement Partnership for Hospitals. This is a joint venture, led by acute hospital trusts and managed by Strategic Health Authorities, in collaboration with local Primary Care Trusts and the Modernisation Agency.

The Trust joined the programme in 2003 and the goal is to provide better care without delay throughout the patient's healthcare journey.

The work will be focussed in three areas - Improving the hospital discharge arrangements, developing a care pathway for Orthopaedic hip and knee replacements and developing a care pathway in Acute Medicine. A Care Pathway is a record of patient care that covers planned treatment within a given time framework to achieve agreed results.

Providing specialist services:

Sheffield Teaching Hospitals provides key specialist services which need to be carefully planned and funded. In order to achieve this, the Trust has continued its close collaboration with the North Trent Commissioning Consortium (NORCOM), which is responsible for the organisation of some specialised services to ensure they meet the needs of the population in these areas. Amongst the many services which are being developed via these arrangements are:

- **Blood and Bone Marrow Transplantation** - in which we have been working to develop a strategy to meet new clinical standards.
- **Spinal Services** - where a review of the adult services has been undertaken with a view to developing service standards and referral networks.
- **Brain Injury Rehabilitation** - in which the availability of specialised services for people with acquired and traumatic brain injury has been reviewed.
- **Cystic Fibrosis services** - which have been scrutinised to ensure action and investment plans are enhanced and also to review the use of high cost drugs in line with accepted clinical practice.

Board of Directors Disclosure at 31 March 2004

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

The directors have declared the following interests and the Board are satisfied that there are no conflicts of interest indicated by any external involvement.

Chairman

Mr D Stone
Trustee, Weston Park Hospital Cancer Appeal
Trustee, Freshgate Trust
Trustee, Sheffield Botanical Gardens Trust
Guardian, Sheffield Assay Office
Honorary Consul, Republic of Finland

Non-Executive Directors

Mr J Stoddart
National Extension College
Bolton Institute
Guardian, Sheffield Assay Office

Mrs O Bright

Mr J Donnelly

Ms V Ferres
Chief Executive, Age Concern Doncaster
Director and Chair, Disability Doncaster
Director and Chair,
South Yorkshire Centre for Integrated Living
Director, Doncaster Energy Services
Director and Chair, John William Chapman Trust

Mr V Powell
Governor, Sheffield College

Professor A Weetman University Representative
Director of Sheffield Centre of Sports Medicine
Medical Advisor and Trustee, British Thyroid Foundation
Panel Member, Wellcome Trust Clinical Interest Group

Executive Directors

Mr A Cash *Chief Executive*
Visiting Chair University of York
Health Services Development Unit

Miss H Drabble *Chief Nurse*
Trustee, Cavendish Centre for Cancer Care, Sheffield

Mr C C Linacre *Director of Service Development*
Director, Medipex Ltd

Professor C Welsh *Medical Director*
Private Medical Practice at Claremont Hospital
Tutor, Medical Leadership Programme - Keele University

Mr N Priestley *Director of Finance*

Mr J Watts
Director of Human Resources

Committee membership

Remuneration Committee

The Remuneration Committee of the Trust comprises the following members;

Mr D Stone

All Non-Executive Directors

The Remuneration Committee determines the remuneration of the Executive and Non-Executive Directors of the Trust together with all staff groups by reference to national guidelines.

Full details of Directors Remuneration can be found in note 5.3 of the accounts.

Professional Indemnity Insurance

The Trust paid £215,840.70 to the NHSLA for liabilities to third parties for 2004/05. This charge covers all legal actions brought against the Trust and its officers and Directors by employees or members of the general public.

The charge for 2003/04 was £104,400. It is not possible to split the charge in respect of Directors and Officers liability from the Trust liability cover.

Management Audit Committee

The Management Audit Committee of the Trust comprises the following Non-Executive Director members:

Mr J Donnelly

Mr V Powell

Ms V Ferres

Clinical Governance Committee

The Clinical Governance Committee of the Trust comprises the following Non-Executive Director members:

Mr J Stoddart

Ms V Ferres

Statement on internal control

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive Officer of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum

I am also personally accountable for all Governance related issues. These responsibilities are reflected in the Trusts Financial Strategy, Risk Management Strategy and Clinical Governance Plan.

These duties include both legislative responsibility to a number of agencies including a duty under the Health Act 1999 to 'put and keep in place arrangements for the purpose of monitoring and improving the quality of patient care'

To allow me to discharge my personal accountabilities I have established a management framework across the whole organisation where roles, functions and objectives of Directors and Directorate Management Teams are unambiguous, clearly detailed and understood. These objectives are regularly monitored and reviewed by my Executive Director colleagues and myself.

Progress against my own objectives is measured, monitored and assessed by the Department of Health via the Strategic Health Authority, the Chairman and the Trust Board, District Audit Office and Internal Audit Services who measure progress against the Governance, Finance and Risk Management core standards and the nineteen supporting organisational control standards.

My Board colleagues and I recognise that the provision and delivery of quality healthcare cannot be achieved in isolation from the wider health and social service community of Sheffield and South Yorkshire The Sheffield Health & Social Care community works together through well established partnership arrangements as part of the citywide partnership, Sheffield First.

The Sheffield City Strategy produced by Sheffield First sets the context for the Sheffield Health and Social Care Community Strategy, which is in turn consistent with the South Yorkshire Strategy for Health and Social Care at Strategic Health Authority level.

The Chief Officers of the health and social care organisations within Sheffield meet regularly to address strategic, performance, financial and service development issues and agree action to be taken to address any system wide risks or concerns. Various partnership boards and sub-committees focussed on particular aspects of the strategy and its implementation are well established and report to the Chief Officers Group.

