Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2005/06

Present to Parliament pursuant to Schedule 1, paragraph 25 (4) of the Health and Social Care (Community Health and Standards) Act 2003

dr foster
Hospital of the Year

Welcome

Sheffield Teaching Hospitals NHS Trust came into existence in 2001 when the two pre-existing adult acute trusts in Sheffield merged.

We became an NHS Foundation Trust on 1st July 2004 as part of the first wave of hospital trusts to achieve this new status. The Trust now has greater freedom from central government, enabling us to set local health targets and invest more in patient care whilst still upholding the ethos of the NHS by providing healthcare free at the point of delivery.

The Trust manages the five adult NHS hospitals in Sheffield; the Northern General, Royal Hallamshire, Charles Clifford, Weston Park and Jessop Wing hospitals, which are situated on two campuses, one centrally located and the other in the north of the city. The Trust provides general hospital services to the people of Sheffield and more specialist services to a regional population of approximately 2.2 million people. Some of our clinical services are national or international centres of excellence.

Sheffield Teaching Hospitals employs more than 13,000 staff. Each year, more than 175,000 operations and day case procedures are performed and over 797,000 outpatient appointments are provided across the hospitals.

The Trust also has a strong commitment to teaching and research and is closely linked with the Universities of Sheffield and Sheffield Hallam.

1 Northern General Hospital
2 Royal Hallamshire Hospital
3 Weston Park Hospital
4 Charles Clifford Dental Hospital
5 Jessop Wing

Contents

During the year a Visitors' Code was introduced which includes new visiting times and infection control guidance.

Chairman's foreword

A challenging year that has tested us but produced very good outcomes

The last year has presented us with many new challenges which we have successfully tackled with vigour and determination. Financially, we have achieved balance for the 5th year in a row whilst treating more patients than ever before. We also became the Dr Foster "Hospital of the Year", demonstrating our commitment to providing high quality, patient-centred care. These are great achievements, which would not have been possible without the hard work and dedication of our staff and I would like personally to thank them all for their valuable contributions.

Many challenges lie ahead and the NHS faces some financial difficulties over the coming years. In order to further improve patient care and remain a successful organisation we need to become even more efficient and reduce our costs. We have introduced a three year programme of change – Adding Value - which will help us to build on our excellent track record.

We have experienced changes in our management team too. I would like to take this opportunity to wish Heather Tierney-Moore well in her new important role in Scotland and thank her for many years of dedication in taking the hospitals forward, most recently in her role as Chief Nurse. I am very pleased that Hilary Scholefield has joined us as the Trust's new Chief Nurse. Hilary has had an excellent career so far and is no stranger to our hospitals, having trained and worked at the Northern General Hospital for a number of years. We look forward to working with her.

David Baldwin has retired after nearly 42 years with the hospitals. David has worked in many roles from administration to Assistant Chief Executive of the Central Sheffield University Hospitals before becoming the Director of Legal and Corporate Services on the merger of the two trusts in 2001. On behalf of the Trust I would like to thank him for the lifetime of dedication he has shown the hospitals and wish him health and happiness for the future.

This annual report focuses on the ten priorities which we believe are key to providing the healthcare that the people of Sheffield and beyond need and want. Some of the excellent work carried out is highlighted in this report. It shows that our professional and enthusiastic staff are constantly making improvements and developing innovations to keep Sheffield at the forefront of modern healthcare.

Our services are going from strength to strength whilst still meeting the changing needs of patients. Amongst many other achievements, which are detailed in the operational review on pages 24-43, we introduced a new clinical management unit in the accident and emergency department that is already improving the transition of patients through the department.

We have been delighted to receive national recognition for our hard work: Ward Orderly Peggy Brownall was invited to Downing Street to meet Prime Minister Tony Blair to explain the work that goes on behind the scenes at our hospitals and >

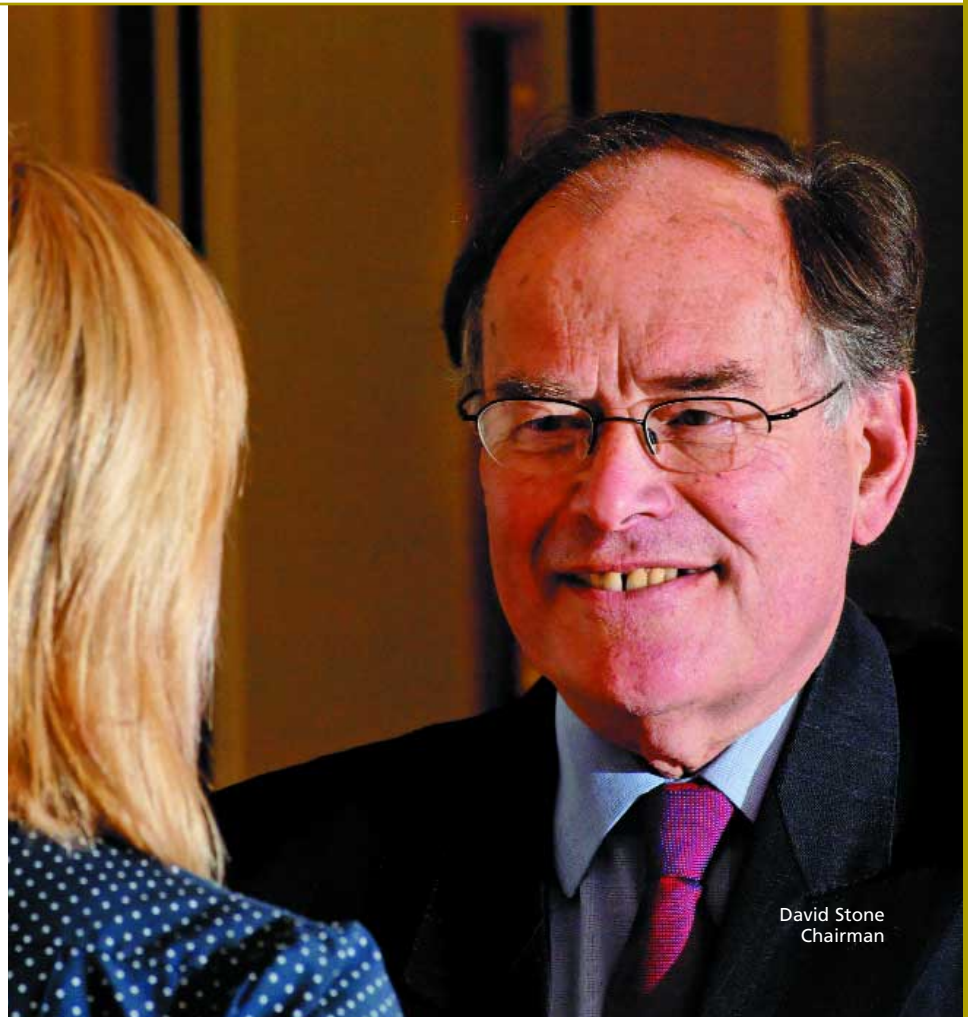
> Clinical Scientist Dr Peter Metherall was recognised for his achievements in helping to improve patient safety at the first ever National Chief Scientific Officer Awards. Many more staff have received the recognition they deserve for their work in healthcare and innovation. Well done to everybody.

Our Governors' Council, representing as they do our patients, staff, populations and partners, has developed its role significantly and is increasingly influencing the direction of Trust strategy. Trust membership has continued to grow and we are looking to increase membership further to enable more people to have a bigger say in the way their hospitals are run. We look forward to further strengthening these relationships and hope that our members will continue to be involved in the shaping of our services.

Over the coming year we will receive the outcome of the new Annual Health Check conducted by the Healthcare Commission, which replaces the star ratings system for 2005/06 and prepare for the introduction of developmental standards which will form part of this assessment from 2006/07 onwards.

I am confident that whilst we will certainly be put to the test, our dedicated staff at STH will ensure that our standards of care remain amongst the best in the country.

David Stone OBE
Chairman



David Stone
Chairman

Chief Executive's foreword

This year has been a year of success for Sheffield Teaching Hospitals NHS Foundation Trust which was named "Hospital of the Year"

It's been nearly two years since Sheffield Teaching Hospitals became one of the first NHS Foundation Trusts and we have already achieved great things under this new and exciting status. All of these achievements are directly attributable to our excellent members of staff, who have a pioneering spirit and eagerness to undertake new challenges whilst still ensuring safe and effective care.

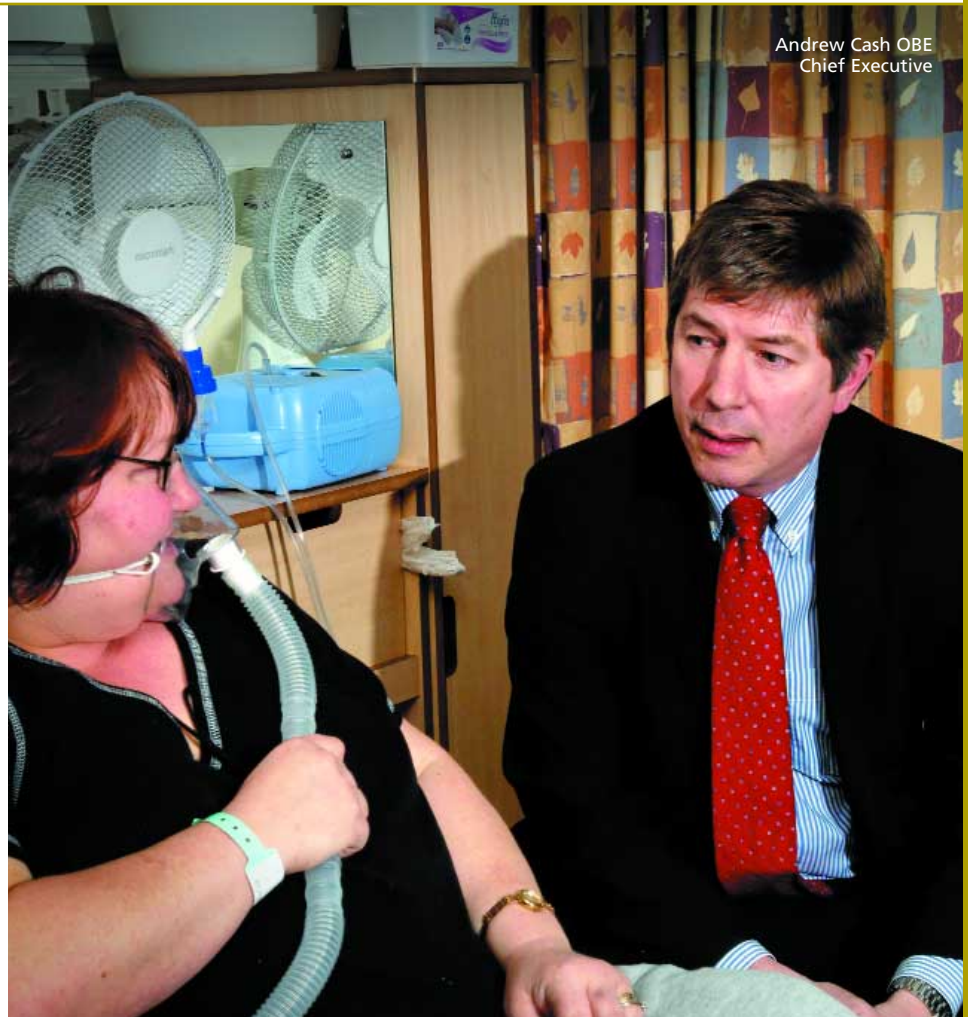
As referred to in the Chairman's foreword, this superb commitment to patient care was highlighted by the Dr Foster Hospital Guide, an independently produced guide to hospital services across the country sponsored by the government, which earlier this year awarded Sheffield Teaching Hospitals NHS Foundation Trust the prestigious title of "Hospital of the Year" for 2005/06.

The data in the hospital guide, which concentrates mainly on patient satisfaction and clinical outcome measures, shows high levels of performance across a wide range of clinical and non-clinical services. For example, we score very well in areas such as cardiac surgery, general surgery and orthopaedics. Similarly, our care for patients with long term conditions is amongst the best in the country with specialist nurse support and many developments to train patients to care for themselves at home. Importantly, the Dr Foster Independent Hospital Guide shows that patients feel they are treated with dignity and respect and rate our staff very highly.

This year we have expanded and improved services in urology, critical care and general surgery to name but a few. We have refurbished the breast screening unit so women are able to have their routine diagnostic tests carried out in a relaxing and comfortable environment. Our major developments; the Hadfield Wing, Chesterman Wing extension and renal service development are all coming along well and are close to completion.

Massive improvements have been made in waiting times. By the end of December 2005 all our inpatients and day case patients were being treated within six months and all new outpatient appointments took place within 13 weeks. People undergoing radiotherapy for cancer are being treated faster in Sheffield than almost anywhere else in the country and waiting times for bone mineral density tests have been reduced from six months to just 4-6 weeks. This shows huge improvements have been made in just one year. Behind the scenes, the introduction of a national Liquid Based Cytology pilot programme across Sheffield has seen waits for cervical smear test results reduced from a high of 40 days to just five days. Great strides have also been made in improving histology services and this includes for example speeding up the processing of biopsies for patients with suspected cancer.

A recent National Cancer Peer Review of the Trust's services has praised the high calibre of staff and the excellent delivery of cancer services, in particular in radiotherapy. In terms of waiting times for cancer >



Andrew Cash OBE
Chief Executive

> treatment; during the final quarter of 2005/2006 all patients urgently referred by their GP were seen within two weeks and the Trust achieved the target of 31 days from diagnosis to first definitive treatment for non-urgent referrals in all cancers.

In relation to the 62 day target – which states that 95% of patients referred urgently by their GP should have started their treatment within 62 days - the Trust ensured that 92% of patients were treated within the target time. This was one of the best results of any cancer centre in England, nevertheless falling slightly short of the national target.

We have also made great improvements in infection control; even so, we narrowly missed our target to reduce the number of patients with MRSA bacteraemia. We increased work to test patients for MRSA at their pre-operation assessments and screened over 11,000 patients throughout the year. We continued our intensive teaching programme with staff and students and maintained our campaign to highlight the importance of hand hygiene to visitors. Although we still reported 90 cases of the infection over 12 months – around eight more than anticipated - this is still a reduction of 12.6% from 2004/05 and we will endeavour to further reduce the number of patients acquiring the infection in the years to come. On both these issues there are significant challenges faced by Teaching Hospitals such as ourselves that need to be >

Chief Executive's foreword continued

This year has been a year of success for Sheffield Teaching Hospitals NHS Foundation Trust which was named "Hospital of the Year"

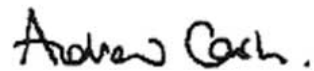
> acknowledged in treating patients with complex needs.

This year we reached the end of our first three-year strategic direction from 2002-2005 and we are now looking to meet the challenges of the next three years. The environment in which we function is changing; it will undoubtedly remain uncertain over the next few years and so our new three year strategy, which will be published in September 2006, is being drawn up to reflect these difficulties.

We have met all our financial duties. However, we have been faced with many new challenges through the introduction of the payment by results tariff system which awards a fixed national fee for each procedure or operation carried out, regardless of cost to the organisation. The uncertainty of our position and that of the NHS in a national context is also compounded by; the cost of reducing waiting times, the choice initiative and competition from other hospitals including the independent sector; NHS Pay Reforms such as Agenda for Change and the GP and consultant contracts; and the new emphasis on NHS care being delivered in the community. This, we anticipate, will leave us with financial shortfalls that we will need to address by becoming more productive and efficient. We will all be working together to achieve these savings and ensure we remain ahead of the game.

In order to accomplish this major challenge, we have implemented a new improvement programme – Adding Value - which we hope will enable us to improve efficiency and make savings of around £90million over three years; approximately five percent of our budget each year. The programme looks at a number of key areas where we can make best use of the resources available whilst continuing to maintain the quality of care we provide to patients in terms of the best possible clinical outcome, patient experience and value for money. Some of the steps we are taking include looking at ways to reduce the length of patient stays and reducing the amount we spend on agency staff.

Despite the challenges ahead of us I remain certain that we will continue to be one of the premier-performing NHS, academic and teaching centres in the UK.



Andrew Cash OBE
Chief Executive

Ward Orderly Peggy Brownall meets Prime Minister Tony Blair at 10 Downing Street in May. Peggy is to the left of the Prime Minister.