Regular meetings are also held by the Strategic Health Authority, involving all key players, to consider issues across the Health Authority and/or health and social care community areas. Formal performance management, via Health and Social Care community reviews and individual organisational reviews, is undertaken by the Strategic Health Authority

2. The purpose of the system of internal control

The system of internal control is designed to manage risks 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 organisation's policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The complete system of internal control has not been in place in Sheffield Teaching Hospitals NHS Trust for the whole year ended 31 March 2004, but was in place by 31st March 2004 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The leadership and accountability arrangements relative to risk management are included in the Risk Management Strategy, job descriptions and identified risk related objectives. A number of structures and committees exist to oversee and monitor the effectiveness of these arrangements.

These include the:

- Management Audit Committee
- Clinical Governance Committee
- Risk Executive Group

Each significant risk theme is owned by an Executive Director. The Directorate of Legal Services and Corporate Governance has an overarching responsibility for the development of a cohesive and integrated framework and shared processes for the management of all risk.

When the management structures for the merged Trust were being devised, Directorate Managers were required to include effective arrangements for the management of risk relevant to their Directorate's size and circumstances.

The Trust has recently reviewed its corporate and local induction programmes; risk management being a key element of both. At the same time, the Trust Board have ratified a Mandatory Training Strategy that spells out in detail the annual update programme for existing staff. The Trust has adopted this approach to ensure that staff receive focused risk-based training that supports the development of a competence framework.

Very detailed, specialised and externally accredited training is provided for the managers and staff within the organisation who have specific responsibility for the management of risk. The overall Risk Management Strategy is widely supported by policies, procedures and guidelines which are subject to scrutiny and dissemination by the Corporate Policy Unit within the Directorate of Legal Services and Corporate Governance. Both the Clinical Governance Committee and the Risk Executive Group work to identify quality initiatives, examples of good practice and risk issues requiring action.

4. The risk and control framework

The Trust's Risk Management Strategy is underpinned by a number of Trust Board agreed principles. These are:

- Risk management must become an integral part of the management and financial planning process of groups, directorates and the Trust as a whole.
- All aspects of risk management are approached in a corporate and structured manner in line with Controls Assurance (HSC 1999/123) and the RPST/CNST framework.

- Objectives, responsibilities and accountabilities for self assessment and risk management are clearly defined at every level of the organisation.
- All staff are competent and safe to practice and are aware of their personal responsibility for the management of all risk.
- All staff are empowered to report risks and register concerns about unsafe practice.
- Support and information systems are in place to assist the implementation of the Strategy and the cultural change that this will entail.
- Strategies, structures and processes are constantly reviewed and evaluated to ensure that objectives are being met.
- Risk is fully integrated into the Trust's governance arrangements and processes.
- The Trust contributes to a risk network within the wider health community.

These principles ensure that risk management is effectively embedded in the day-to-day activity of the organisation.

A great deal of work has been undertaken on the development and integration of an assurance framework. This has involved the adoption of principal objectives, based upon the key themes identified in the Trust's Strategic Direction document and the Patient Services Plan, the identification and assessment of principal risks to achieving those objectives, consideration of key controls; and, where necessary, action plans.

Our framework has identified a number of required developments in assurance and controls, particularly in the areas of changes associated with Foundation Trust status, strategies for dealing comprehensively with a demographically dynamic and changing population and case mix structure and the development of a whole health and social care community approach to improving the patient experience. The Trust is developing action plans, where they do not already exist, to manage these areas of risk.

As Accountable Officer, I need to gain assurances on the effectiveness of all internal control systems, which, in turn, enable me to sign this Statement of Internal Control on behalf of my Trust Board colleagues.

Sheffield Teaching Hospitals NHS Trust is a large complex organisation. A number of the risks it faces have the potential to impact on other members of the healthcare community, the Sheffield Universities and ultimately the people of Sheffield. In order to ensure that all stakeholders are adequately informed and involved in the management of these risks, the Trust participates fully in the Sheffield City Council Scrutiny Board and liaises closely with the academic institutions.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- the recent CHI Review and the subsequent report published in May 2003
- the Management Letter to Directors from the District Auditor
- independent reviews undertaken on behalf of the National Health Service Litigation Authority (NHSLA)
- independent audits commissioned by the South Yorkshire Strategic Health Authority
- internal audit 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 Management Audit Committee, the Clinical Governance Committee and the Risk Executive Group. A plan to address weaknesses and ensure continuous improvement of the system is in place. As part of this process the Executive Directors have been actively engaged in considering and reviewing the system of internal control. The Management Audit Committee has been receiving and monitoring relevant audit reports.

The Risk Executive Group have been actively involved in the management of a Risk Register and the Internal Audit Service continue to work against a risk-based audit plan. At the same time the Assurance Framework exercise described

earlier has been progressively developed, the core Controls Assurance Standards and the supporting organisational control standards have been reassessed, showing incremental progression and subsequently verified by the Internal Audit Service

Chief Executive Officer
(on behalf of the board)

Date

Independent Auditor's Report to Sheffield Teaching Hospitals NHS Trust

I have audited the financial statements on pages x to y which have been prepared in accordance with the accounting policies relevant to the National Health Service as set out on pages x to y.

This report is made solely to the Sheffield Teaching Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective Responsibilities of Directors and Auditors

As described on page x the Directors are responsible for the preparation of the financial statements in accordance with directions issued by the Secretary of State. My responsibilities, as independent auditor, are established by statute, the Code of Audit Practice issued by the Audit Commission and my profession's ethical guidance.

I report to you my opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

I review whether the directors' statement on internal control reflects compliance with the Department of Health's guidance 'The Statement on Internal Control 2003/2004' issued on 15 September 2003. I report if it does not meet the requirements specified by the Department of Health 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 directors' statement on internal control covers all risks and controls. I am also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. My review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

I read the information contained in the Annual Report and consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission, which requires compliance with relevant auditing standards 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. It also includes an assessment of the significant estimates and judgements 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. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In my opinion the financial statements give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Trust as at 31 March 2004 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Date

John Prentice
District Auditor
Audit Commission
Littlemoor House
Littlemoor
Sheffield
S21 4EF

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers' Memorandum issued by the Department of Health.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Date

Chief Executive

Statement of the Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Services Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirement outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Date

Chief Executive

Date

Finance Director

Foreword to the Accounts

Sheffield Teaching Hospitals NHS Trust
Income and Expenditure Account for the Year Ended 31 March 2004

These accounts for the year ended 31 March 2004 have been prepared by the Sheffield Teaching Hospitals NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

			2002/03
	NOTE	**£000**	£000
Income from activities:			
Continuing operations	3	**410,620**	367,782
Other operating income:			
Continuing operations	4	**90,263**	81,337
Operating expenses:			
Continuing operations	5-7	**(489,908)**	(432,659)
OPERATING SURPLUS:			
Continuing operations		**10,975**	16,460
Profit (loss) on disposal of fixed assets	8	**0**	0
SURPLUS BEFORE INTEREST		**10,975**	16,460
Interest receivable		**501**	450
Interest payable	9	**(130)**	0
Other finance costs - unwinding of discount		**(94)**	0
Other finance costs - change in discount rate on provisions		**(257)**	0
SURPLUS FOR THE FINANCIAL YEAR		**10,995**	16,910
Public Dividend Capital dividends payable		**(10,781)**	(16,819)
RETAINED SURPLUS FOR THE YEAR		**214**	91

Note to the Income and Expenditure Account for the Year Ended 31 March 2004

	£000
Retained surplus for the year	**214**
Financial support included in retained surplus for the year	**0**
Retained surplus for the year excluding financial support	**214**

Balance Sheet as at 31 March 2004

			31 March 2003
	NOTE	**£000**	£000
FIXED ASSETS			
Intangible assets	10	**592**	384
Tangible assets	11	**365,586**	329,325
		366,178	329,709
CURRENT ASSETS			
Stocks and work in progress	12	**8,872**	9,120
Debtors	13	**23,589**	21,642
Cash at bank and in hand	17.3	**1,431**	551
		33,892	31,313
CREDITORS: Amounts falling due within one year	14	**(42,216)**	(45,732)
NET CURRENT (LIABILITIES)		**(8,324)**	(14,419)
TOTAL ASSETS LESS CURRENT LIABILITIES		**357,854**	315,290
CREDITORS: Amounts falling due after more than one year	14	**(358)**	(679)
PROVISIONS FOR LIABILITIES AND CHARGES	15	**(8,464)**	(1,246)
TOTAL ASSETS EMPLOYED		**349,032**	313,365
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		**271,275**	265,494
Revaluation reserve	16	**40,985**	22,974
Donated Asset reserve	16	**34,057**	24,349
Income and expenditure reserve	16	**2,715**	548
TOTAL TAXPAYERS EQUITY		**349,032**	313,365

Signed: Andrew Cash. (Chief Executive)

Date: 22nd July 2004

Statement of Total Recognised Gains and Loses for the Year Ended 31 March 2004

		2002/2003
	£000	£000
Surplus for the financial year before dividend payments	**10,995**	16,910
Fixed asset impairment losses	**(6,940)**	(41,374)
Unrealised surplus on fixed asset revaluations/ indexation	**28,737**	62,842
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**9,676**	1,979
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	**(1,801)**	(1,567)
Total recognised gains and losses for the financial year	**40,667**	38,790
Prior period adjustment		
- Pre-95 early retirement	**0**	(1,179)
Total gains and losses recognised in the financial year	**40,667**	37,611

Cash Flow Statement for the Year Ended 31 March 2004

			2002/03
	NOTE	**£000**	£000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	17.1	**29,030**	32,698
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**495**	437
Interest paid		**(130)**	0
Net cash inflow from returns on investments and servicing of finance		**365**	437
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(22,139)**	(22,003)
Receipts from sale of tangible fixed assets		**0**	80
Payments to acquire intangible assets		**(135)**	(140)
Net cash (outflow) from capital expenditure		**(22,274)**	(22,063)
DIVIDENDS PAID		**(10,781)**	(16,819)
Net cash (outflow) before financing		**(3,660)**	(5,747)
FINANCING			
Public dividend capital received		**7,998**	5,217
Public dividend capital repaid (not previously accrued)		**(2,217)**	(3,000)
Public dividend capital repaid (accrued in prior period)		**(2,199)**	(491)
Other capital receipts		**958**	4,021
Net cash inflow from financing		**4,540**	5,747
Increase in cash		**880**	0

Notes to the Accounts

1 ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS trusts Manual for Accounts which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2003/04 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource Accounting 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 fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

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.

1.4 Pooled Budgets

The Trust has entered into a pooled budget with certain other Health Care Organizations in Sheffield. Under the arrangement funds are pooled under S31 of the Health Act 1999 for rapid assessment and rehabilitation activities and note 25 to the accounts provides details of this.

1.5 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a trust's activities for more the 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 and 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

- individually have a cost of at least £5,000; or

- collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost

From 2003/04, the method of accounting for second hand assets, on acquisition, has been changed from disclosing gross cost and accumulated depreciation, to disclosing net acquisition cost. This change will have no effect on the balance sheet figures and comparative figures have not been amended.