Board of Directors

The Board of Directors comprises the Chairman, six Non-Executive Directors and six Executive Directors. Non-Executive Directors have a majority on the Trust Board

The Non-Executives (including the Chairman) are not full-time employees of the Teaching Hospitals. They are people who live or work in the area and have shown a genuine interest in helping to improve the health of local people.

Chairman

David Stone OBE - Chairman
David Stone has been Chairman of the Board since the formation of Sheffield Teaching Hospitals in 2001. He was previously Chairman of Weston Park Hospital and Central Sheffield University Hospitals NHS Trusts. His professional career was in the steel industry and he has held posts in several Sheffield steel manufacturing companies including Managing Director of British Steel Engineering Steels and Stocksbridge Engineering Steels. Mr Stone was awarded the OBE in 1997.

Executive Directors

Andrew Cash OBE - Chief Executive
Andrew Cash was a graduate entrant to the NHS on the national management training scheme. In his earlier career he worked for the Nuffield Centre for Health Service Studies at the University of Leeds. He has been an NHS chief executive for 18 years and has worked at regional and national level. He is currently the chair of the national Foundation Trust Network. Mr Cash was awarded the OBE in 2001.

Heather Tierney-Moore OBE - Chief Nurse until December 2005
Heather Tierney-Moore originally trained as a nurse in Sheffield working at both the Royal Hallamshire and Northern General Hospitals. She has held previous posts in executive management and clinical services. Mrs Tierney-Moore was awarded the OBE in 2002.

Alison Smith – Acting Chief Nurse from December 2005 until March 2006
Alison trained as a nurse in West Sussex and specialised in renal nursing, contributing to the National Service Framework for renal services. Her substantive post is deputy Chief Nurse at the Trust working locally and nationally in a number of areas including Essence of Care standards and Infection Control.

Hilary Scholefield - Chief Nurse from March 2006
Hilary Scholefield joined the Trust on 6th March 2006 as Chief Nurse. Hilary began her nursing career at the Northern General Hospital, where she undertook her training and worked as Staff Nurse and then Sister in both the cardiothoracic and critical care areas.

Hilary previously held the post of Chief Nurse at the University Hospitals Coventry and Warwickshire NHS Trust. She chairs the National Association of UK University Hospitals Nurse Directors Group.

Chris Linacre - Director of Service Development
Chris Linacre joined the NHS in 1971 and has worked in hospital management and specialist personnel management wholly within Sheffield since that time. >

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> He has held posts as Director of Organisational Development at the Royal Hallamshire Hospital and General Manager of Lodge Moor and King Edward Hospitals prior to becoming Director of Corporate Strategy for the former Central Sheffield University Hospitals NHS Trust when it was formed in 1992.

Neil Priestley - Director of Finance
Neil Priestley previously held the post of Head of Finance at the NHS Executive Trent Regional Office. He had been seconded to the Northern General Hospital prior to the Trust merger where he was acting as Director of Finance. Mr Priestley is a Fellow of the Chartered Association of Certified Accountants.

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

Professor Chris Welsh - Medical Director
Professor Chris Welsh trained as a Vascular Surgeon and was appointed to a consultant post at the Northern General Hospital in 1984.
Before becoming Medical Director, Professor Welsh held the post of Regional Postgraduate Dean for the NHS Trent Region for six years.

Non-Executive Directors
Ony Bright
Onyema Bright had a background in Mental Health Nursing before becoming Project Manager for a management and professional training initiative for black and asian people. Ms Bright is also part of the ethnic programmes team at BBC Radio Sheffield where she presents a weekly show. She was formerly a Non-Executive director at the Central Sheffield University Hospitals NHS Trust.

John Donnelly
Before retiring, John Donnelly was a Chief Superintendent with South Yorkshire Police and Commander for the district that covers the Trust's hospitals. He joined the Police as a cadet in 1966 and, in time, headed up the Force's Research & Development, Community >

Board of Directors continued

The Board of Directors comprises the Chairman, six Non-Executive Directors and six Executive Directors. Non-Executive Directors have a majority on the Trust Board

> Relations, and Police Traffic Departments.

Vickie Ferres
Vickie Ferres is Director of Age Concern in Doncaster - a position held since 1983. During this time the organisation's annual turnover has grown from £20,000 to over £1.25 million. A Sheffield resident, Vickie has extensive experience in working with elderly people and understanding the health and social care issues that affect them. Mrs Ferres was formerly a Non-Executive Director at the Northern General Hospital NHS Trust.

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

John Stoddart CBE
Trust Vice Chairman John Stoddart has a background in higher education and was Vice Chancellor of Sheffield Hallam University until his retirement. He holds honorary degrees from both the University of Sheffield and Sheffield Hallam University. He is a Director of Sheffield Assay Office. Mr Stoddart was previously a Non-Executive Director at the Northern General Hospital NHS Trust. He was appointed a CBE in 1995 for services to higher education.

Professor Anthony Weetman
Professor Anthony Weetman is Dean of the Medical School at the University of Sheffield and is the appointed academic representative on the Trust Board. Professor Weetman is Professor of Medicine and an Honorary Consultant at the Trust with a special interest in thyroid disease and autoimmune endocrine disorders. He was formerly a Non-Executive Director with both Sheffield Health Authority and the Northern General Hospital NHS Trust.

The Non-Executive Directors' Terms of Office are for a set period and will finish as follows:

- 1st July 2006 John Donnelly and John Stoddart
- 1st July 2007 Vic Powell and Ony Bright
- 1st July 2009 Vickie Ferres and Anthony Weetman
- The Chairman's Term of Office will finish on 1st July 2007.

Recommendations for appointments are made by the Foundation Trust's Appointments Committee and approved by the Governors' Council. Remuneration for Non-Executive Directors (including the Chairman) is recommended by the Remuneration Committee and approved by the Governors' Council.

Remuneration of Executive Directors is carried out through the Trust Board's Remuneration Committee. Further details are given in the remuneration report on page 52.

Celebrating Foundation Trust status

In our first full financial year as a Foundation Trust, Sheffield Teaching Hospitals has faced and overcome many new challenges thanks to the support of everyday local people who have taken an active interest in the way their hospitals are run.

The Governors' Council is made up of 36 governors who have volunteered to represent the views of public, patients and staff who are members of the Foundation Trust. Six governors are elected to represent patients who have used the hospitals' services within the last five years; the public are represented by 12 governors; five staff groups each have their own governor; and there are also 13 representatives who act for the interests of our key partner organisations.

So far, the Governors' Council has proven to be a great success; meeting formally four times every year, the governors have had a great deal of input into specific projects and initiatives where their own particular experience or expertise has proved an invaluable resource to the Trust. They have a duty to represent the views of their constituency and are expected to actively seek the views of other Foundation Trust members and report back their opinions on key developments.

Other statutory duties of the Governors' Council include:

- Appointing Non-Executive Directors, including the Trust Chairman, via an Appointment Committee supported by an Independent Assessor
- Determining the remuneration of the Chair and Non-Executive Directors via a Remuneration Committee advised by the Director of Human Resources
- Approving the appointment or removal of the Trust's auditor following a recommendation from a nominated sub-group of the Board of Directors

Members of the Foundation Trust are invited to become involved in the hospitals by attending the Annual Health Fair. Each year, around 500 people attend the Health Fair, which incorporates the Annual General Meeting and provides members with information about their local hospital services as well as an opportunity to meet staff from across the hospitals who give advice on all sorts of health-related issues. Over the coming year, the Trust is also introducing other members' events including talks and lectures on popular health topics by our expert nurses and doctors.

Membership of the Foundation Trust is completely free of charge. To become a member, please contact our membership manager Jane Pellegrina on 0114 2714322.

Currently, membership of the Foundation Trust stands at:

Public Constituency: 1870 members

Patient Constituency: 3475 members

Staff Constituency: 12,823 members

Total membership: 18,168 members

Our Governors' Council

The Governors' Council is made up of everyday people who represent the interests of our patients, the public and our partner organisations.

Governors are elected to stand for office by members of the constituency they are interested in representing. Each election is held in accordance with the election rules as stated in the Foundation Trust Constitution, using an independent electoral service.

The first set of governors was elected in May 2004 when terms of office ranging from one to three years were allocated. Since then, there has been a subsequent election to find three patient governors and four public governors. In total, there were 24 candidates for these posts, the terms of which will run for three years.

Further elections being held in May 2006 will aim to fill 13 positions including five staff vacancies, five public vacancies and three patient vacancies. All Governors elected from May 2005 onwards will serve a three year term of office.

The Governors cover the following constituencies:

Public
This constituency currently has 1870 members and is represented by twelve Governors. The Public Constituency is divided into four areas which mirror the Primary Care Trusts in Sheffield: Sheffield North, Sheffield South West, Sheffield West and Sheffield South East, but is defined by electoral ward boundaries.

Public Membership is open to all members of the Sheffield public living within the electoral ward boundaries.

Public Members have an option to become Patient Members providing they have been a patient in the Trust in the period since 1998. There are currently 1889 public members.

Patient
Patient Members are those patients who live outside the Sheffield electoral ward boundaries and those within Sheffield who opt to be a patient rather than public member and have been patients of the Trust in the period since 1998. The patient constituency has seven representatives on the Governors' Council who currently represent 3,475 members.

Staff
The staff constituency is further broken down into five categories: medical & dental, nursing & midwifery, allied health professionals, scientists & technicians, managerial, administrative & clerical and ancillary, works & maintenance. Any member of staff employed on a Sheffield Teaching Hospitals contract is eligible to become a staff member of the Foundation Trust. There are currently 12,823 staff members of the Foundation Trust.

Representing our Communities
The Foundation Trust continues to strengthen the size and diversity of its membership through a number of key initiatives. The Trust is working with its Disability Steering Group and local disability charities to increase membership among disabled users and is also working >

> closely with the UK Youth Parliament and Voice and Influence Team of Sheffield Futures to encourage younger people to take an active interest in their local hospitals.

In the public constituencies black and minority ethnic representation has increased from 7.3% to 11%. The Trust is committed to further increasing the number of black and minority ethnic members and has formed links with the Black Community Forum in Sheffield - a community organisation representing 90 membership organisations from across the ethnic communities.

The Governors' Council as at the end of March 2006:

Patient Governors
Diana Chadwick
Susan Coldwell
John Holden
Kenneth Murta
Heather Gordon
Helen Wilde

Staff Governors
Mike Collins
Rose Bollands
Stephen Westby
Mark Hattersley
Dave Weston

Public Governors
North Sheffield
Chris Suddes
Sharon Tabberer
Margaret Whiteley

Sheffield South West
Sylvia Bennett
Philip Seager
Susan Wilson

Sheffield West
Martin Colclough
James Smith
Beryl Wilson

South East Sheffield
Richard Chapman
Hazel Hughes
Edwin Speight

Partner Organisations
Paul Schatzberger
North Sheffield Primary Care Trust

Nicholas Steele
Sheffield South West Primary Care Trust

Simon Gilby
Sheffield West Primary Care Trust

Lynne Young
South East Sheffield Primary Care Trust

Bob Kerslake/ Jan Wilson
Sheffield City Council

Alan Wittrick
South Yorkshire Strategic Health Authority

Chris Bentley
South Yorkshire Public Health Network

Diana Green
Sheffield Hallam University

Bob Boucher
University of Sheffield

Sylvia Yates
Sheffield First Partnership

Beryl Seaman
Voluntary Action Sheffield

Cathy Edwards
NORCOM (Commissioning Consortium)

Investing in buildings and equipment

Through our continued investment we are ensuring that Sheffield Teaching Hospitals continues to change and grow to offer first class patient services in a comforting environment.

The total capital expenditure for the year was £45.7 million, which was used to purchase new and replacement equipment, support initiatives to meet statutory compliance and improve waiting list and access, and a number of infrastructure improvements. We also introduced a number of new service developments associated with the Trust's Service Development Strategy. A breakdown of capital expenditure is shown here.

The Trust has entered into a Private Finance Initiative (PFI) agreement with an estimated capital value of £25.7million which will enable the construction of the Hadfield wing, a new medical ward block on the Northern General Hospital site. The full annual payment in relation to this scheme is £2.5m and the project has a length of 30 years.

Expenditure	£000	£000
Medical Equipment	**9,837**	
MRI Scanner (NGH)		1,415
Digital Imaging Equipment in A&E (NGH)		1,162
Replacement Linear Accelerator (WPH)		1,116
Multi-slice CT Scanner (RHH)		1,175
Multi-slice CT Scanner (NGH)		976
Other		3,993
Statutory Compliance	**3,545**	
Upgrade of Ward J2 to Firecode compliance (RHH)		2,027
Other Firecode Works		611
Bone and Tissue Bank		308
Other (eg Health & Safety, Disability Discrimination, Legionella etc)		599
Information Technology	**839**	
Theatre Computer System		228
Other		611
Infrastructure	**11,073**	
Basic Sciences Project (RHH)		4,781
Expansion of Electrical Capacity and Infrastructure (NGH)		3,910
Sterile Services Facilities (RHH)		200
Other		2,182
Service Development	**20,419**	
Cardiology Capacity Expansion (NGH)		8,262
Renal Facilities Expansion (NGH)		5,916

Expenditure	£000	£000
WPH Site Redevelopment		1,138
Stem Cell Research Facilities (JW)		1,130
Office Accommodation (NGH & RHH)		681
Dental Clinical Skills Facility (CCDH)		603
Critical Care Expansion (NGH)		598
Post Operative Surgical Unit (NGH)		535
Expansion Neurosciences Critical Care Capacity (RHH)		219
Relocation Patient Discharge Lounge (NGH)		155
Dental School Expansion (CCDH)		124
Post Operative Surgical Unit (RHH)		118
Car Parking (NGH/WPH)		68
Other smaller schemes		872
Total Expenditure	**45,713**	

Total capital income available to the Trust for the year was £55 million, including £7.1 million from donations and other contributions towards capital expenditure. The capital income is analysed as shown here.

Income	£000
Resources available from the Department of Health/Internally Generated	47,912
Sheffield University investment (largely in respect of Basic Sciences Project)	5,801
Other Donations/Contributions	1,331
Total Income	**55,044**

The new Cancer Information and Support Centre opened in April 2005.

Performance overview

During 2005-2006, the Trust reduced waiting times even further to new low levels whilst still managing to treat more patients than ever before.

There has been an increase in the number of patients undergoing inpatient and day case treatments and more patients are coming for outpatient appointments than ever before.

During the year, there was a period of sustained pressure due to a rise in emergency admissions to the hospital. Despite these pressures, the Trust still managed to meet its targets and reduce waiting times:

- No patients waited more than six months for inpatient or day case treatment
- No patients waited more than 13 weeks for an outpatient appointment
- The number of patients on our inpatient waiting list decreased by 3%
- 99% of patients with suspected cancer who were referred by their GP for an urgent appointment were seen within two weeks.

	Target 2005/06	Actual Activity 2005/06	Actual Activity 2004/05	% Actual Activity Increase
Inpatient and day case episodes	168,918	174,932	165,070	+6%
Outpatient attendances	773,475	797,295	766,586	+4%

During 2005/06 the number of patients attending for outpatient appointments increased by 4%, again this is an impressive achievement in the current challenging times in which we operate.

	Target	31 March 2006	31 March 2005	% Change between 2005 & 2006
Total inpatient waiting list	9477	11414	11727	-3%
Inpatients waiting 6 months & over	0	0	708	-100%
Outpatients waiting 13 weeks and over	0	0	703	-100%

The year at a glance

So much has happened over the last twelve months that it is difficult to mention even a few of our success stories. Here are some of the highlights.

- **April**
  The new Cancer Information and Support Centre opens to provide advice and information for patients diagnosed with cancer and Clinical scientists Dr Paul Bacon and Dr Ben Heller take first prize in the "Innovative Device or Technology" category of the prestigious Medipex Innovations Awards.

- **May**
  Ward Orderly Peggy Brownall is invited to meet Prime Minister Tony Blair at a 10 Downing Street reception and the Trust announced a further £1million investment in improving cleanliness.

- **June**
  The day nursery, which cares for employees' children, is commended by education watchdog OFSTED.

- **July**
  Staff in the gastroenterology department launch a campaign to raise awareness of coeliac disease.

- **August**
  Nurse Simon Palfreyman is awarded £90,000 by the Smith and Nephew Foundation to study the quality of life of patients with venous leg ulcers.

- **September**
  Laughter is the order of the day when local poet and TV personality Ian McMillan visits to host some poetry workshops to help patients find new ways of expressing their thoughts and feelings about their health.