From 2003/04, expenditure on digital hearing aids has been treated as capital expenditure, giving rise to an increase in fixed assets regardless of the cost of the individual hearing aids.

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 each year. 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 and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 1999 as at the prospective valuation date of 1 April 2000.

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.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Total Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of

ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost using the indexes as for land and buildings, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets as 'assets under construction and payments on account' where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual interest plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trusts estate.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. 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 and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

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

Impairment losses resulting from short-term changes in price that are considered to be recoverable in the longer term are taken in full to the revaluation reserve. These include impairments resulting from the revaluation of fixed assets from their cost to their value in existing use when they become operational. This may lead to a negative revaluation reserve in certain instances.

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.

Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income may be paid by the Trust's main commissioner using funding provided by the NHS Bank.

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 funds from NHS bodies or funds awarded by Parliamentary Vote. The government grants reserve is maintained at a level equal to the net book value of the assets which it has financed.

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 the FRS 5 Amendment.

PFI schemes are schemes under which the PFI operator receives an annual payment from the Trust for the services provided by the PFI operator

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments 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. Partially completed contracts for patient services are not accounted for as work-in-progress.

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, or are reasonably expected to be available 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. NHS Trusts are 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 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 significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 3.5% in real terms.

This is a change from the rate of 6% applied in 2002/03 and earlier. The effect of the change is to increase the carrying value of the provision and this is shown in the Income and Expenditure Account and at Note 15.

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 15.

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 2003/04 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.

1.13 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 Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. The total employer contribution payable in 2003/04 was £14,853,682 (£13,555,478 for 2002/03).

The notional surplus of the scheme is £1.1 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1994 to 31 March 1999. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. It was recommended that employers' contributions remain at 7% of pensionable pay until 31 March 2003 and then be increased to 14% of pensionable pay with effect from 1 April 2003.

The Scheme is subject to a full valuation every four years (previously every five years). The last valuation took place as at 31 March 2003. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account,

published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

NHS bodies are directed by the Secretary of State to charge employers pension costs contributions to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following a scheme valuation carried out by the Government Actuary. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. At the last valuation (31 March 1999) on which contribution rates were based employer contribution rates for 2003/04 were set at 14% of pensionable pay (2002/03 - 7%). Until 2002/03 HM Treasury paid the Retail Price Indexation costs of the NHS Pension scheme direct but as part of the Spending Review Settlement, these costs have been devolved in full. For 2003/04 the additional funding has been retained as a Central Budget by the Department of Health and has been paid direct to the NHS Pensions Agency and the employers' contribution has remained at 7%. From 2004/05 this funding will be devolved in full to NHS Pension Scheme employers and the employers' contribution rate will rise to 14%. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the Trust can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.
Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, 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 of payment.

FRS 17 has been fully adopted from 2003/04.

1.14 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.

1.15 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.

1.16 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.

1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 27 to the accounts.

1.18 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 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.

1.19 Dividend

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 assets in the course of construction, donated assets and cash with the Office of the Paymaster General. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

2 SEGMENTAL ANALYSIS

Sheffield Teaching Hospitals NHS Trust is not a lead body or member of any NHS consortium, and consequently no segmental analysis is required.

3. Income from Activities

		2002/03
	£000	£000
Strategic Health Authorities	**3,894**	4,266
Primary Care Trusts*	**402,251**	358,979
Local Authorities	**130**	0
Non NHS:		
- Private Patients	**2,560**	2,774
- Overseas patients (non-reciprocal)	**289**	173
- Road Traffic Act**	**1,496**	1,549
- Other	**0**	41
	410,620	367,782

*Includes £1,538,570 to offset fixed asset impairments charged to operating expenses and £678,430 to fund accelerated depreciation.

**Road Traffic Act income is subject to a provision for doubtful debts of 6% to reflect expected rates of collection

4. Other Operating Income

		2002/03
	£000	£000
Education, training and research	**51,596**	48,046
Transfers from donated asset reserve	**1,801**	1,567
Non-patient care services to other bodies	**26,984**	23,244
Other income	**9,882**	8,480
	90,263	81,337

5. Operating Expenses

5.1 Operating expenses comprise:

		2002/03
	£000	£000
Services from other NHS Trusts	**7,617**	6,510
Services from other NHS bodies	**4,826**	5,708
Purchase of healthcare from non NHS bodies	**6,073**	3,884
Directors' costs	**875**	773
Staff costs	**316,122**	277,549
Supplies and services		
- clinical	**93,328**	81,066
- general	**6,655**	6,349
Establishment	**6,381**	5,973
Transport	**477**	477
Premises	**15,999**	14,143
Bad debts	**342**	320
Depreciation and amortisation	**20,144**	18,735
Fixed asset impairments and reversals	**1,563**	1,696
Audit fees	**231**	200
Clinical negligence	**2,885**	3,486
Pre-95 early retirements	**(304)**	0
Other	**6,694**	5,790
	489,908	432,659

5.2 Operating leases

5.2/1 Operating expenses include:

		2002/03
	£000	£000
Other operating lease rentals	**1,722**	1,654
	1,722	1,654

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

	Land and buildings		**Other leases**	
		2002/03		2002/03
	£000	£000	**£000**	£000
Operating leases which expire:				
Within 1 year	**0**	0	**596**	83
Between 1 and 5 years	**33**	33	**860**	1,331
After 5 years	**193**	191	**126**	64
	226	224	**1,582**	1,478

5.3 Salary and Pension entitlements of senior managers

Name and Title	Age	Salary	Other Remuneration	Golden hello/ compensation for loss of office	Real increase in pension at age 60	Total accrued pension at age 60 at 31 March 2004	Benefits in kind
		(bands of £5000)	(bands of £5000)		(bands of £2500)	(bands of £5000)	(Rounded to the nearest £100)
		£000	£000	£000	£000	£000	£
2003/04							
Mr A Cash, Chief Executive	48	145-150	-	-	2.5 - 5	45-50	-
Mr C C Linacre,Director of Service Development	54	105-110	-	-	2.5 - 5	40-45	-
Mr D Stone, Chairman	68	20-25	-	-	-	-	-
Mr J Donnelly, Non Executive Director	54	5-10	-	-	-	-	-
Mr J Stoddart, Non Executive Director	65	5-10	-	-	-	-	-
Mr J Watts, Director of Human Resources	56	100-105	-	-	2.5 - 5	40-45	-
Mr N Priestley, Director of Finance	42	100-105	-	-	2.5-5	25-30	-
Mr V Powell, Non Executive Director	57	5-10	-	-	-	-	-
Miss H Drabble, Chief Nurse	43	100-105	-	-	2.5-5	25-30	-
Mrs O Bright, Non Executive Director	43	5-10	-	-	-	-	-
Ms V Ferres, Non Executive Director	50	5-10	-	-	-	-	-
Professor A P Weetman, Non Executive Director	51	5-10	-	-	-	-	-
Professor C Welsh, Medical Director	57	120-125	-	-	2.5 - 5	45-50	-
2002/03							
Mr A Cash, Chief Executive	47	135-140	-	-	(0-2.5)	40-45	-
Mr C C Linacre,Director of Service Development	53	95-100	-	-	(0-2.5)	35-40	-
Mr D Stone, Chairman	67	20-25	-	-	-		-
Mr J Donnelly, Non Executive Director	53	5-10	-	-	-		-
Mr J Stoddart, Non Executive Director	64	5-10	-	-	-		-
Mr J Watts, Director of Human Resources	55	90-95	-	-	(0-2.5)	35-40	-
Mr N Priestley, Director of Finance	41	90-95	-	-	0-2.5	20-25	-
Mr V Powell, Non Executive Director	56	5-10	-	-	-		-
Miss H Drabble, Chief Nurse	42	90-95	-	-	(0-2.5)	20-25	-
Mrs O Bright, Non Executive Director	42	5-10	-	-	-		-
Ms V Ferres, Non Executive Director	49	5-10	-	-	-		-
Professor A P Weetman, Non Executive Director	50	5-10	-	-	-		-
Professor C Welsh, Medical Director	56	115-120	-	-	0-2.5	40-45	-

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

6. Staff costs and numbers

6.1 Staff costs

		2002/03
	£000	£000
Salaries and wages	**277,150**	244,289
Social Security Costs	**19,597**	15,794
Employer contributions to NHSPA	**14,854**	13,555
Other pension costs	**785**	638
Agency and contract staff	**4,545**	3,998
Seconded-in staff	**0**	0
	316,931	278,274

Included in the above figure of £316,931k (2002/03 £278,274k) is the figure of £615k in respect of capitalized salary costs (2002/03 £684k).

6.2 Average number of persons employed

	Total	Senior Managers	Others	Agency, temporary & contract staff	2002/03
	Number	Number	Number	Number	Number
Medical and dental	**1,184**	0	1,095	89	1,082
Administration & estates	**2,159**	6	2,060	93	2,078
Healthcare assistants & other support staff	**1,200**	0	1,200	0	1,224
Nursing, midwifery & health visiting staff	**4,476**	0	4,145	331	4,218
Scientific, therapeutic and technical staff	**1,714**	0	1,686	28	1,656
Total	**10,733**	6	10,186	541	10,258

6.3 Management costs

		2002/03
	£000	£000
Management costs	**15,002**	14,518
Income	**500,883**	449,119

Management costs are as defined in the document 'NHS Management Costs 2002/03' which can be found on the internet at http://www.doh.gov.uk/managementcosts.

6.4 Retirement due to ill-health

During 2003/04 (prior year 2002/03) there were 26 (23) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £939k (£638k). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

7. Public Sector Payment Policy

7.1 Better Payment Practice Code - measure of compliance

	Number	**£000**
Total bills paid in the year	**140,879**	**167,293**
Total bills paid within target	**129,216**	**151,244**
Percentage of bills paid within target	**91.72%**	**90.41%**

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

		2002/03
	£000	£000
Amounts included within Interest Payable (Note 9)	**0**	0
arising from claims made under this legislation		
Compensation paid to cover debt recovery costs	**0**	0
under this legislation		

8. Profit (Loss) on Disposal of Fixed Assets

There was no profit or loss on fixed assets disposed of during 2003-04 (and none on assets disposed of in 2002-03).