- **October**
  Domestic assistant Janice Swords takes centre stage at the Trust's annual Thank You Awards after winning the prestigious Chief Executive's Award for Excellence.

- **November**
  Clinical Scientist Dr Peter Metherall is named as one of the top two healthcare scientists in England for innovation and development at the first ever Chief Scientific Officer awards.

- **December**
  Doctors at the Northern General hospital undertake a research project that could help improve the safety of some treatments given to patients at risk of having a stroke.

- **January 2006**
  A £2.2million refurbishment of the urology department to provide better consulting and examination facilities is officially opened.

- **February**
  A New Visitors' Code with infection control guidance for visitors and set visiting times is approved by the Trust Board.

- **March**
  Expanded renal services including a brand new, dedicated outpatient department are opened at the Northern General hospital.

Our staff

This year's annual report is based on our achievements in meeting 10 Key Aims: our top priorities which we know are important to the people we serve.

All of these priorities are underpinned by our ongoing commitment to improving the quality of care by providing the best training and medical education, and recruiting, developing and retaining the very best workforce that reflects the diverse community we serve. Without our staff, the Trust would not be able to provide the best in hospital care whilst leading the field in research and new treatments.

One way of ensuring our staff are happy and feel secure in their work is by making sure they are safe. The Trust has spent around £400,000 on improving security by adding extra closed circuit television cameras and increasing security patrols around the sites. Two personal safety training advisors have also been employed as part of the Trust's zero tolerance policy on abusive behaviour to teach 8000 frontline staff how to diffuse potentially aggressive situations before they escalate.

Over the last year, the Trust has made clear its intention to reduce incidents of verbal and physical abuse against staff. Reports of this behaviour have decreased year on year since the Trust first started collating and reporting the data to the Counter Fraud and Security Management Service (CFSMS) in 2003.

Work is continuing to reduce these assaults further and this year the Trust has used its policy on violence and aggression to protect staff and patients by excluding a deliberately and persistently violent patient from receiving treatment at the hospital. Other patients have been given warnings and asked to follow "contracts of care" - agreements between the hospital and the patient that spell out acceptable behaviour.

Director of Human Resources, John Watts, says, "These measures are important because they ensure our staff are able to carry out their jobs to the best of their ability and provide high quality care without feeling threatened. We always take into consideration a patient's condition or the medication they are taking which in a significant number of cases makes them confused, disorientated and more likely to lash out. However, there are a small number of people who are deliberately abusive and we take a hard line on the perpetrators of any such actions."

One of our core objectives is to continually improve the working lives of our staff and ensure they have access to policies that can help them to balance their home and work lives successfully. One such policy ensures that staff from all levels of the organisation can access training and personal development opportunities.

Anthony Brookes first began working at the Northern General hospital in 1992 as a porter with the Diagnostic Imaging Department and, although he enjoyed this role for nearly five years, working closely with the X-ray team had made Anthony realise that he wanted to develop a career in radiography. Through the support and training provided >

> by the Trust, he became a support worker with the department before undertaking training to secure a job as a radiography assistant in 2000.

Under a new four-tier system introduced to relieve recruitment problems in radiography across the country, Anthony became eligible to study for the post of assistant practitioner and was soon able to undertake limited radiography tasks such as taking some X-rays. His burning ambition to become a fully qualified radiographer led him to enrol at university where, with the support of his training manager, he is on the way to obtaining his ultimate goal. He said, "I was encouraged by my training manager to fulfil my desire to go on to become a fully qualified radiographer and have gained a place at Derby University. All this would not have been possible without all the support given to me by my departmental colleagues and the Trust's Improving Working Lives team."

Anthony, who has two young children, is continuing to juggle his home life with his role as a radiography assistant practitioner whilst studying at university for two or three half days a week, supported by the Diagnostic Imaging Department.

Trainee Radiographer Anthony Brookes.

Improving safety for our patients

The safety of our patients is also of great importance to us and much work is carried out behind the scenes to improve our services, reduce clinical risks and ensure patients receive the best possible care.

Staff in the pharmacy department have introduced a new system to improve communication between day duty and on-call staff and ensure that some patients are able to access their specialist medication in a timely manner.

To improve convenience for patients and ensure there is no break in their medicine-taking routine, the pharmacy department makes arrangements for certain patients with long term conditions, such as multiple sclerosis or those receiving dialysis, to receive certain specialised medicines via a home delivery service. If the patient is admitted to hospital, the hospital's pharmacy team will take delivery of the medicines on the patient's behalf so they can continue with the treatment whilst in hospital.

Previously, the absence of a separate logging facility for these types of medicines - which aren't usually supplied by the Trust and therefore don't automatically come under the Trust's rigorous medicines management system- meant that staff working out of normal hours weren't always aware of when the delivery was taken or where the medicines were stored, which could lead to a slight delay in the patient receiving their medication. A new system was introduced in July 2005 that ensures that medicines awaiting collection or delivery are logged and can be easily located by on-call staff at any time of the day or night to ensure the patient receives their medication on time.

The Trust has also been very involved in working to improve safety for patients and staff by reducing the risk of allergic reactions to latex.

Around six percent of the UK population are allergic to latex protein or the chemicals used to process natural rubber products and the allergic reactions they experience can be mild, moderate or severe and in rare cases may even cause fatalities. People who come into regular contact with latex can also become "sensitised" meaning that they develop an allergy to the product.

Clinical procurement specialist, David Newton, is one of the team leading the introduction of latex-free gloves. He said, "Each year we get through around 19 million latex gloves at the hospital, which means a lot of people with this allergy could potentially come into contact with latex during their work or treatment. To improve safety for patients and staff, particularly those who receive regular hospital care, we have recently introduced latex-free examination gloves across all of our hospitals."

An innovative approach thought up by a team of staff has improved patient safety and communications with general practitioners (GPs) by making the best use of existing hospital resources and without added cost to the Trust.

Previously, patients being discharged from hospital were given a discharge sheet on leaving hospital with important details of their stay and the >

> medication they were prescribed. However, an audit found that only 26% of patients remembered to inform their GP of their hospital stay and pass on the discharge sheet. To improve safety by ensuring GPs have the most up to date information on their patient's condition, a team from the Trust set about looking at ways to improve the communication between the hospitals and primary care services. A number of options were considered, including an expensive and complicated electronic system. However, the team used their knowledge and innovative thinking to make the best use of resources available.

Now, patients' discharge sheets are delivered on time to GP surgeries across the city by a team of "specimen drivers" - porters who already collect and deliver mail, samples and swabs from GP surgeries and clinics to the hospitals for testing. By utilising this well-established service, the team has relieved the burden on patients by ensuring that now over 80% of GPs are directly receiving their patients' discharge information in a timely manner.

The specimen drivers' service has helped improve communication with GPs.

Extra beds for our hospitals

This time last year, the Trust pledged to increase the number of hospital beds across the Trust.

With limited space for expansion, innovative ways of using existing facilities had to be found to ensure this development could take place; Ward J2 proved to be one of these new ways.

The ward, on J floor of the Royal Hallamshire hospital, had been turned into offices many years ago to accommodate clinical and administration & clerical staff. It was fully re-commissioned and opened on 2nd January with a total of 28 beds which are used for acute medical patients.

A distinct advantage of the new ward, which has been fully re-wired and updated with new security and patient call systems, is that it has been developed specifically to enable a flexibility of service like no other. The ward was opened as part of the Trust's winter planning to provide extra inpatient facilities when we know the service is under more demand. During the summer months, when there is a lull in demand for medical inpatient care, the ward will be used to "decant" other wards, to enable the Trust's infection control programme of wall washing to continue quickly and efficiently.

Providing "extra beds" isn't just about the physical space but the ability to better manage each patient's care to ensure they remain in hospital only as long as is necessary. It is well recognised that medical patients, particularly those with other conditions such as dementia, are likely to spend more time in hospital. A case management system has now been set up on some wards to address this issue and ensure patients are discharged from hospital in a timely manner. Over the last year the system has been implemented on eight wards which care for patients with stroke, dementia or older people with orthopaedic problems to help reduce the length of stay of some patients and free up beds for other patients.

Each ward has a team of staff working alongside a discharge liaison nurse, who co-ordinates each patient's care with other departments and outside agencies such as social services to ensure occupational therapy assessments are carried out and the correct care package is in place to support the patient once they return home or to residential care.

The case management programme has so far been very successful in reducing the average length of stay of patients on the stroke ward by around 15 days and has improved the flow of patients to the dedicated stroke unit so more patients are receiving specialist care on the ward much more quickly. This work has freed up hospital beds which can be used to care for patients undergoing elective care thus reduce waiting times for treatment.

Advances in medical technology have meant that many operations and procedures can now be carried out in a day case setting rather than requiring patients to stay overnight. Less than fifteen years ago, a person undergoing surgery to remove symptomatic gallstones would have spent around five days recovering in hospital.

These new developments have meant that most patients undergoing a day case procedure can return home the same day, improving their experience and reducing the need for a hospital bed thus freeing extra beds for other patients. Since the introduction of a day case laparoscopic cholecystectomy service at the Royal Hallamshire hospital in 2005, more than 30 patients have undergone keyhole surgery to remove their gallstones. One third of people needing their gallstones removed are eligible to undergo the procedure, which is much less invasive, more comfortable for the patient and also means that, in over 90% of cases, the patient is able to return home within 8-9 hours of coming to hospital.

A new environment for ward J2.

Reduced hospital infections

At Sheffield Teaching Hospitals, the control of infection is taken very seriously by staff in every occupation and at all levels of the organisation.

August 2005 also saw the first set of figures published by the Health Protection Agency showing rates of the bacterium Clostridium Difficile reported in patients over 65 across the country.

Clostridium difficile lives naturally in the gut of around 3% of healthy adults where it rarely causes problems. However, when certain antibiotics disturb the balance of 'normal' bacteria in the gut Clostridium difficile can cause illness. It can also be spread from person to person on the hands, and spores can contaminate the environment, such as beds and equipment, if not correctly cleaned.

In 2004 - the latest full year for which figures are available - 464 cases of C. difficile were reported at the Trust, giving a rate of 1.15 cases per 1000 bed days and ranking the Trust eighth best nationally compared to other specialist hospitals.

Cases of the condition have been successfully managed by introducing thorough hand hygiene and cleaning procedures as well as developing a strict policy for the prescription and use of antibiotics. Tim Gleeson, an antibiotic pharmacist, says, "Clostridium difficile does occur naturally in the gut of some people. When we use antibiotics, the balance of the bacteria (flora) in the gut can change which can lead to diarrhoea or severe inflammation of the bowel. One way we tackle this problem is to ensure that patients are only given antibiotics when absolutely necessary and for the shortest amount of time possible for their particular condition."

The last twelve months have seen new developments in infection control with the onus very much on involving and empowering staff at the frontline to tackle infection risks head on. This has helped us to reduce rates of Methicillin Resistant Staphylococcus Aureus (MRSA) infection by 12.6%.

Staphylococcus Aureus is a very common type of bacteria. In fact, it lives on the skin and in the nose of around a third of us without causing infection or doing any harm at all. Methicillin is a type of antibiotic that some Staphylococcus Aureus have become resistant to over time. If the bacteria are resistant it makes any infection they cause more difficult to treat (although MRSA can be treated with other antibiotics).

Many infections such as MRSA, which has been widely reported in the news, are spread through direct human contact and can affect people who are already very unwell such as people in hospital. In order to tackle these infections the Trust announced an extra investment of £1million to be used to improve cleanliness. We also introduced alcohol hand rub – which kills 99.9 percent of the most commonly found germs – to every ward entrance and hospital bedside across our hospitals and we are actively encouraging visitors and staff to use the hand rub before and after visiting patients to reduce the risk of cross infection. >

> Hospital head porter Graham Biggins became the first member of staff to volunteer as a local hand hygiene champion and inform colleagues of the importance of using correct hand-washing techniques and alcohol hand rub. Graham has been fully trained by infection control nurses to ensure he is able to demonstrate the correct hand cleaning techniques to colleagues across the hospitals.

Since then, around 100 members of staff have pledged to spread the word by becoming local hand hygiene champions in their areas. A ward accreditation scheme introduced in March 2006 has also been very successful with two wards already receiving a certificate for excellence in infection prevention and control.

Shorter waiting times

We recognise that being ill is a stressful experience, which is why we've worked hard to reduce the time people spend waiting for diagnostic tests and treatments.

Waiting times for cancer have always been a high priority for Sheffield and nationally there are a number of targets that need to be met to ensure that patients are receiving the best care.

In radiotherapy, which is used to treat some cancer patients, Sheffield has become one of the premier performing centres for providing this treatment in a timely manner. In January 2006, the government introduced a set of waiting time targets that state 95% of cancer patients referred urgently by GPs should be treated within 62 days of referral and 98% of all cancer patients should receive their first definitive treatment within 31 days of the decision to treat.

However, the Trust felt that these targets needed to be complemented by specific higher aims: to treat patients requiring curative treatment within 28 days, palliative patients within 14 days, and emergency patients within 48 hours. Over 90% of patients requiring radiotherapy are now treated within these time frames: some of the highest rates in the country.

Clinical Director for Radiation Services, Dr Peter Kirkbride, says, "Fundamental to this success has been visionary and sustained investment. Since 1999 we have undergone two expansions to the service and have increased the number of linear accelerators – the machines used to deliver radiotherapy - from four to seven as well as increasing CT and MRI facilities. However it is impossible to implement these changes without the support of all levels of staff."

An initiative within the metabolic bone centre has led to a dramatic reduction in waiting times for the measurement of bone mineral density, which is used to assess an individual's risk of sustaining a fracture. In June 2003 the metabolic bone centre moved into newly refurbished premises adjacent to the Sorby Wing. However, the move caused some disruption to the service and by January 2005 the wait for a routine bone scan had reached six months.

Clinical staff and the centre's management team worked together to map out the "patient pathway" to identify where a number of changes could be made. The results showed that many scanning appointments were wasted by patients cancelling at the last minute and that scanning times could be reduced if the correct support team was in place to help prepare patients for their scan.

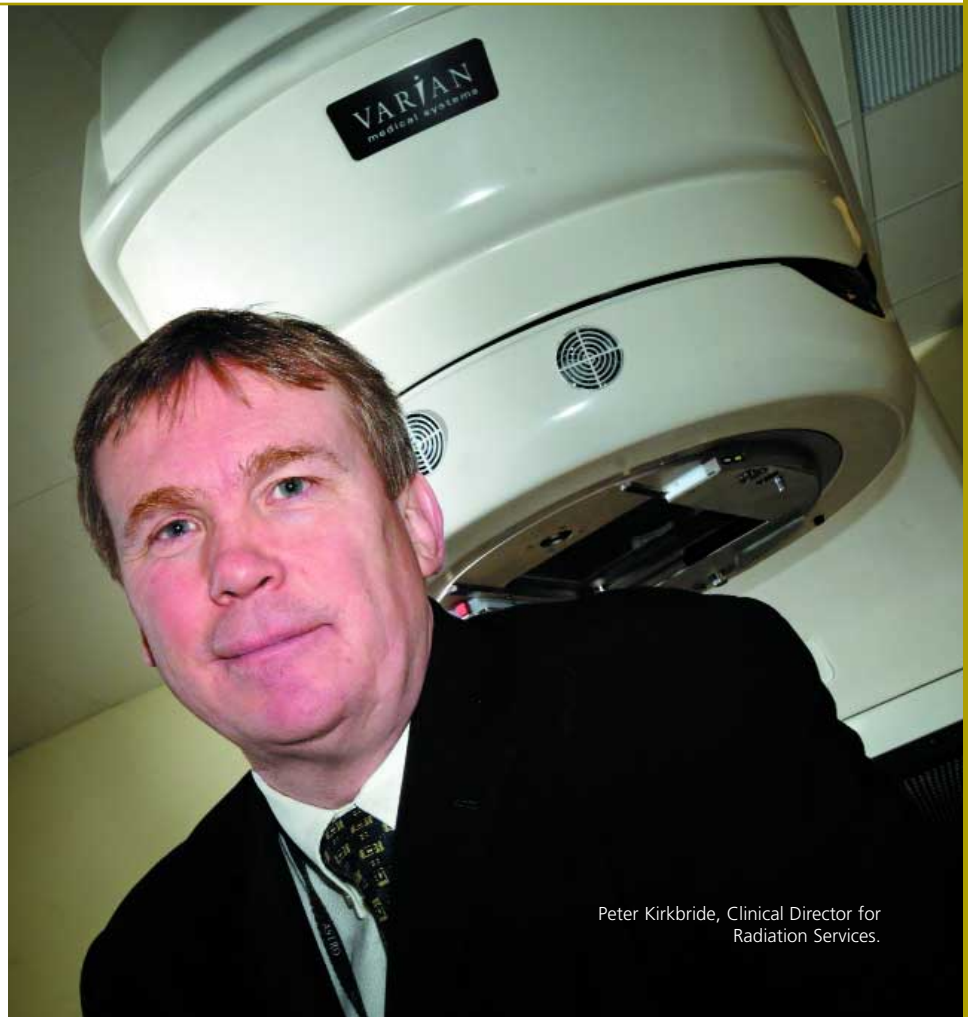
In May 2005 the team put these and other changes into practice by slightly increasing the hours worked by the support workers and appointing a clerk to prevent a backlog of reports as the scanning activity increased. Thanks to these changes and the hard work of staff in all areas of the department, waiting times by the end of September 2005 were at an all time low of just 4-6 weeks.