9. Interest Payable

		2002/03
	£000	£000
Other - early retirement costs	**130**	0
	130	0

10. Intangible Fixed Assets

	Software Licenses	**Total**
	£000	**£000**
Gross cost at 1 April 2003	659	659
Reclassifications	69	69
Additions - purchased	268	268
Additions - donated/government granted	19	19
Disposals	(27)	(27)
Gross cost at 31 March 2004	**988**	**988**
Accumulated amortisation at 1 April 2003	275	275
Impairments	9	9
Reclassifications	1	1
Provided during the year	138	138
Disposals	(27)	(27)
Accumulated amortisation at 31 March 2004	**396**	**396**
Net book value		
- Purchased at 1 April 2003	384	384
- Total at 1 April 2003	**384**	**384**
- Purchased at 31 March 2004	567	567
- Donated at 31 March 2004	25	25
- Total at 31 March 2004	**592**	**592**

11. Tangible Fixed Assets

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account*	Plant & Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2003	23,598	251,071	2,282	11,811	88,390	831	16,961	13,129	408,073
Additions - purchased *	0	3,038	0	17,849	4,362	35	836	314	26,434
Additions - donated/government granted	0	80	7	9,093	467	0	0	10	9,657
Impairments	0	(6,940)	0	0	0	0	0	0	(6,940)
Reclassifications	0	12,526	0	(18,852)	5,022	0	199	1,036	(69)
Indexation	1,348	24,561	224	890	1,952	18	0	290	29,283
Other in year revaluation	0	908	0	0	0	0	0	0	908
Disposals	0	0	0	0	(12,496)	(56)	(4,386)	(224)	(17,162)
At 31 March 2004	**24,946**	**285,244**	**2,513**	**20,791**	**87,697**	**828**	**13,610**	**14,555**	**450,184**
Accumulated depreciation at 1 April 2003	0	0	0	0	57,657	619	12,883	7,589	78,748
Provided during the year	0	11,065	94	0	6,469	56	1,147	1,175	20,006
Impairments	0	1,143	0	0	347	0	58	6	1,554
Reclassifications	0	0	0	0	0	0	(1)	0	(1)
Indexation	0	0	0	0	1,272	14	0	167	1,453
Disposals	0	0	0	0	(12,496)	(56)	(4,386)	(224)	(17,162)
Accumulated depreciation at 31 March 2004	**0**	**12,208**	**94**	**0**	**53,249**	**633**	**9,701**	**8,713**	**84,598**
Net book value									
- Purchased at 1 April 2003	22,391	235,445	2,094	11,512	24,334	179	3,975	5,047	304,977
- Donated at 1 April 2003	1,207	15,626	188	299	6,399	33	103	493	24,348
Total at 31 March 2003	**23,598**	**251,071**	**2,282**	**11,811**	**30,733**	**212**	**4,078**	**5,540**	**329,325**
- Purchased at 31 March 2004	23,671	256,367	2,214	11,469	28,421	167	3,870	5,376	331,555
- Donated at 31 March 2004	1,275	16,669	205	9,322	6,027	28	39	466	34,031
Total at 31 March 2004	**24,946**	**273,036**	**2,419**	**20,791**	**34,448**	**195**	**3,909**	**5,842**	**365,586**

* Additions include £3m for equipment which was being held by several of the Trust's suppliers at 31 March 2004.
The Trust was unable to accept delivery before 31 March 2004, as site preparations were incomplete.
No assets were held at open market value at 31 March 2004.

During the period certain of the Trust's assets had a material change in the estimate of useful economic life/residual value. The financial effect of this change in estimate was £2,240k.

11.2 The net book value of land, buildings and dwellings at 31 March 2004 comprises:

		31 March 2003
	£000	£000
Freehold	300,401	276,951
TOTAL	**300,401**	276,951

12. Stocks and Work in Progress

		31 March 2003
	£000	£000
Raw materials and consumables	**8,872**	9,120
TOTAL	**8,872**	9,120

13. Debtors

		31 March 2003
	£000	£000
Amounts falling due within one year:		
NHS debtors	**12,610**	11,595
Provision for irrecoverable debts	**(642)**	(504)
Other prepayments and accrued income	**888**	1,227
Other debtors	**8,999**	8,179
	21,855	20,497
Amounts falling due after more than one year:		
NHS debtors	**246**	0
Other debtors	**1,488**	1,145
	1,734	1,145
TOTAL	**23,589**	21,642

14 Creditors

14.1 Creditors at the balance sheet date compromise:

		31 March 2003
	£000	£000
Amounts falling due within one year:		
NHS creditors	**5,781**	8,348
Non - NHS trade creditors - revenue - other	**9,294**	9,440
Non - NHS trade creditors - capital	**12,394**	7,273
Tax and social security costs	**207**	5,665
Other creditors	**3,596**	3,131
Accruals and deferred income	**10,944**	11,875
	42,216	45,732
Amounts falling due after more than one year:		
NHS creditors	**358**	679
	358	679
TOTAL	**42,574**	46,411

NHS creditors include;

-£657k (31 March 2003 £1,018k) for payments due in future years under arrangements to buy out the liability for three early retirements (31 March 2003, 3 early retirements) over 5 years; and

-£2,442k outstanding pensions contributions at 31 March 2004 (31 March 2003 £2,191k).

15. Provision for liabilities and charges

	Pensions relating to other staff	Legal Claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2003	1,111	135	0	**1,246**
Change in the discount rate	236	21	0	**257**
Arising during the year - Other	977	944	5,820	**7,741**
Utilised during the year	(117)	(170)	0	**(287)**
Reversed unused	(385)	(202)	0	**(587)**
Unwinding of discount	73	21	0	**94**
At 31 March 2004	1,895	749	5,820	**8,464**
Expected timing of cashflows:				
Within 1 year	124	749	5,820	**6,693**
1 - 5 years	529	0	0	**529**
Over 5 years	1,242	0	0	**1,242**

Pensions relating to other staff represents the liability relating to staff retiring before April 1995 (£824k) and Injury Benefit Liabilities (£1,071k).

Injury Benefits payable relate 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 inherent 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.

"Other" costs relate to costs likely to be incurred under the new Consultant Contract. These amounts are subject to agreement with individual Consultants. Negotiation on an individual basis on this matter is continuing.

Of the above total provision and related payments, some £1,016,549 has been covered by "back-to-back" income arrangements with the Trust's major Purchasers.

£18,928K is included in the provisions of the NHS Litigation Authority at 31 March 2004 in respect of clinical negligence liabilities of the Trust (31 March 2003, £17,788k).

16. Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve	Donated Asset reserve	Income and Expenditure reserve	**Total**
	£000	£000	£000	**£000**
At 1 April 2003	22,974	24,349	548	**47,871**
Transfer from the income and expenditure account	0	0	214	**214**
Fixed asset impairments	(6,927)	(13)	0	**(6,940)**
Surplus on other revaluations /indexation of fixed assets	26,891	1,846	0	**28,737**
Transfer of realised profits (losses) to the Income and Expenditure reserve	(30)	0	30	**0**
Receipt of donated/ government granted assets	0	9,676	0	**9,676**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/government granted assets	0	(1,801)	0	**(1,801)**
Other transfers between reserves	(1,923)	0	1,923	**0**
At 31 March 2004	**40,985**	**34,057**	**2,715**	**77,757**

17. Notes to the Cash Flow Statement

17.1 reconciliation of operating surplus to net cash flow from operating activities:

		2002/03
	£000	£000
Total operating surplus	**10,975**	16,460
Depreciation and amortisation charge	**20,144**	18,735
Fixed asset impairments and reversals	**1,563**	1,696
Transfer from donated asset reserve	**(1,801)**	(1,567)
Decrease / (increase) in stocks	**248**	(802)
(Increase) in debtors	**(2,208)**	(3,446)
(Decrease) / increase in creditors	**(7,109)**	1,487
Increase in provisions	**7,218**	135
Net cash inflow from operating activities	**29,030**	32,698

17.2 Reconciliation of net cash flow to movement in net debt:

		2002/03
	£000	£000
Increase in cash in the period	**880**	0
Change in net debt resulting from cashflows	**880**	0
Net debt at 1 April 2003	**551**	551
Net debt at 31 March 2004	**1,431**	551

17.3 Analysis of changes in net debt

	At 31 March 2004	Cash changes	At 1 April
	2004	in year	2003
	£000	£000	£000
OPG cash at bank	**1,266**	783	483
Commercial cash at bank and in hand	**165**	97	68
	1,431	**880**	**551**

18. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £10,053k (2002/03 £4,238k)

19. Post Balance Sheet Events

Foundation Trusts

During the financial year the Trust was involved in a process to gain Foundation Trust status. The Trust was licensed on 30th June 2004 to operate as a Foundation Trust with effect from 1st July 2004.

Vickers Corridor Replacement

The process to select a Private Finance Initiative partner to replace the Vickers Corridor wards at the Northern General Hospital with a new medical ward block is now complete.

The Trust has selected Kajima Europe as its partner organization to work on the £30m development. The project is scheduled to begin in Autumn 2004, and be complete within two years.

20. Contingencies

		2002/03
	£000	£000
Gross Value	**(533)**	(1,307)
Amounts recoverable	**0**	360
Net contingent liability	**(533)**	(947)

The net contingent liabilities relate to the possible future net costs of settling the outstanding claims made against the Trust

regarding employers liability and public liability over and above the amounts already provided for in note 15.

21. Movements in Government Funds

		2002/03
	£000	£000
Surplus for the financial year	**10,995**	16,910
Public dividend capital dividends	**(10,781)**	(16,819)
	214	91
Gains from revaluation/indexation of purchased fixed assets	**19,964**	21,840
New public dividend capital (cash receipt)	**7,998**	5,217
Public dividend capital repaid	**(2,217)**	(3,000)
Public dividend capital repayable	**0**	(2,199)
Net addition in government funds	**25,959**	21,949
Opening government funds	**289,016**	267,067
Closing government funds	**314,975**	289,016

22. Financial Performance Targets

22.1 Breakeven performance

The Trust's breakeven performance for 2003/2004 is as follows:

	2001/02	**2002/03**	**2003/04**
	£000	**£000**	**£000**
Turnover	401,885	449,119	500,883
Retained surplus for the year	2	91	214
Break-even in-year position	2	91	214
Break-even cumulative position	2	93	307
Materiality test:			
- Break-even in-year position	0.00%	0.02%	0.04%
- Break-even cumulative position	0.00%	0.02%	0.06%

22.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £10,781k, bears to the average relevant net assets* of £289,631k, that is 3.7%.

The variance from 3.5% is within the NHS Executive's materiality range of 3% - 4%.
Prior to 2003/04, the cost of capital rate was 6% of average relevant net assets. However, funding of NHS commissioners was changed at the time of change of the rate in such a way that the ability to meet the target was unaffected.

* The average relevant net assets calculation differs from 02/03 as no adjustment is made to the net relevant assets and associated creditors for government granted assets and loans and overdrafts.

22.3 External financing

The Trust is given an eEternal Financing Limit which it is permitted to undershoot.

			2002/03
	£000	**£000**	£000
External financing limit set by the Department of Health		**2,702**	1,726
Cash flow financing	3,660		5,747
Other capital receipts	(958)		(4,021)
External financing requirement		**2,702**	1,726
Undershoot (overshoot)		**0**	0

22.4 Capital Resource Limit

The Trust is given a Capital resource Limit which it is not permitted to overspend

		2002/03
	£000	£000
Gross capital expenditure*	36,378	21,930
Less: book value of assets disposed of	0	(80)
Less: donations	(9,676)	(1,979)
Charge against the CRL	**26,702**	19,871
Capital resource limit	26,770	19,927
Underspend against the CRL	**68**	56

* Gross capital expenditure includes £3m for equipment which was being held by several of the Trust's suppliers at 31 March 2004.