It isn't just waiting times for treatment that have been >

> reduced. In an effort to ensure patients waiting for hospital transport are made more comfortable and dealt with more efficiently and effectively during their appointment at the Charles Clifford Dental Hospital, an Ambulance Liaison desk and designated waiting area has been created.

This new feature, on the ground floor main reception area, has been specifically designed for use by patients and their escorts attending by hospital transport. On arrival the patient reports to the reception desk where a member of reception staff then informs the appropriate department. If necessary a nurse will be asked to come and escort the patient to the department for treatment. All transport patients are given a red card to enable them to be 'fast-tracked' though the various clinical procedures for example X-ray, to help make sure they are ready to be collected on time and minimize time spent in the waiting areas.

When their treatment has been completed the patient waits in comfort for their transport to arrive in a new waiting area, which has been specifically designed to provide a quiet rest area, away from draughts and the activity of the main waiting area. Reception staff are on hand to monitor patients during their wait and to provide blankets and hot drinks to keep patients warm.



Peter Kirkbride, Clinical Director for Radiation Services.

Investment in new buildings

Continued investment has improved services for patients in wards and departments as well as "behind the scenes".

The Trust's newly refurbished urology outpatient department at the Royal Hallamshire Hospital was official opened in January by Sheffield born actor Thomas Craig, who starred as Tommy Harris in the popular ITV soap Coronation Street.

The department underwent a £2.2 million refurbishment to provide more space for consulting and examination rooms as well as quiet rooms where patients can spend time with clinicians and counselling staff discussing their diagnosis. Deputy outpatient manager and refurbishment project lead Sue Beaumont said, "The refurbishment project has been a great success and has made a real difference for both staff and patients. Accommodation space has been increased by two thirds and as a result clinics have been improved with real benefit for our patients. The changes have also enhanced the working environment for our staff in terms of light and space, making the department a much brighter and happier place to work."

A £10.5 million development of renal services at the Northern General hospital is underway and will almost double the number of inpatient beds on the unit. The first phase of the work has already been completed and a brand new, dedicated outpatients building opened in March 2006.

The outpatients department provides a much improved environment, enabling patients to undergo their entire outpatient care in one dedicated centre. The new facilities have also increased the number of clinics that are held to cater for approximately 13,000 patients a year and have enabled special services such as anaemia clinics, peritoneal home dialysis training and counselling sessions to be held in a relaxing and comforting environment.

Further developments will improve inpatient facilities by providing a further 34 beds for renal patients and seven dialysis "stations" for patients undergoing kidney dialysis.

A little known yet vital service was reopened at the Northern General hospital in October after undergoing a full refurbishment. The new, state of the art facility was officially opened to enable surgeons from Sheffield – the biggest individual orthopaedic unit in the country – and other centres across the country to request donated bone for use in surgery.

Bone is actually the second most commonly transplanted tissue after blood and performs a vital role in many orthopaedic operations. Bone can be donated by patients undergoing orthopaedic operations - such as hip replacement - when a piece of their bone is removed which would otherwise go to waste. The bone bank holds stores of donated bone which is tested, prepared and deep frozen at a temperature of around minus 80°C in the special freezer units for use in future surgery such as hip replacement operations.

"Many people are aware of organ donation and are very supportive of it but very few people know much about donation of bone and the role it plays in thousands of operations carried out in hospitals each year," says Mr Bob Kerry, orthopaedic surgeon, "Sheffield surgeons helped pioneer the use of donated bone in joint replacement surgery and as one of the biggest specialised joint replacement centres nationwide, I think it is vital that we have a facility like this which is one of the best in the country."

Donated bone is stored at -80°C.

Improved cancer care

In Sheffield, we are constantly pioneering new ways of delivering cancer care that truly meet the physical, psychological and emotional needs of the patient.

Patients with colorectal cancer are very satisfied with the care they receive from the Trust's unique follow-up service which is provided by two colorectal nurse specialists.
A recent satisfaction survey showed more than 97% of patients think the service is "good", "very good" or "excellent". Nurse specialists Jill Dean and Viv Goodfellow provide a holistic service, including psychological support, to over 300 bowel cancer patients for five years after surgery. The team manage the patients' care, organising investigations and monitoring their progress with the support of colorectal cancer surgeons. They also work closely with the Cancer Support and Information Centre to help patients regain their confidence and cope with lifestyle changes.

Jill Dean says, "I think the service really works well because we are able to offer more than just the medical perspective. Colorectal cancer can have a huge impact on a person's life. Not just physically but emotionally and financially too. The service was set up to help ensure that patients undergoing surgery for colorectal cancer are able to access the information and support that they need to help them cope after surgery and we spend as much time as they need talking through the challenges they face."

Cancer detection and prevention are also a high priority and particularly so for breast cancer, which is one of the government's key targets. Last July, local MP Meg Munn joined staff and patients to officially unveil the newly refurbished breast screening unit at the Royal Hallamshire hospital.

In Sheffield around 16,000 women attend the unit each year for a mammogram – a form of x-ray for each breast. Around five percent of women are recalled for further tests and last year the unit found 67 invasive cancers and 25 pre-invasive cancers that may have otherwise gone undiscovered. This enabled the women involved to start potentially lifesaving treatment as quickly as possible.

The £135,000 makeover has enabled staff to screen an extra 4000 patients in the last year by providing larger scanning rooms, extra changing facilities and vital training and clerical space. The new development also boasts better disabled access and is housed in a non-clinical building away from the main hospital building, which helps women having a routine mammogram to feel less anxious about the test.

The unit has been named Marsden House in memory of a former breast cancer patient, Jayne Marsden, and to thank her husband and family for their tireless charitable work raising funds for the unit and also for Weston Park Hospital.

We are continually improving our services to make sure our patients receive high quality care in the best environment. Earlier this year, two services were introduced to reduce the time cancer patients wait for their chemotherapy treatment. Chemotherapy is the use of a combination of drugs to help treat many different types of cancer. >

> Around 700 patients a month who undergo their chemotherapy treatment as an outpatient are now able to start their treatment in a timely manner after the service was re-designed to reduce the time patients spend waiting for chemotherapy sessions to begin. Previously, patients would come to one appointment where they would be assessed and have their bloods and other tests carried out and a chemotherapy prescription written up which would then be delivered to the pharmacy department to be made up whilst the patient waited for as much as a few hours for the chemotherapy drugs to be ready.

To streamline the process and reduce the amount of time patients spend in hospital, the new pre-assessment service splits the patient's appointment over two days so that all tests can be carried out at the first part of the appointment and the chemotherapy prepared in readiness to be administered to the patient at the second part of the appointment, usually the following day. This eliminates the long wait for patients and means that around 85% of patients now receive their chemotherapy within 30 minutes of their appointment start time. An admission clinic has also been introduced for inpatients; they are now assessed before admission to hospital so that their chemotherapy can be made available for treatment avoiding an extra wait for the patient whilst in the hospital bed and reducing the demand on inpatient beds.

Local MP Meg Munn (left) with the breast screening team.

Fewer cancelled operations

The Trust's rate of cancelled operations is one of the lowest in the country but we are still striving to reduce this number even further.

In previous years, some planned operations have had to be cancelled because more emergency patients were brought in needing high dependency care leading to higher demand for critical care beds. Last year the Trust introduced a new Post-Operative Surgical Unit (POSU) providing seven dedicated high dependency beds for people undergoing planned surgery.

The POSU opened in August and is designed specifically for patients who are expected to need higher dependency care after their surgery. This is often when a patient needing relatively routine surgery also has an underlying health condition (such as breathing problems or diabetes) that means they will need extra care as part of their recovery, or their surgery involves a procedure where extra support is needed during recovery.

Staff from various occupations jointly designed the unit which caters solely for surgical patients who have been booked and screened for infection in advance therefore making the unit an MRSA-free facility.

A 36 bed theatre admissions unit which opened at the beginning of last year has also played a key role in providing more surgical procedures to patients and in reducing the number of operations that are cancelled due to emergency pressures on hospital beds. The ward enables patients to come in to hospital on the day of their operation rather than needing a hospital bed the night before. As part of the service, patients have all of their pre-operative tests carried out in advance of coming in for their surgery and simply need to come to the unit on the morning of their operation for final preparation. This saves the patient spending the traditional night in hospital before an operation, enabling them to remain in the comfort of their own home and, as a bed is not needed overnight, it also reduces the risk of surgery being cancelled due to pressure on beds from emergency cases.

Another initiative that has helped to reduce the number of cancelled operations is the Huntsman 3 project at the Northern General hospital site, which involved the refurbishment of a 34 bed orthopaedic ward and the introduction of nationally accredited methods of infection control.

Patients planned to undergo hip and knee replacement operations are screened for MRSA before admission and those without the bacterium can be treated on the ward. Patients who may test positive for MRSA, or who have previously had MRSA are admitted to another orthopaedic ward, where they can be cared for appropriately. The ward does not accept emergencies, non-orthopaedic or medical patients, which means patients having planned operations are guaranteed a bed for their recovery and best use is made of the time in theatre. This also helps to ensure that the ward is kept free from MRSA, and the very careful control of infection procedures ensures that there is a very >

> low incidence of all other forms of infection as well.

Since the ward opened in its new format in October 2005 the number of patients planned to be admitted who had to be cancelled has been reduced, and in the first three months 44% fewer patients had their operations cancelled. The Huntsman 3 project has also reduced the length of time patients spend in hospital and there has been a significant reduction in the cost of treating infections with antibiotics.

A new POSU has been planned for the Royal Hallamshire hospital, which will open in 2007 to provide 14 dedicated critical care beds for patients undergoing planned operations at the hospital.

Faster diagnostic tests

Ground-breaking diagnostic tests and new ways of working have been introduced to reduce the time patients spend waiting for a diagnosis.

The Trust has introduced an award winning service for early bowel cancer detection that can show results in as little as six hours without the need for major surgery. Using new advances in magnification and ultrasound not available anywhere else in the UK, endoscopists are able to diagnose, stage (detect how far a cancer has spread) and treat early colonic bowel cancers in one go under sedation and as a day case procedure, meaning patients can normally return home within six hours.

The service, developed by pioneering Consultant Endoscopist and Gastroenterologist, Paul Hurlstone, provides a one-stop shop enabling patients to receive fast, effective treatment for early colonic cancers. The technique is four times better at detecting cancers than traditional endoscopy and the service is so successful that 96% patients followed up after their treatments have no recurrence of cancer. Patients undergo a single colonoscopy procedure rather than diagnosis then a separate surgical procedure to remove any cancerous tissue, reducing anxieties and the possible risk of complications during surgery. Paul says, "It's fantastic that we are able to use modern technology such as this to detect and treat early colonic cancers which previously could only be treated by major abdominal surgery. It means that people are treated much quicker and more easily enabling them to get back and enjoy their lives as soon as possible, with the minimum intervention."

A new national project piloted in Sheffield last year has also shown vast improvements in diagnostic tests which will improve services for more than 2200 local women. Previously around 6% of cervical smear tests could not be read. Introducing the Liquid Based Cytology programme - which is a new way of taking and managing cervical smear tests - has ensured that 99% of smear tests can now be analysed first time without the patient needing to undergo a repeat test. The new system has also caused a dramatic reduction in the laboratory turnaround time for results which had been running at over 40 days, but is now down to less than five days so that women get the result of their screening test much more quickly than in the past.

The histology service plays a crucial role in providing an accurate and timely diagnosis for patients undergoing tests to find out if they have cancer. The department is responsible for reporting back the results of samples or biopsies to the consultant in charge of the patient's care.

Like many departments in the Trust the histology team were under pressure to meet the ever increasing numbers of samples and biopsies for processing and overcoming the mounting complexity of tests they perform whilst also increasing the speed at which they produce results. By July 2005, only 78% of samples and biopsies were being reported within two weeks – an unacceptable >

> wait for patients and one which didn't meet the high professional standards of the staff in the department.

Immediate action was taken to address the situation - department staff together with colleagues in cancer care and service improvement set about mapping the journey of a specimen through the department to see where improvements could be made. A business plan was then developed to ensure that the service would be able to speed up the processing of specimens and meet the new National Cancer Waiting Times coming into effect in December 2005.

With seven additional biomedical scientists, two support staff and five additional consultant pathologists, the department has already reduced the turnaround time for 95% of specimens to around 19 days. Further developments including a refurbishment of the laboratory and introduction of a state of the art tissue processor have been planned, which will ensure 95% of future specimens will be processed in a maximum of six days.

In 2005, the histology service processed over 40,000 cases - often made up of more than one specimen.

The new equipment can process a tissue sample in only two hours.

More convenient chronic disease care

Having an illness doesn't always mean that a patient needs to be in hospital. In a large number of cases people can receive more convenient treatment and care in the comfort of their own homes.

The neurology department based at the Royal Hallamshire Hospital has always been pro-active in its approach and delivery of care to people with chronic neurological conditions and over the last decade or so has developed sophisticated teams of nurse specialists, physiotherapists and occupational therapists who provide more convenient chronic disease care in the community.

Over the last year, a review of the Neurology Outreach Therapy Service (NOTS) has been carried out to examine the service from a wide range of perspectives. The review acknowledged the important role in the delivery of care that the NOTS service provides to over 1000 patients across South Yorkshire and the potential to deliver a specialist service in future which meets the needs and wishes of patients.

The re-designed service has since developed to include supporting the Multiple Sclerosis (MS) specialist nursing service in providing an MS nurse-led clinic to local patients in each of the district general hospitals alongside the consultant neurologists who already run neurology clinics locally, making it more convenient for some patients who in the past have had to travel long distances to reach the Royal Hallamshire Hospital.

Nationally, emphasis has been given to the importance of providing more hospital services in the community; an ideology supported by the Trust, which recently joined the city's South West Primary Care Trust to open an innovative community-based clinic for the care of patients with a common respiratory condition.

The clinic, which was opened in Nether Edge, provides a holistic approach to care for patients with Chronic Obstructive Pulmonary Disease (COPD) – a disease associated with smoking and industry which takes the lives of more than 1000 Sheffield people every year. As well as affecting the lungs directly, causing breathlessness and limiting activity, COPD often leads to weight loss, loss of muscle mass, and poor cardiovascular conditioning; bringing on a spiral of decline in health which can result in patients being admitted to hospital for significant periods of time.

The new service enables patients with more severe COPD, who are deemed to be at high risk of their health declining to the point of needing hospital care, to be looked after by a dedicated team in the community. This team provides advice and care for patients with the option to consult a chest physician from the Royal Hallamshire hospital for further specialist advice as required, particularly where more complicated cases are involved. The specialist also regularly assesses patients in the community and can arrange rapid access to emergency clinics in hospital when secondary care is appropriate.

As well as redesigning services to bring them up to speed with the ever-changing needs of patients, the Trust is also one of the first in the country to trial a pioneering project to >

> provide intravenous (IV) antibiotics in an outpatient setting for appropriate patients.

The Outpatient and Home Parenteral Antibiotic Treatment Project (OHPAT) is enabling earlier discharge of patients from hospital and started in January 2006 as a six month pilot project. The project is being run through the Department of Infection and Tropical Medicine and will treat patients requiring a short course of therapy for illnesses such as severe skin infections, or for appropriate patients with deeper infections such as brain infections requiring a longer period of treatment.
Patients requiring short term therapy have their antibiotics delivered by the OHPAT nurses, and their condition monitored daily. Patients requiring longer term therapy are offered the choice of antibiotics being delivered by community nurses or being trained to self-administer the antibiotics. In such cases, patients/carers undergo a rigorous training programme and are being assessed for competence. The IV self care is integrated into the patients care package and the team liaises with carers and other health professionals in the community as necessary.

It is hoped that the project will prove an important addition to health care delivery in Sheffield, enabling patients to go to work and live life normally whilst continuing their care with support from members of the team.

OHPAT nurse Kathryn Eaves talks a patient through their treatment.

Research and new treatments

Sheffield's hospitals are pioneers of research, and many new treatments and techniques are derived from the work carried out in the city's NHS organisations.

Since April, Sheffield has been the focal point for a new research project which could have a far reaching influence on the detection and treatment of early stage kidney disease across the nation. Two separate studies; The Kidney Evaluation and Awareness Programme for Sheffield (KEAPS) and the Kidney Evaluation of Obese Population of Sheffield (KEOPS) will look at the incidences of early kidney disease in the general population as well as groups of people at risk of the condition to ascertain how widespread kidney conditions are.

Renal consultant, Professor Meguid El-Nahas, says, "An ageing population and lifestyle factors such as smoking and high blood pressure as well as the type of diabetes brought on by being severely overweight have all contributed to an increase of around 10 percent of people being at risk of having kidney problems."

It is believed that the results of the research, which will test more than 1000 residents of Sheffield, will enable health care professionals to provide medical treatment at the earliest opportunity to prevent the progression of the disease and avoid the need for kidney dialysis treatment later in life for many people.

Another condition that requires early detection to aid successful treatment is cervical cancer, a devastating condition which kills around 1500 women each year. Although the NHS cervical screening programme has been very effective in reducing the number of cases diagnosed in the UK, doctors and medical engineers at the Trust have developed a pioneering new piece of equipment that will provide a more accurate, on-the-spot method of identifying abnormal cervical cells then the traditional "smear test".

Consultant Gynaecologist, Mr John Tidy, has been leading the development:

"Our aim was to develop a method of diagnosis that could provide doctors with accurate, on-the-spot results. This will cut the time between diagnosis and treatment and avoid causing women to worry, often unnecessarily, whilst they wait for results.

"The introduction of a probe instead of smear testing may prove beneficial in the future as it will reduce the costs of the national screening programme. We are also facing a national shortage of histopathologists so replacing smear tests could ensure that waiting times for test results are kept to a minimum."

The cervical probe has been so successful that the Trust has formed a partnership with Medipex, the NHS Innovation Hub that manages the commercial exploitation of good ideas on behalf of the NHS in Yorkshire & Humber. Medipex are raising finance to further evaluate the probe's potential and eventually hope to market the cervical probe to other healthcare providers across the UK and overseas.

A significant amount of the research carried out at the >

> Trust is funded through charitable donations and public fundraising. Some patients are so overwhelmed with the treatment they received that they even leave substantial legacies to the hospitals to enhance services for other patients. One such patient was Clifford Robertshaw who wanted to show his appreciation of the care he received for a brain tumour by leaving a legacy to the Sheffield Hospitals Charitable Trust, who manage and co-ordinate legacies and donations on behalf of the hospitals.

Cheryl Halder, Mr Robertshaw's daughter, said her father had really appreciated the care he had received. "He was very appreciative of the care he received throughout his illness. The care he got made him feel very special. I am pleased that his wishes will be carried out and that the money he has left will be used to help other patients either through research or equipment."

Mr Robertshaw, who was from Hoyland, Barnsley, left a substantial part of his estate – around £45,000 – which will be used to fund laboratory research looking at the genetic component of particular types of brain tumour; work by Mr Robertshaw's consultants, Mr David Jellinek and Dr David Levy, into the use of MRI scans to assess tumours and their suitability for surgery; and research into the needs of patients with brain tumours and their carers to help improve the service they receive.

Consultant gynaecologist John Tidy with the cervical probe.

Playing our part in the local community

As one of the largest organisations in Sheffield we have a responsibility to involve and enrich the communities we serve, which have some of the highest levels of deprivation and unemployment in the UK.

We have become a full partner in the regeneration of the region by participating in the Yorkshire and Humberside Regional Assembly's Employability Programme to help unemployed people back to work. Under this scheme, five people who were previously out of work completed the first 24 week accredited training programme that has enabled them to go into full, paid employment at the Trust.

Shaun Bent, one of the first trainees on the scheme, said: "I wanted to get back to work to show my kids that there are opportunities out there. I want to be a role model for them. The course is good and you have to put in the effort, but it is all worth it. I'm hoping to stay at the hospital now because it's a good place to work."

Young people play a significant role in our community and its future development. The Trust is keen to encourage the development of these young people to ensure the workforce of the future have access to experiences that will help them develop skills that will be beneficial to them in life and in work.

The Trust has also joined the Fir Vale Strategic Partnership Board which is committed to local regeneration of the area around the Northern General hospital; an area which has been identified as an area of high priority for change due to housing market failure and is the focus of regeneration investment activity. The partnership board is made up of major employers and public bodies in the area who provide a strategic steer for future regeneration proposals in areas such as housing, employment and social inclusion.

This year, the Trust launched a young people's volunteering project to reduce social isolation and provide people aged 16-24 years the chance to experience the many different opportunities available within the health service.

The Trust hopes to recruit around 300 young volunteers on an open access policy from a variety of backgrounds; unemployed people, people from black and minority ethnic communities and people with disabilities as well as those from socially excluded areas are all encouraged to join the scheme.

Young People's Volunteer Co-ordinator, Alan Smith says, "The project really has a dual purpose: youth volunteering is an excellent way to develop a potential future workforce for the NHS as well as enabling us to equip young people with both work and general life skills. However, we are also really committed to developing hospital services to incorporate young people's views and we'll be using this as an opportunity to see what they think of the hospital by launching a youth parliament."

Under the new scheme volunteers will be able to draw up a personal development plan and will have access to accredited training opportunities to make sure they gain the most benefit from their experiences.

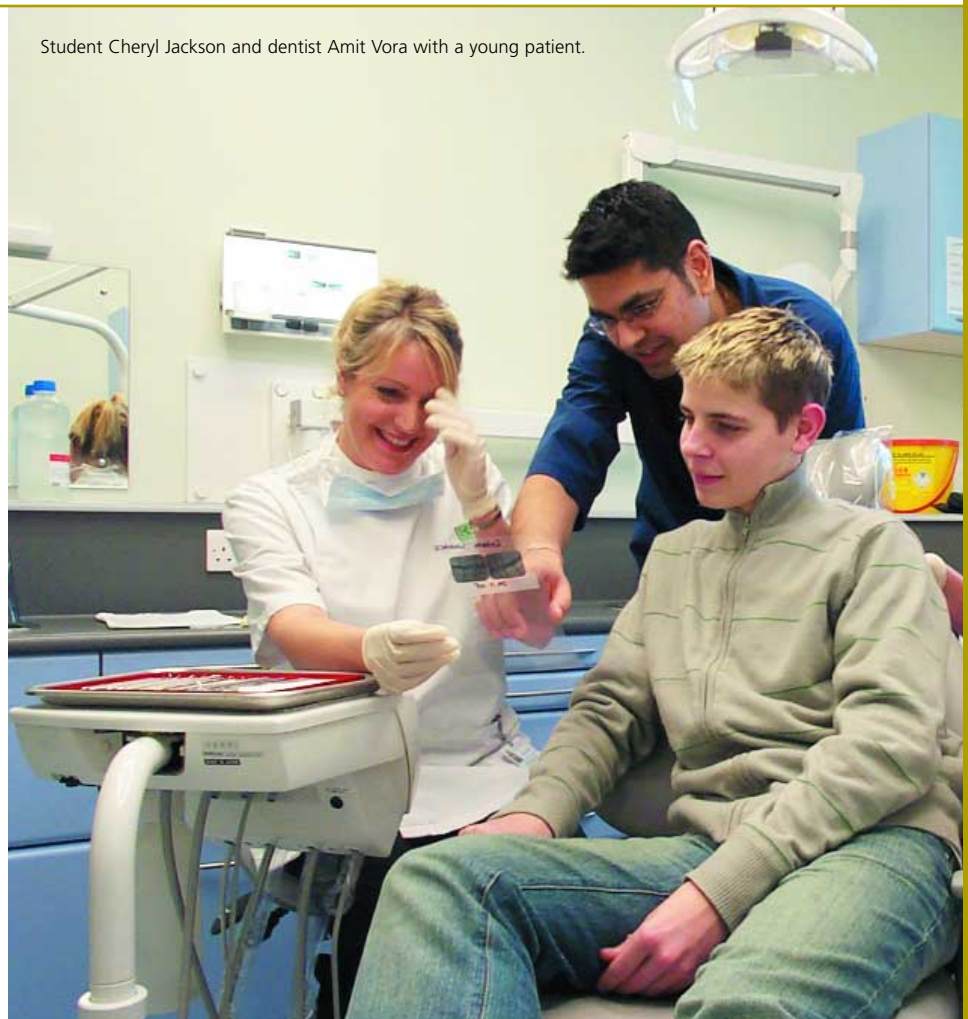
Playing our part in the >

> community also means ensuring a future workforce that is fully equipped to understand the health needs of people in the community as well as in a hospital setting. During their training, student dentists, hygienists and therapists at Charles Clifford now undertake several weeks of outreach work placements in community settings that enables them to develop their skills.

Unlike medical students, dental students routinely both diagnose and undertake full clinical procedures on patients during their training but previously their experience had centred on the work of the dental hospital. Now the dental school and salaried dental services in Sheffield, Mexborough, Rotherham and Chesterfield have jointly developed a successful programme of outreach placements that has increased confidence and competence in treatment planning as well as introducing students to a greater range of patients.

Professor Peter Robinson says, "Together with other developments, outreach has enabled the dental school to triple the number of hygiene and therapy students on the course and substantially increase the number of dental students we take in each year. However, it is not just about numbers; this will undoubtedly help to build a dental workforce better prepared to meet the needs of local communities."

Student Cheryl Jackson and dentist Amit Vora with a young patient.



Learning from our patients

We are focused on ensuring our hospital services are truly patient-centred to give the best possible experience at what we realise is often a difficult time.

The Trust is committed to addressing complaints raised by patients. During the year the Trust received 672 complaints of which 86% were resolved within our target of 20 working days. 43 requests for independent review were received this year from the Healthcare Commission and two were accepted.

We always try to learn from complaints and this year we have used these patient comments to make improvements including:

- Providing a mobile phone for the hearing services department so that patients who cannot use the telephone normally due to their hearing problems are able to send text messages to communicate with staff
- Carrying out communication skills workshops within the Obstetrics, Gynaecology, Neonatology and Urology Directorate. These workshops will initially be for midwives but could later be extended to include other grades and staff disciplines.
- Creating a Clinical Management Unit for the A&E department. This is a designated area where patients needing non urgent tests are assessed and monitored. We also now admit Bed Bureau patients directly to a Medical Assessment Unit rather than through A&E which has eased the pressure on the department.

The Trust also receives a great many compliments about the hospitals, our staff and services each year. Each hospital has been highlighted in emails, letters and telephone calls from grateful patients, many of whom have been treated by the Trust for many years and are pleased with the excellent standards of care they continue to receive to this day. Here are just a few of their comments:

"From entering the building (Northern General Hospital) to leaving I was treated with the utmost respect by everyone I encountered. The organisation was first class as was the cleanliness. My husband was also a patient. He was taken to A&E via ambulance and the attention he received from everyone was professional and very reassuring – an excellent place to be looked after." *Patient, Sheffield*

"I was a patient at Weston Park for many years and was then transferred for care at the Northern General Hospital's plastic surgery department. I always found that both hospitals and staff were very caring and could not do enough for me. Thank you all." *Patient, Sheffield*

"Although I was apprehensive before going into hospital for my operation I can honestly say I almost "enjoyed" the week I spent at the Royal Hallamshire Hospital. Everyone I was in contact with was so kind to me – nothing was too much trouble. They made what was on the face of it a very frightening experience into a bearable one. The overall care and accommodation was excellent, like a 5 star hotel with room service. Can I book in for a week of rest and recuperation after Christmas?!" *Patient, Sheffield*

Chemotherapy services have been re-designed following suggestions from patients.

Finance review

The Trust achieved a small Income and Expenditure (I&E) Account surplus of £602.5k in 2005/06 which equates to just under 0.1% of annual turnover of £611.6m.

This reflects a good balance between management of risk to achieve financial balance whilst maximising use of available resources. The 2005/06 financial year was again a very challenging one with key issues being:

- The general NHS financial environment.
- Income uncertainty arising from the relatively new Payment by Results funding system and disputed shortfalls on Education and Training contract values.
- Ongoing funding shortfalls on national pay reforms.
- Massive increases in energy prices.
- Major productivity and efficiency savings to be achieved.
- Particular financial difficulties in key specialties.
- Delivery of key service targets and quality standards.
- Uncertainties over potential impairment charges on new build capital schemes brought into use.
- Uncertainty over the implications of the new requirement to account for partially completed spells, i.e. inpatient episodes where discharge had not taken place at 31 March 2006.

In the event, the major out-turn issues were overspends of £2.7m and £3.3m respectively in the General Surgery and Orthopaedics Directorates and an overspend of £3.4m on energy and utilities. Income from patient services activity was £2.75m above the Trust's plan. Strong performance by a number of Directorates plus central contingencies and other one-off funding sources offset the pressures and enabled the small surplus to be achieved.

The Trust's capital investment in the year totalled a very sizeable £45.7m. Planning and other delays on a number of centrally funded schemes resulted in a £9.3m undershoot but these resources have been carried forward to 2006/07 to enable completion of the relevant schemes. The Trust's capital investments reflected a balance between the need to enhance the basic infrastructure of its buildings, equipment and IT whilst developing capacity to improve services for patients. More detailed information is provided elsewhere in the Annual Report. As always there were many competing demands and prioritisation of investments remains a key challenge for the organisation.

Cash balances were £22.1m at the year-end and the Trust had net current assets of £14.8m. However, in both cases the position will be much less favourable when the £9.3m of capital funding referred to above is utilised and provisions of £9.9m for Agenda for Change and Consultant Contract salary uplifts crystallise. However, the underlying working capital position has again shown a small improvement and presentationally the position is further improved by the recognition of an asset for partially completed spells.

At no stage during the year did the Trust need to borrow money, either for short term >

The Trust achieved a small Income and Expenditure (I&E) Account surplus of £602.5k in 2005/06 which equates to just under 0.1% of annual turnover of £611.6m.

> working capital purposes or for longer term investments. Clearly, therefore, the Trust was at all times compliant with the Prudential Borrowing Limit set by Monitor, the Foundation Trust Regulator. On Monitor's financial risk rating of 1 to 5, where 1 represents very high risk and 5 represents very low risk, the Trust was assessed as a 4 at the 2005/06 plan stage and at every quarter during the year.

Operational issues

The Trust's many achievements in terms of services provided during 2005/06 are recorded in detail elsewhere in the Annual Report. The Trust faces ever increasing requirements in terms of:

- Meeting healthcare targets, particularly in respect of reducing waiting times for treatment.
- Satisfying other critical demands for key patient services.
- Meeting NHS qualitative standards.
- Delivering other qualitative improvements to the patient experience.
- Meeting external regulatory standards.
- Achieving governance standards for Research and Development (R&D).
- Meeting accreditation standards for teaching.

All of this has to be achieved in the context of a complex NHS environment, particularly where policy initiatives such as patient choice and competition from new providers can appear to be at odds with financial pressures experienced by the Trust and its commissioners. Clearly, such requirements also have to be achieved within the resource constraints, whether they be financial, manpower or facilities, faced by the Trust.

In the main, the Trust was very successful in reconciling the many competing demands in 2005/06. However, for 2006/07 and beyond it is clear that these challenges will become even greater as the requirements are increased whilst baseline funding is reduced. This will require the Trust to be ever more innovative in improving services at the same time that it has to become more cost effective.

Looking ahead

There are many risks, challenges and opportunities facing the Trust in 2006/07 and beyond.

From a positive perspective the Trust continues to provide a good range of high quality secondary and tertiary services from good facilities, is a key provider of services for the people of Sheffield and North Trent and is likely to continue to grow as investment in faster access times and other service improvements continues.