The Trust was unable to accept delivery before 31 March 2004, as site preparations were incomplete.

23 Related Party Transactions

Sheffield Teaching Hospitals NHS 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 anymaterial transactions with Sheffield Teaching Hospitals NHS Trust.

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

These entities are listed below:

	Income	Expenditure
	£ million	£ million
North Sheffield PCT	73.0	
Sheffield West PCT	54.0	
Sheffield South West PCT	56.0	
Sheffield South East PCT	84.0	
North Eastern Derbyshire PCT	28.8	
Barnsley PCT	28.8	
Rotherham PCT	25.0	
Doncaster Central PCT	24.0	
Bassetlaw PCT	9.9	
West Lincolnshire PCT	3.4	
Sheffield Children's Hospital	2.6	
North East Lincolnshire PCT	2.7	
Doncaster and Bassetlaw Hospitals	1.3	
Sheffield Care Trust	1.0	0.9
Barnsley District General Hospital	1.3	
Blood Transfusion Service		4.7
South Yorkshire Ambulance Service		3.2

Also received from the Department of Health and from the Trent and South Yorkshire Workforce Confederations in 2003/04 is £51.6m in respect of Education ,Training and Research Funding.

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 Sheffield City Council in respect of joint enterprises.

Of the Trust's total debtors of £23,589k at 31 March 2004, (note 13) £14.3m 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. £3.2m was receivable from the University of Sheffield at 31 March 2004 in respect of clinical and estates support services provided.

Professor C Welsh and Professor A P Weetman have clinical commitments at Thornbury and Claremont private hospitals, both of which are sited in Sheffield. In 2003/04 the Trust purchased healthcare from these two hospitals in the sum of £1.2m and £3.5m respectively.

Creditors falling due within one year of £42,574k (note 14) include £6,139k 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.

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in 2003/04 from this Charity amounted to £1.8m.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

24. Private Finance Transactions

24.1 PFI schemes deemed to be off-balance sheet

	£000	2002/03
		£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	0	0
Amortisation of PFI deferred asset	0	0
Net charge to operating expenses	**0**	0

The Trust is not commited to make any future payments

24.2 'Service' element of PFI schemes deemed to be on-balance sheet

	£000	2002/03
		£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-balance sheet	0	0
Amortisation of PFI deferred asset	0	0
Net charge to operating expenses	**0**	0

The Trust is not commited to make any future payments

25. Pooled Budget

The Trust participates in a pooled budget arrangement which aims to provide Rapid Assessment Clinics and Intermediate Care Liaison Nurses to patients of the Trust. This pooled budget allocation is in conjunction with other Health Organizations in Sheffield to promote effective intermediate care arrangements.

The Trust's share of this pooled budget in 2003/04 amounted to £171,400. £107,100 was used to fund the Rapid Assessment Clinics and £64,300 was used within the Rehabilitation and Resource Centre.

26. Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed limit. Sheffield Teaching Hospitals NHS Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk

7.4% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Sheffield Teaching Hospitals NHS Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

26.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate Weighted average interest rate	Fixed rate Weighted average period for which fixed	Non-interest bearing Weighted average term	
	£000	£000	£000	£000	%	Years	Years	
At 31 March 2004								
Sterling	1,430	1,306	0	124	0.0%	0	0	Note e
Other	246	0	246	0	3.5%	1	0	
Gross financial assets	**1,676**	**1,306**	**246**	**124**				
At 31 March 2003 (prior year)								
Sterling	551	507	0	44	0.0%	0	0	Note e
Other	0	0	0	0	0.0%	0	0	
Gross financial assets	**551**	**507**	**0**	**44**				

26.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate Weighted average interest rate	Fixed rate Weighted average period for which fixed	Non-interest bearing Weighted average term	
	£000	£000	£000	£000	%	Years	Years	
At 31 March 2004								
Sterling	0	0	0	0	0.0%	0	0	
Other	(280,097)	0	(8,822)	(271,275)	3.7%	1	0	Note f
Gross financial liabilities	**(280,097)**	**0**	**(8,822)**	**(271,275)**				
At 31 March 2003 (prior year)								
Sterling	0	0	0	0	0.0%	0	0	
Other	(266,173)	0	(679)	(265,494)	9.0%	1	0	Note f
Gross financial liabilities	**(266,173)**	**0**	**(679)**	**(265,494)**				

Foreign Currency Risk

The Trust has no/negligible foreign currency income or expenditure.

26.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2004.

	Book Value	Fair Value	Basis of fair valuation
	£000s	£000s	
Financial assets			
Cash	1,431	1,431	
Debtors over 1 year:			
-Agreements with commissioners to cover creditors and provisions	246	246	Note a
Total	1,677	1,677	
Financial liabilities			
Creditors over 1 year:			
-Early retirements	(358)	(358)	Note b
Provisions under contract	(8,464)	(8,464)	Note c
Public dividend capital*	(271,275)	(271,275)	Note d
Total	(280,097)	(280,097)	

a These debtors reflect agreements with commissioners to cover creditors over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with notes c and e, below, fair value is not significantly different from book value.

b Fair value is not significantly different from book value since interest at 9% is paid on early retirement creditors.

c Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 3.5% in real terms.

d This figure is the full value of PDC in the balance sheet and 'book value' equals 'fair value'.

e The Trust holds cash balances with its' commercial bankers - these are non interest bearing and have no fixed maturity date

f The Trust's non interest bearing financial liabilities comprise its' Public Dividend Capital, which is of an unlimited term.

27. Third Party Assets

The Trust held £12k cash at bank and in hand at 31/03/04 (£14k - Prior Year) 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.