The high level challenge for the Trust is to deliver the required ongoing patient service, teaching and R&D improvements within a very constrained financial position. The key factors causing this financial constraint are:

- Annual national efficiency requirements which for 2006/07 resulting in a 2.5% reduction to the Trust's income. >

Finance review continued

The Trust achieved a small Income and Expenditure (I&E) Account surplus of £602.5k in 2005/06 which equates to just under 0.1% of annual turnover of £611.6m.

- A moderate level of internal pressures and investments each year for which no external funding is received.
- Income losses arising from the transition from historic levels of funding for patient services to the tariff based funding system of "Payment by Results".

As a result of these issues the Trust has identified a need to deliver productivity and efficiency gains of £90m over the three years from 2006/07 to 2008/09 to offset these funding gaps. This equates to around 15% of current turnover over the three years.

There are many issues which may change over the next three years which could influence this assumed level of efficiency savings requirement. These include an expectation that developments to national tariffs will better reflect the complex treatments undertaken by Teaching Hospitals and that there will be changes to the Market Forces Factor, which reduces the Trust's tariff income by around 6% largely due to perceived lower labour costs despite there being national NHS payscales. However, there are just as many issues which could further damage the position. The Trust has, therefore, launched a three year productivity and efficiency programme to identify the £90m of gains which it is currently assumed will be required.

In terms of the key risks facing the Trust in trying to deliver the demands on it within the constrained financial position, the key issues are likely to be:

- The currently difficult overall NHS environment which will influence areas such as policy, tariff setting and commissioner funding flexibility.
- The specific financial pressures facing the Sheffield Primary Care Trusts which will influence their ability to afford required activity levels.
- Demand Management initiatives by PCTs which, if successful, could reduce the Trust's income whilst leaving it with limited ability to reduce fixed costs.
- Increasing competition from other NHS providers and new independent sector treatment centres.
- Additional unplanned costs arising from areas such as pay reform and escalating energy prices.
- Unsatisfactory development of national tariffs and inadequate annual uplifts to reflect true nationally driven NHS cost inflation.
- Inability within the Trust to deliver sufficient cultural change and capacity to achieve sizeable productivity and efficiency gains whilst continuing to improve services and maintain standards.
- A likely less favourable NHS funding settlement from 2008/09. >

- Potential changes to current funding systems for R&D and Education and Training which could again impact on the Trust's income.
- The ongoing process of medical advancement running ahead of NHS resources.

The Trust will continue to identify the key risks, challenges and opportunities it faces and to develop its business planning and governance processes to ensure that it is equipped to manage key issues and optimise its delivery of high quality and cost effective services. The Trust is clear that this can only be achieved with the full engagement of its entire staff and external partners as it will require innovative solutions to competing pressures in a great many areas.

Neil Priestley
Director of Finance
May 2006

Public interest disclosure

The Trust Board of Directors comprises the Chairman, six Non-Executive Directors and six Executive Directors.

The following interests have been declared by the Directors and the Board are satisfied that there are no conflicts of interest indicated by any external involvement. This disclosure is updated regularly and is available on our Internet site for public access at www.sth.nhs.uk.

Chairman

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

Non-Executive Directors

Mr J Stoddart	National Extension College Bolton Institute Guardian, Sheffield Assay Office
Ms O Bright	
Mr J Donnelly	Trustee, Sheffield Hospitals Charitable Trust Associate Investigator, Parliamentary and Health Service Ombudsman Lay Member of GMC Fitness to Practice Panel
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 Independent Assessor for CHAI
Mr V Powell	Governor, Sheffield College Member of FTFF Credit Committee
Professor A Weetman	University Representative Medical Advisor and Trustee, British Thyroid Foundation Private Medial Practice at Thornbury Hospital

Executive Directors

Mr A Cash	Chief Executive Visiting Professor University of York Health Services Development Unit Non Executive Director of Medilink (Yorkshire and Humber) Ltd Chair of Foundation Trust Network >

Mrs H Tierney-Moore	Chief Nurse (to 16 December 2005) Trustee, Cavendish Centre for Cancer Care, Sheffield
Ms A Smith	Acting Chief Nurse (17 December 2005 to 5 March 2006)
Ms H Scholefield	Chief Nurse (from 6 March 2006)
Mr CC Linacre	Director of Service Development Non Executive Director, Medipex Ltd
Professor C Welsh	Medical Director Private Medical Practice at Claremont Hospital Tutor, Medical Leadership Programme – Keele University Part Owner and Director of CL Welsh and Company Ltd
Mr N Priestley	Director of Finance
Mr J Watts	Director of Human Resources

1 Andrew Cash
2 Chris Linacre
3 Chris Welsh
4 Neil Priestley
5 John Watts
6 Hilary Scholefield

Remuneration report

The Pay and Remuneration Committee is a formally appointed committee of the Trust Board. Its terms of reference comply with the Secretary of State's "Code of Conduct and Accountability for NHS Boards".

The membership of the Committee comprises the Non-Executive Directors of the Trust Board, together with the Chairman.

The Directors of Finance and Human Resources, and the Chief Executive are in attendance at all meetings to advise the Committee and ensure that an appropriate record of proceedings is kept.

Remuneration of senior managers
In determining the Pay and Conditions of Employment for Senior Managers, the Committee takes account of National Pay Awards given to the Pay and Non-Pay Review staff groups, together with the "NHS Board Room Pay Report" findings for Executive Directors produced by Incomes Data Services Ltd.

Assessment of performance
All Executive and Non-Executive Directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1st April to the following 31st March. During the year regular reviews take place to discuss progress, and there is an end of year review to assess achievements and performance. The Executive Directors are assessed by the Chief Executive, following which there is a meeting between the Chairman and each of the Executive Directors to discuss their performance.

The Chairman undertakes the performance review of the Chief Executive and non-Executive Directors. Individual performance review is well established in the Trust, and is an integral part of developing the Executive and Non-Executive Directors' Personal Development Plan.

Performance pay
No element of the Executive and Non-Executive Directors' remuneration is performance related.

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

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

Chairman
Mr D.R. Stone
1st July 2007

Non-Executive Directors
Mrs O. Bright
1st July 2007

Mr J. Donnelly
1st July 2006

Ms V. Ferres
1st July 2009

Mr V.G.W. Powell
1st July 2007

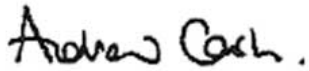
Mr J. Stoddart
1st July 2006

Professor A.P. Weetman
1st July 2009

Early termination liability
Depending on the circumstances of the early termination the Trust would, if the termination was due to redundancy, apply redundancy terms under Section 45 of the General Whitley Council Handbook or consider severance settlements in accordance with HSG94(18) and HSG95(25). In addition, there may be an entitlement to early retirement benefits under the provisions of the NHS (Compensation for Premature Retirement) Regulations 1981 if the dismissal is on grounds of redundancy and the individual is over 50 with at least 5 years' service in the Superannuation Scheme.

Other information
Please refer to the notes in the 05/06 Accounts contained in the Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Increases in Pension at age 60 during 05/06
- Value of the cash equivalent transfer value at the beginning of the year
- Increase in the cash equivalent transfer value during 05/06.



Andrew Cash OBE
Chief Executive
15 June 2006

1 John Donnelly
2 Ony Bright
3 Vic Powell
4 John Stoddart
5 Anthony Weetman
6 Vickie Ferres

Independent Auditor's Report

I have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2006 under the Health and Social Care (Community Health and Standards) Act 2003, which comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

This report is made solely to the Governors' Council of Sheffield Teaching Hospitals NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003. My work was undertaken so that I might state to the Governors' Council those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of Directors, the Accounting Officer and auditor

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

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Independent Regulator as being relevant to NHS Foundation Trusts.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of the Independent Regulator contained in the NHS Foundation Trust Financial Reporting Manual 2005/06. I report if it does not meet the requirements specified by the Independent Regulator or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises only the Chairman's Statement, the Chief Executive's Statement, >

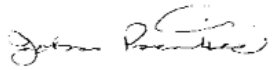
> Background Information, Operating and Financial Review, the sections on the Governors' Council, the Board of Directors, membership and public interest disclosures and the un-audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion
I conducted my audit in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and the Audit Code for NHS Foundation Trusts issued by the Independent Regulator, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board.
An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. 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 Foundation Trust as at 31 March 2006 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust.

Certificate
I certify that I have completed the audit of the accounts in accordance with the requirements of the Health and Social Care (Community Health and Standards) Act 2003 and the Audit Code for NHS Foundation Trusts issued by the Independent Regulator.



J G Prentice FCCA
Officer of the Audit Commission

19 June 2006

Littlemoor House
Littlemoor
Eckington
Sheffield S21 4EF

Statement of responsibilities

The Health and Social Care (Community Health and Standards) Act 2003 states that the Chief Executive is the accounting officer of the NHS Foundation Trust.

The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the Health and Social Care (Community Health and Standards) Act 2003, Monitor has directed the Sheffield Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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

Signed Andrew Cash.

Mr Andrew Cash OBE,
Chief Executive
15 June 2006

Foreword to the accounts

These accounts for the year ended 31 March 2006 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with schedule 1 paragraphs 24 and 25 of the Health and Social Care (Community Health and Standards) Act 2003 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed: Andrew Cash.

Mr Andrew Cash OBE, Chief Executive

15 June 2006

INCOME AND EXPENDITURE ACCOUNT FOR THE 12 MONTHS ENDED 31 MARCH 2006

	NOTE	2005/06 £000	9 Months to 31/3/05 (restated) £000
Income from activities	3	**505,482**	351,590
Other operating income	4	**106,090**	75,358
Operating expenses	5-7	**(599,324)**	(418,546)
OPERATING SURPLUS		**12,248**	8,402
Surplus on sale of fixed assets	8	**103**	23
SURPLUS BEFORE INTEREST		**12,351**	8,425
Interest receivable		**1,078**	627
Interest payable	9	**0**	(45)
Other finance costs - unwinding of discount		**(45)**	(69)
Other finance costs - change in discount rate on provisions		**(253)**	0
SURPLUS FOR THE YEAR / PERIOD		**13,131**	8,938
Public Dividend Capital dividends payable		**(12,529)**	(8,645)
RETAINED SURPLUS FOR THE YEAR / PERIOD		**602**	293

The notes on pages 57 to 95 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 MARCH 2006

	NOTE	£000	31 March 2005 (restated) £000
FIXED ASSETS			
Intangible assets	10	**798**	900
Tangible assets	11	**434,091**	416,019
Investments	12	**0**	0
		434,889	416,919
CURRENT ASSETS			
Stocks	13	**8,097**	8,931
Debtors	14	**34,791**	30,403
Investment	15	**0**	0
Cash	19.3	**22,055**	8,957
		64,943	48,291
CREDITORS: Amounts falling due within one year	16	**(50,151)**	(48,693)
NET CURRENT ASSETS / (LIABILITIES)		**14,792**	(402)
TOTAL ASSETS LESS CURRENT LIABILITIES		**449,681**	416,517
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(13,328)**	(6,829)
TOTAL ASSETS EMPLOYED		**436,353**	409,688

	NOTE	£000	31 March 2005 (restated) £000
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital	18.2	**305,119**	280,275
Revaluation reserve	18.3	**86,022**	90,082
Donated asset reserve	18.3	**40,208**	38,213
Government grant reserve	18.3	**0**	0
Income and expenditure reserve	18.3	**5,004**	1,118
TOTAL TAXPAYERS' EQUITY		**436,353**	409,688

Signed: Andrew Cash.

Mr Andrew Cash OBE
Chief Executive
15 June 2006

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE 12 MONTHS ENDED 31 MARCH 2006

	2005/06	9 Months to 31/3/05 (restated)
	£000	£000
Surplus for the year / period before dividend payments	**13,131**	8,938
Fixed asset impairment losses	**0**	(2,916)
Unrealised (loss) / surplus on fixed asset revaluations/indexation	**(3,186)**	22,394
Increases in the donated asset reserve due to receipt of donated assets	**6,864**	2,897
Reductions in the donated asset reserve due to depreciation, impairment, and / or disposal of donated assets	**(2,459)**	(2,333)
Total recognised gains for the year / period	**14,350**	28,980

The restated surplus for the nine month period incorporates a prior period adjustment of £192k in respect of the recognition of income due from partially completed patient spells. The accounting policy regarding income recognition is detailed in note 1.4 to the Accounts.

CASH FLOW STATEMENT FOR THE 12 MONTHS ENDED 31 MARCH 2006

	NOTE	2005/06 £000	9 Months to 31/3/05 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	19.1	**39,899**	24,696
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**1,048**	630
Interest paid		**0**	(45)
Net cash inflow from returns on investments and servicing of finance		**1,048**	585
CAPITAL EXPENDITURE			
(Payments) to acquire tangible assets		**(46,595)**	(23,056)
Receipts from sale of Tangible Fixed Assets		**149**	23
(Payments) to acquire intangible assets		**(144)**	(530)
Net cash (outflow) from capital expenditure		**(46,590)**	(23,563)
DIVIDENDS PAID		**(12,529)**	(11,526)
Net cash (outflow) before management of liquid resources and financing		**(18,172)**	(9,808)

MANAGEMENT OF LIQUID RESOURCES

	2005/06 £000	9 Months to 31/3/05 £000
(Purchase) of current asset investments	**(180,000)**	(75,000)
Sale of current asset investments	**180,000**	75,000
Net cash flow from management of liquid resources	**0**	0
Net cash (outflow) before financing	**(18,172)**	(9,808)
FINANCING		
Public dividend capital received	**24,844**	9,000
Other capital receipts	**6,426**	2,438
Net cash inflow from financing	**31,270**	11,438
Increase in cash	**13,098**	1,630

Notes to the accounts

Accounting Policies for the Year Ending 31st March 2006

1 Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2005/06 NHS Foundation Trust Financial Reporting Manual issued by Monitor, the body responsible for overseeing Foundation Trust activities. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting period.
The Trust achieved Foundation Status on 1st July 2004. The comparative figures are therefore presented on a 9 month basis i.e. 1 July 2004 to 31 March 2005.

1.2 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 Foundation Trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

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

a) the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;
b) if a termination, the former activities have ceased permanently;
c) the sale or termination has a material effect on the nature and focus of the reporting Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the Trust's continuing operations;
d) the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes;

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

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

1.4 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.

The Trust has amended its accounting policy on income recognition where the provision of a healthcare service has commenced before the Year End. For these partially completed

patient spells, the income relating to the patient activity is accrued. The accrued income is calculated based on the number of days of incomplete spells accrued at an average tariff for that type of procedure. The change in accounting policy has resulted in a prior period adjustment to the NHS Foundation Trust's 2004/05 accounts, and an income accrual in the current year. The change of accounting treatment is in accordance with FRS 5 and UITF 40.

The NHS Foundation Trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology from 2004/05. To manage the financial impact of this change on the NHS Foundation Trust and on its commissioners the Department of Health has implemented transitional gain and clawback arrangements. These are on a sliding scale, as the change is phased in over the four year period to 2008/09. Under these arrangements the Trust received income protection of £6,908,000 from the Department of Health during 2005/06.

1.5 Intangible fixed assets

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

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

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence 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 and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they 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 of a new building, ward or unit irrespective of their individual or collective cost
- Digital Hearing Aids were capitalised in accordance with the direction of the Secretary of State in 2003-04 and the first quarter of 2004-05, and will be written down over 5 years.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value periodically. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

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

out. Professional valuations are carried out by the Valuation Office. The valuations are carried out in accordance with the Royal Institution 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 2004 as at the prospective valuation date of 1 April 2005 and were applied on 31 March 2005.

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 once they have been taken out of operational use and subsequently disposed of.

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

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

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value from the Gross Domestic Product 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 Foundation Trust, respectively.

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

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

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

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

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

1.8 Government Grants
Government grants are grants from Government bodies other than income from primary care trusts or NHS Foundation Trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants. Where the Government grant is used to fund revenue, expenditure it is taken to the Income and Expenditure Account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the Income and Expenditure Account over the life of the asset on a basis consistent with the depreciation charge for the asset.

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

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

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

1.10 Stocks
Stocks 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.

1.11 Research and Development
Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - its resulting in a product or service which will eventually be brought into use;
  - adequate resources exist to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Income and Expenditure Account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost.

The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Foundation 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 material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

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

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2005/06 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 the 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 the year to 31 March 2006 was £35,353k (nine months to 31 March 2005, £24,849k). Employers pension cost contributions are charged to operating expenses as and when they are incurred.

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

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. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

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 26 to the accounts.

1.18 Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 Public Dividend Capital (PDC) and PDC Dividend
Public Dividend Capital represents the outstanding public debt of an NHS Foundation Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Foundation Trust.

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

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

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

3. Income

3.1 Income from Activities	2005/06 £000	9 Months to 31/3/05 £000
Elective income	**121,901**	85,287
Non Elective income	**155,292**	104,673
Outpatient income	**81,250**	56,722
Other types of activity income	**117,860**	82,184
A&E Income	**9,804**	6,682
PBR transitional relief	**16,114**	13,677
Private Patient Income	**3,261**	2,365
TOTAL	**505,482**	351,590

3.2 Private patient income:	2005/06 £000	Base year (2002-03) £000
Private Patient Income	**3,261**	2,774
Total patient related income	**505,482**	367,782
Proportion (as percentage)	**0.65%**	0.75%

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

3.3 Income from Activities	2005/06 £000	9 Months to 31/3/05 £000
Primary Care Trusts	**473,468**	344,653
Local Authorities	**216**	387
Department of Health	**25,533**	2,225
NHS Other	**1,096**	597
Non NHS: Private patients	**2,319**	2,230
Non NHS: Overseas patients (non reciprocal)	**942**	135
Road Traffic Act	**1,840**	1,321
Non NHS: Other	**68**	42
TOTAL	**505,482**	351,590

4. Other Operating Income

	2005/06 £000	9 Months to 31/3/05 £000
Research and Development	**7,764**	5,633
Education and Training	**52,044**	36,178
Transfers from the donated asset reserve in respect of depreciation, impairment, disposal of donated asset	**2,459**	1,502
Transfers from the government grant reserve in respect of depreciation, impairment and disposal of government grant financed assets	**0**	831
Non patient care services to other bodies	**33,487**	22,608
Other	**10,336**	8,606
TOTAL	**106,090**	75,358

5. Operating Expenses

5.1 Operating expenses comprise:	2005/06 Total	9 Months to 31/3/05
	£000	£000
Services from other NHS Foundation Trusts	**2,417**	556
Services from other NHS Trusts	**6,016**	5,655
Services from other NHS bodies	**5,266**	4,728
Purchase of healthcare from non NHS bodies	**5,029**	4,988
Directors' costs	**1,209**	717
Staff costs	**396,021**	274,979
Drugs costs	**50,294**	34,440
Supplies and services - clinical	**60,700**	42,760
Supplies and services - general	**7,193**	5,176
Establishment	**7,094**	4,837
Transport	**683**	454
Premises	**19,476**	12,201
Bad debts	**840**	180
Depreciation and amortisation	**23,145**	16,178
Fixed asset impairments and reversals	**1,346**	2,096
Audit fees	**115**	137
Other auditor's remuneration	**20**	0
Clinical negligence	**5,819**	3,836
Other	**6,641**	4,628
TOTAL	**599,324**	418,546

5.2 Operating leases

5.2/1 Operating expenses include:	**2005/06**	9 Months to 31/3/05
	£000	£000
Other operating lease rentals	**1,728**	1,218
	1,728	1,218

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

	2005/06	**2005/06**	9 Months to 31/3/05	9 Months to 31/3/05
	Land and buildings	**Other leases**	Land and buildings	Other leases
	£000	**£000**	£000	£000
Operating leases which expire:				
Within 1 year	**0**	**276**	2	318
Between 1 and 5 years	**236**	**724**	0	651
After 5 years	**157**	**247**	264	312
	393	**1,247**	266	1,281

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	To 31 March 2006		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mr A J Cash, Chief Executive	185-190	-	-
Mr J Watts, Director of Human Resources	110-115	-	-
Mr N Priestley, Director of Finance	130-135	-	-
Mrs H Tierney - Moore, Chief Nurse (Left 1 January 2006)	85-90	-	-
Miss A Smith, Acting Chief Nurse (28 November 2005 - 5 March 2006)	25-30	-	-
Mrs H Scholefield, Chief Nurse (Commenced 1 February 2006)	15-20	-	-
Mr C Welsh, Medical Director	145-150	-	-
Mr C C Linacre, Director of Service Development	115-120	-	-
Mr J P Donnelly, Non-Executive Director	15-20	-	-
Ms V R Ferres, Non Executive Director	15-20	-	-
Mr V G W Powell, Non Executive Director	15-20	-	-
Mr J M Stoddart, Non Executive Director	15-20	-	-
Professor A P Weetman, Non Executive Director	15-20	-	-
Ms O V Bright, Non Executive Director	15-20	-	-
Mr D Stone, Chairman	55-60	-	-

5.3 Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500)	Total accrued pension and related lump sum at age 60 at 31 March 2005 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2006	Cash Equivalent Transfer Value at 31 March 2005	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
	£000	£000	£000	£000	£000	To nearest £100
Mr A J Cash	47.5 - 50	260 - 265	1,022	789	150	25,900
Mr J Watts	12.5 - 15	190 - 195	814	718	55	15,800
Mr N Priestley	32.5 - 35	140 - 145	467	340	83	18,200
Mrs H Tierney - Moore, Chief Nurse (Left 1 January 2006)	10 - 12.5	135 - 140	463	403	26	11,900
Miss A Smith, Acting Chief Nurse (28 November 2005 - 5 March 2006)	10 - 12.5	80 - 85	252	203	8	3,500
Mrs H Scholefield, Chief Nurse (Commenced 1 February 2006)	0 - 2.5	125 - 30	391	344	4	2,600
Mr C Welsh	27.5 - 30	235 - 240	1,086	917	102	20,300
Mr C C Linacre	15 - 17.5	205 - 210	917	809	62	16,700

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

6. Staff costs and numbers

6.1 Staff costs

	2005/06 Total	2005/06 Permanently Employed	2005/06 Other	9 Months to 31/3/05 Total	9 Months to 31/3/05 Permanently Employed	9 Months to 31/3/05 Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**331,258**	325,877	5,381	227,534	223,166	4,368
Social Security Costs	**23,716**	23,716	0	17,442	17,442	0
Employer contributions to NHSPA	**35,354**	35,354	0	24,849	24,849	0
Other pension costs	**(81)**	(81)	0	(130)	(130)	0
Agency/contract staff	**6,804**	0	6,804	5,952	0	5,952
	397,051	**384,866**	**12,185**	275,647	265,327	10,320

In addition to the above, £929k (9 months to 31.3.2005, £574k) is included in the cost of fixed asset additions (note 11.1) in respect of capitalised salary costs.

6.2 Average number of persons employed

	2005/06 Total	2005/06 Permanently Employed	2005/06 Other	9 Months to 31/3/05 Total	9 Months to 31/3/05 Permanently Employed	9 Months to 31/3/05 Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**1,325**	1,273	52	1,263	1,215	48
Administration and estates	**2,433**	2,310	123	2,301	2,198	103
Healthcare assistants and other support staff	**1,308**	1,308	0	1,209	1,209	0
Nursing, midwifery and health visiting staff	**4,815**	4,426	389	4,615	4,274	341
Scientific, therapeutic and technical staff	**1,873**	1,853	20	1,825	1,800	25
Total	**11,754**	**11,170**	**584**	11,213	10,696	517

6.3 Employee benefits

	2005/06	9 Months to 31/3/05
	£000	£000
None	**0**	0
	0	0

6.4 Early Retirements Due to Ill Health

	2005/06	2005/06	9 Months to 31/03/05	9 Months to 31/03/05
	£000	**Number**	£000	Number
Number of early retirements agreed on the grounds of ill health		**23**		31
Cost of early retirements agreed on grounds of ill health	**802**		675	

As explained in note 1.13, these costs were borne by the NHS Pensions Agency.

7. Performance on payment of debts

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against this code is set out below:

	2005/06	9 Months to 31/3/05
Number of non NHS invoices paid	**144,803**	105,858
Number of non NHS invoices paid within 30 days	**136,713**	101,071
Percentage of invoices paid within 30 days	**94.41**	95.48
	£000	£000
Value of non NHS invoices paid	**207,946**	150,997
Value of non NHS invoices paid within 30days	**196,705**	137,793
Percentage of invoices paid within 30 days	**94.59**	91.26
Amounts included within Interest Payable (Note 9) arising from claims made under the Late Payment of Debts (Interest) Act 1998	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

8. Profit on Disposal of Fixed Assets

Profit/loss on the disposal of fixed assets is made up as follows:	2005/06 **Total**	9 Months to 31/3/05 Total
	£000	£000
Profit on disposal of land and buildings	**0**	23
Profit on disposal of equipment	**103**	0
	103	23

9. Interest Payable and similar charges

	2005/06	9 Months to 31/3/05 Total
	£000	£000
Interest on early retirements - directors' early retirements costs repayable over five years	**0**	45
	0	45

10.1 Intangible Fixed Assets

	Software Licences	Total
	£000	**£000**
Gross cost at start of period	**1,477**	**1,477**
Reclassifications	93	93
Additions purchased	27	27
Disposals	(151)	(151)
Gross cost at 31 March 2006	**1,446**	**1,446**
Amortisation at start of period	577	577
Impairments	3	3
Provided during the year	219	219
Disposals	(151)	(151)
Amortisation at 31 March 2006	**648**	**648**
Net book value		
- Purchased at start of period	885	885
- Donated at start of period	15	15
- Total at start of period	**900**	**900**
- Purchased at 31 March 2006	787	787
- Donated at 31 March 2006	11	11
- Total at 31 March 2006	**798**	**798**

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 and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at start of period	26,444	323,093	2,586	19,026	90,456	785	14,238	16,393	493,021
Additions purchased	0	2,188	15	33,309	2,422	96	215	576	38,821
Additions donated	0	(1)	0	5,915	935	0	14	0	6,863
Impairments	0	(513)	0	(409)	0	0	0	0	(922)
Reclassifications	0	15,368	0	(20,650)	3,735	0	756	698	(93)
Other in year revaluation	0	(4,566)	0	88	1,817	16	0	347	(2,298)
Disposals	0	0	0	0	(5,782)	(67)	(1,368)	(100)	(7,317)
At 31 March 2006	26,444	335,569	2,601	37,279	93,583	830	13,855	17,914	528,075
Depreciation at 1 April 2005	0	0	0	0	55,316	620	10,469	10,597	77,002
Provided during the year	0	13,720	109	0	6,739	47	1,035	1,276	22,926
Impairments	0	0	0	0	323	3	68	27	421
Reclassifications	0	446	0	0	(458)	0	(27)	39	0
Other in year revaluation	0	(446)	0	0	1,099	12	0	223	888
Disposals	0	0	0	0	(5,718)	(67)	(1,368)	(100)	(7,253)
Depreciation at 31 March 2006	0	13,720	109	0	57,301	615	10,177	12,062	93,984
Net book value									
- Purchased at start of period	25,098	294,610	2,397	17,507	28,935	142	3,743	5,389	377,821
- Donated at start of period	1,346	28,483	189	1,519	6,205	23	26	407	38,198
Total at start of period	26,444	323,093	2,586	19,026	35,140	165	3,769	5,796	416,019
- Purchased at 31 March 2006	25,098	295,316	2,312	31,700	30,125	198	3,646	5,499	393,894
- Donated at 31 March 2006	1,346	26,533	180	5,579	6,157	17	32	353	40,197
Total at 31 March 2006	**26,444**	**321,849**	**2,492**	**37,279**	**36,282**	**215**	**3,678**	**5,852**	**434,091**

11.2 Analysis of tangible fixed assets:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
- protected assets at 31 March 2006	26,444	321,849	2,492	0	0	0	0	0	350,785
- unprotected assets at 31 March 2006	0	0	0	37,279	36,282	215	3,678	5,852	83,306
Total at 31 March 2006	**26,444**	**321,849**	**2,492**	**37,279**	**36,282**	**215**	**3,678**	**5,852**	**434,091**

11.3 Assets held at open market value

There were no assets held at open market value at the Balance Sheet date.

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

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

11.5 The net book value of land, buildings and dwellings at 31 March 2006 comprises:

	31 March 2006			31 March 2005		
	Total	**Protected**	**Unprotected**	Total	Protected	Unprotected
	£000	**£000**	**£000**	£000	£000	£000
Freehold	**350,785**	**350,785**	**0**	352,123	352,123	0

12. Fixed asset investments

No fixed asset investments were held at the Balance Sheet date.

13. Stocks

	31 March 2006 £000	31 March 2005 £000
Raw materials and consumables	**8,097**	8,931
TOTAL	**8,097**	8,931

14. Debtors

	31 March 2006 £000	31 March 2005 £000
Amounts falling due within one year:		
NHS debtors	**23,064**	18,434
Provision for irrecoverable debts	**(1,400)**	(712)
Other prepayments and accrued income	**1,751**	1,060
VAT Receivable	**685**	594
Other debtors	**8,270**	8,983
Sub Total	**32,370**	28,359
Amounts falling due after more than one year:		
NHS debtors	**277**	240
Other debtors	**2,144**	1,804
Sub Total	**2,421**	2,044
TOTAL	**34,791**	30,403

NHS Debtors include £0 prepaid pension contributions at 31 March 2006 (£53k at 31 March 2005.)

15. Current Asset Investments

	2005/06 Total £000	9 Months to 1 March 2005 Total £000
Balance at start of period	**0**	0
Investments purchased	**180,000**	75,000
Investments sold	**(180,000)**	(75,000)
At end of period	**0**	0

16. Creditors

16.1 Creditors at the balance sheet date are made up of:

	31 March 2006 £000	31 March 2005 £000
Amounts falling due within one year:		
NHS creditors	**10,727**	7,588
Non - NHS trade creditors - revenue - other	**13,738**	11,420
Non - NHS trade creditors - capital	**6,554**	7,639
Tax and social security costs	**8,076**	7,779
Other creditors	**3,608**	3,576
Accruals and deferred income	**7,448**	10,691
	50,151	48,693

NHS creditors include;

- £0k (31 March 2005, £358k) for payments due in future years under arrangements to buy out the liability for early retirements; and

- £4,411k (31 March 2005, £4,082k) outstanding pensions contributions at 31 March 2006.

16.2 Prudential Borrowing Limit

	2005/06 Target £000	2005/06 Actual £000	2005/06 Planned £000	9 Months to 31/3/05 Target £000	9 Months to 31/3/05 Actual £000	9 Months to 31/3/05 Planned £000
Prudential Borrowing Limit set by Monitor	85,200	0	0	10,000	0.00	0.00
Working Capital Facility	46,000	0	0	15,000	0.00	0.00
Actual borrowing in year	0	0	0	0	0	0
Minimum Dividend Cover	> 1	2.92	2.91	> 1	3.15	2.75

As the Trust did not require any loans in 2005/06, only the minimum dividend cover ratio is applicable.

The NHS foundation trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

17. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	**31 March 2006 Total**	31 March 2005 Total
	£000	£000	£000	**£000**	£000
At start of period	1,807	818	4,204	**6,829**	10,540
Change in discount rate	253	0	0	**253**	0
Arising during the year	702	466	6,838	**8,006**	6,678
Utilised during the year	(184)	(240)	(907)	**(1,331)**	(10,048)
Reversed unused	(107)	(149)	(218)	**(474)**	(410)
Unwinding of discount	45	0	0	**45**	69
At 31 March 2006	**2,516**	**895**	**9,917**	**13,328**	6,829
Expected timing of cashflows					
Within one year	146	895	9,917	**10,958**	5,142
Between one and five years	553	0	0	**553**	439
After five years	1,817	0	0	**1,817**	1,248

Pensions relating to other staff represent the liability relating to staff retiring before April 95 (£611k) and Injury benefit Liabilities (£1,905k).

Injury Benefits are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority.

The value shown is the discounted present value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown.

Legal claims relate to claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by the NHSLA, who provide an estimate of the Trust's probable liability.

Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA, and not included above.

"Other" costs relate to costs likely to be incurred under the new Consultant Contract (£128k),amounts provided under the 'Agenda for Change' pay deal (£9,725k) and provisions under the Carbon Emmissions Trading Scheme (£64k). Consultation with individual members of staff on the Agenda For Change and Consultants' Contracts is continuing. The amount that becomes payable under the Carbon Emmissions Scheme is subject to the Trust's actual emissions in 2006-07.

Of the above total provision and related payments , some £609,683 has been covered by "back-to-back" income arrangements with the Trust's major Purchasers.

£23,006,752 is included in the provisions of the NHS Litigation Authority at 31/03/2006 in respect of clinical negligence liabilities of the Trust (31/3/2005 £19,933,755).

18 Reserves

18.1 Movement in taxpayers' equity:		9 Months to
	31 March 2006	31 March 2005
	£000	£000
Taxpayers' equity at start of period	**409,688**	375,656
Prior period adjustment	**0**	4,866
1 April 2005 (restated)	**409,688**	380,522
Surplus for the financial year	**13,131**	8,938
Public dividend capital dividend	**(12,529)**	(8,645)
(Losses) / gains from revaluation of purchased fixed assets	**(776)**	18,795
New public dividend capital received	**24,844**	9,000
Transfers from donated asset reserve	**1,995**	1,078
	436,353	409,688

18.2 Movements in public dividend capital		9 Months to
	31 March 2006	31 March 2005
	£000	£000
Public Dividend Capital at start of period	**280,275**	271,275
New Public Dividend Capital received	**24,844**	9,000
Public Dividend Capital at 31 March 2006	**305,119**	280,275

18.3 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Government Grant Reserve	Income and Expenditure Reserve	2005/06 Total
	£000	£000	£000	£000	**£000**
At start of period	80,634	38,213	169	5,508	**124,524**
Prior period adjustment	9,448	0	(169)	(4,390)	**4,889**
1 April 2005 (restated)	90,082	38,213	0	1,118	**129,413**
Transfer from the Income and Expenditure Account	0	0	0	602	**602**
Loss on other revaluations/indexation of fixed assets	(776)	(2,410)	0	0	**(3,186)**
Transfer of realised profits (losses) to the Income and Expenditure Account	(30)	0	0	30	**0**
Receipt of donated assets	0	6,864	0	0	**6,864**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	0	(2,459)	0	0	**(2,459)**
Other transfers between reserves	(3,254)	0	0	3,254	**0**
At 31 March 2006	**86,022**	**40,208**	**0**	**5,004**	**131,234**

19. Notes to the Cash Flow Statement

19. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2005/06 £000	9 Months to 31 March 2005 £000
Total operating surplus	**12,248**	8,402
Depreciation and amortisation charge	**23,145**	16,178
Fixed asset impairments and reversals	**1,346**	2,096
Transfer from donated asset reserve	**(2,459)**	(1,502)
Transfer from the government grant reserve	**0**	(831)
(Increase)/decrease in stocks	**834**	517
(Increase)/decrease in debtors	**(3,959)**	5,970
Increase / (decrease) in creditors	**2,543**	(2,972)
Increase / (decrease) in provisions	**6,201**	(3,162)
Net cash inflow from operating activities	**39,899**	24,696

19.2 Reconciliation of net cash flow to movement in net debt

	2005/06 £000	9 Months to 31 March 2005 £000
Increase in cash in the period	**13,098**	1,630
Change in net debt resulting from cashflows	**13,098**	1,630
Net funds at start of period	**8,957**	7,327
Net funds at 31 March 2006	**22,055**	8,957

19.3 Analysis of changes in net debt

	At 1st April 2005	Cash changes in year	**At 31 March 2006**
	£000	£000	**£000**
OPG cash at bank	396	20,793	**21,189**
Commercial cash at bank and in hand	8,561	(7,695)	**866**
	8,957	13,098	**22,055**
Third party assets held by the NHS Foundation Trust (note 26)	21		

20. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £12.7million (31 March 2005, £26.3 million).

The major components of these commitments are as follows:

Scheme	Amount
	£000
Renal expansion	2,538
Weston Park Hospital site redevelopment	2,134
Research facilities	2,029
Cardiology expansion scheme	1,507
Electrical infrastructure development	1,217
Medical equipment	1,354

21. Post Balance Sheet Events

There were no material Post Balance Sheet events.

22. Contingencies

	2005/06	9 Months to 31 March 2005
	£000	£000
Gross value	(413)	(339)
Amounts recoverable	0	0
Net contingent liability	**(413)**	(339)

Contingencies represent the consequences of losing all current third party legal claims.

23. Related Party Transactions

Sheffield Teaching Hospitals NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common control of Monitor. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The value of activity undertaken with these organisations was not material to the accounts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Sheffield Teaching Hospitals NHS Foundation Trust.

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 the period the Trust purchased healthcare from these two hospitals in the sum of £825k and £1.0m respectively.

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company who manage healthcare provided at the above hospitals. This amounted to £2.5m during the period. Certain members of the Trust's employees have an interest in this company.

Certain members of the Trust's Governors' Council are appointed from key organisations with which the Trust works closely. These governors represent the views of the staff and of the organizations with and for whom they work.
This representation on the Governors' Council gives important perspectives from these key organisations on the running of the Trust, and is not considered to give rise to any potential conflicts of interest.

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in the year from this Charity amounted to £1.7m.
The Trust has also received revenue and capital payments from a number of other charitable funds.

Certain of the trustees of the charitable trusts from whom the Trust has received grants are members of the NHS Foundation Trust Board.

24. Private Finance Transactions

24.1 PFI schemes deemed to be off-balance sheet	**2005/06**	9 Months to 31 March 2005
	£000	£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 committed to make the following payments during the next year, in which the commitment expires:		
31st to 35th years (inclusive)	622	0

The estimated annual payments in future years are expected to be materially different from those which the trust is committed to make during the next year. The likely financial effect of this is £2,483k (31.3.05 £2,483k). This is the full year annual payment , whilst next year's payments will only start partway through the year.

	£000
Estimated capital value of the PFI scheme	25,700
Contract Start date:	Dec. 2006
Length of project (years)	30
Number of years to end of project	32
Contract end date	Nov 2036

The PFI scheme is a scheme to build a new medical ward block on the Northern General Hospital Site (Hadfield Block).

Key dates:

Financial Close - 20 December 2004
Projected Practical completion - December 2006 (date of commencement of unitary charge)
End of concession period - November 2036

The unitary payment is £2,483,000 per annum at 2004/05 prices . This will be increased in line with the rise in the Retail Price Index on 1 April each year.
The residual interest projected value at November 2036 is based on average percentage for similar schemes, and will be replaced by projections from professional valuers on practical completion of the scheme.
There are no deferred assets associated with this scheme.

Detail;	£,000
- value of deferred asset	0
- value of residual interest	17,658

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

There are no PFI schemes deemed to be on-balance sheet.

25 Financial Instruments

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 Foundation 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 Foundation 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 Foundation 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. Provisions are shown gross. Any amounts expected in reimbursement against a provision (and included in debtors) are separately disclosed.

Liquidity risk
The NHS Foundation 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 NHS Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. Sheffield Teaching Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk
3.06% of the Trust's financial assets and 100% of its financial liabilities disclosed under this note carry nil or fixed rates of interest. Sheffield Teaching Hospitals NHS Foundation 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:

25.1 Financial Assets

					Fixed rate		Non-interest bearing
	Total	**Floating rate**	**Fixed rate**	**Non-interest bearing**	**Weighted average interest rate**	**Weighted average period for which fixed**	**Weighted average term**
Currency	**£000**	**£000**	**£000**	**£000**	**%**	**Years**	**Years**
At 31 March 2006							
Sterling	22,332	21,648	277	407	2.2%	n/a	n/a
Gross financial assets	22,332	21,648	277	407			
Currency							
At 31 March 2005	£000	£000	£000	£000	%		
Sterling	9,197	8,295	240	662	2.2%	n/a	n/a
Gross Financial assets	9,197	8,295	240	662			

25.2 Financial Liabilities

					Fixed rate		Non-interest bearing
	Total	Floating rate	Fixed rate	Non-interest bearing	Weighted average interest rate	Weighted average period for which fixed	Weighted average term
Currency	**£000**	**£000**	**£000**	**£000**	**%**	**Years**	**Years**
At 31 March 2006							
Sterling	(315,036)	0	(9,917)	(305,119)	2.2%	n/a	n/a
Gross financial liabilities	(315,036)	0	(9,917)	(305,119)			
Currency	£000	£000	£000	£000	%		
At 31 March 2005							
Sterling	(287,104)	0	(6,829)	(280,275)	2.2%	n/a	n/a
Gross financial liabilities	(287,104)	0	(6,829)	(280,275)			

Note: The public dividend capital is of unlimited term.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

25.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Foundation Trust's financial assets and liabilities as at 31 March 2006.

	Book Value	Fair Value	Basis of fair valuation
	£000	£000	
Financial assets			
Cash	22,055	22,055	
Debtors over 1 year:			
- Agreements with commissioners to cover creditors and provisions	277	277	Note a
	22,332	22,332	
Financial liabilities			
Provisions under contract	(9,917)	(9,917)	Note b
Public dividend capital	(305,119)	(305,119)	Note c
Total	(315,036)	(315,036)	

Notes

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 note b below, fair value is not significantly different from book value.

b 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 2.2% in real terms.

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

26 Third Party Assets

The Trust held £21,168 (31 March 2005 £7,654) at bank and in hand at 31 March 2006 which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

27 Losses and Special Payments

There were 562 (9 months to 31 March 2005, 131) cases of losses and special payments totalling £1,106k (9 months to 31 March 2005, £125k) approved during financial year.

There were 2 cases (9 months to 31 March 2005 - no cases) of losses exceeding £100,000. Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

28. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £12,529k (9 months to 31 March 2005 £11,526k) bear to the average net relevant assets during the twelve month period of £363,772k (9 months to 31 March 2005 £344,474k), that is 3.4%.

This is calculated as follows:

	31st March 2006	31 March 2005
	£000	£000
Total Capital and Reserves	**436,353**	409,687
Less - Donated Asset Reserve	**(40,208)**	(38,213)
Less - Cash held at Office of the Paymaster General	**(21,189)**	(396)
Net Relevant Assets before revaluation	**374,956**	371,078
National Revaluation Exercise		(18,489)
Total Net Relevant Asssets	**374,956**	352,589
Average Net Relevant Assets	**363,772**	344,474
Dividend paid per Cash Flow statement	**12,529**	11,526
Percentage	**3.4%**	3.3%

The Trust's actual rate of return of 3.4% (9 months to 31 March 2005 3.3%) is not materially different from its forecast rate of 3.5%.

Statement on internal control 2005/06

The Trusts conducts its affairs in accordance with the principles of sound corporate governence

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum. I am also personally accountable for all governance related issues. These responsibilities are reflected in the Trust's Governance Framework including its Financial Strategy and Risk Management Strategy.

These duties include both legislative responsibility to a number of statutory established agencies and 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'.

The Independent Regulator of NHS Foundation Trusts has established a risk-based approach towards regulation and the Trust's compliance with the terms of authorisation. This consists of three main components; the annual plan, in-year monitoring and, where appropriate, interventions.

To allow me to discharge my personal accountabilities I have in place a governance and management framework across the whole organisation, which includes a Governance Committee and a Healthcare Governance Committee, which are Committees of the Trust Board. I have also taken steps to ensure that 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.

The Governors' Council, established in compliance with the Health Service Act, is now well established and contributing effectively to the governance of the Trust with elected Governors sitting on various committees and steering groups throughout the Trust.

Progress against my own objectives is measured, monitored and assessed by the Independent Regulator of NHS Foundation Trusts, the Chairman and the Trust Board.

The Audit Commission and Internal Audit Services provide independent assurance and monitor progress against the development and integration of an Assurance Framework as well as ensuring that the organisation operates within the six principles of Good Governance in Public Services which are set out below:

- Focusing on the organisation's purpose and on outcomes for citizens and service users >

- Performing effectively in clearly defined functions and roles
- Promoting values for the whole organisation and demonstrating good governance through behaviour
- Taking informed, transparent decisions and managing risk
- Developing the capacity and capability of the governing body to be effective
- Engaging stakeholders and making accountability real

These principles underpin the need for absolute accountability, probity and transparency within the NHS.

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 of Sheffield Teaching Hospitals NHS Foundation Trust,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2006, and up to the date of approval of the annual report and accounts.

This system has been subjected to independent audit and verification by the Internal Audit Service.

Capacity to handle risk

A number of structures and committees exist to provide this. These include the:

- Management Audit Committee
- Governance Committee
- Healthcare Governance Committee
- Finance Committee
- HR Committee
- Remuneration Committee

The above are formal committees of the Trust Board with Executive and Non-Executive Director membership. The Governance Committee has a defined role to oversee the actions taken to manage significant risk issues, its focus being provided by the Assurance Framework.

Each significant risk theme is owned by one or more Executive Directors and my office, through my Assistant Chief Executive, have an overarching responsibility for the development of a cohesive and integrated framework and shared processes for the management of all risk.

Directorate Managers are required to have in place effective arrangements for the management of risk relevant to their Directorate's size and circumstances. 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 risk and control framework

The Assurance Framework has identified a number of gaps in assurance and controls. The most significant gap concerns the assurance and controls to manage the uncertainties created by the complex policy environment in which the NHS as a whole operates and which is felt particularly keenly by Foundation Trusts. Specifically the management of anticipated changes in the level of emergency patient flows into the Trust is a particular challenge. The framework has also identified gaps in the risk management arrangements and the internal major >

> incident arrangements. Across all the gaps identified above action plans are in place which are rigorously and regularly monitored by the Board when it meets to consider governance issues.

Risk appetites are determined by the process of setting the Trust's plan for the forthcoming year in the context of the uncertainties of the external environment. The key aspects of the plan are then monitored in-year by the Board and adjusted accordingly as the risks can be better assessed. In particular the financial risks identified at the beginning of the year are reviewed by the Board each month including an assessment of the financial consequences of the risk and an assessment of the likelihood that it will occur.

In line with the requirements of the Healthcare Commission the Trust has assessed itself against the Standards for Better Health and submitted its final declaration indicating compliance with the 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 and that 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 and South Yorkshire.

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 and the Sheffield Health & Social Care community works together through well established partnership arrangements.
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.
The PALS service in the Trust was one of the pilot sites set up across the country as this new service was introduced four years ago. The service has different ways of feeding back information gained through contact with patients in order for the Trust to develop services and improve patient care, and their overall experience at one of our hospitals. This feedback is delivered at a local directorate level and also at a strategic level, and encompasses both individual experiences and also emerging patterns.

Review of economy, efficiency and effectiveness of the use of resources
The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plans for improving productivity and efficiency in order to offset the income losses arising from the national efficiency target applied to all NHS providers and the implementation of the Payment by Results funding system; plus local investment proposals. The financial plans reflect organisation wide plans and initiatives but are also translated into Directorate budgets and productivity and efficiency plans. Increasingly, financial planning at all levels is influenced by the income assumed from national tariffs and Reference Cost Indices which broadly compare actual costs to expected tariff income. Financial plans are approved by the Board, supported by detailed scrutiny from its Finance Committee. An Annual Plan is submitted to Monitor, reflecting financial, service and governance aspects, each of which is ascribed a risk rating by Monitor. >

> This plan incorporates projections for the following two years which facilitates forward planning by the Trust.

The in-year use of resources is monitored by the Board and its sub committees via a series of detailed monthly reports covering finance, activity, capacity, human resource management and risk. These documents are a consolidation of detailed reports that are provided at Directorate and Department level to allow active management of resources on an operational level. Quarterly monitoring returns are submitted to Monitor from which a risk rating is again attributed to the financial, service and governance aspects.

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

The Trust also makes use of both Internal and External Audit functions to ensure the controls are operating effectively and to advise on areas for improvement. All action plans agreed are monitored and implementation is reviewed regularly and reported to Management Audit Committee as appropriate. Any high-risk issues identified are corrected immediately.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Management Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Governance Committee of the Trust Board has reviewed the Assurance Framework with a particular focus on the significant risks facing the Trust as a whole and within each objective the two principle risks facing the Trust in relation to that objective. Significant actions have already been taken to improve controls against these risks and the Governance Committee monitors the ongoing action plans on a quarterly basis. In particular the Trust has identified the uncertainties created by national financial (payment by results) and planning systems as the most significant risk.

The Assurance Framework itself provides me with evidence that the effectiveness of controls intended to manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- the Management Letter to Directors from the Audit Commission
- independent reviews undertaken on behalf of the National Health Service Litigation Authority (NHSLA)
- Internal Audit reports
- External Audit Reports

My review of the effectiveness of the system of internal control is assisted by the deliberation of the Management Audit Committee and the Governance Committee. 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 and the Internal Audit Service continues to work against a risk-based audit plan.

Signed Andrew Cash.
Chief Executive Officer
(On behalf of the board)
15 June 2006

This annual report and accounts has been produced by Sheffield Teaching Hospitals NHS Foundation Trust. For further information on any aspect of this report or enquiries regarding our services, please visit www.sth.nhs.uk or write to:

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