Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts

2007-2008

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Sheffield Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2007 - 2008

Welcome

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

Among the largest employers in the region, Sheffield Teaching Hospitals employs around 13,500 talented and dedicated people who continually strive to enhance the patient experience and improve clinical outcomes to meet the needs of the local, regional and national population that we serve.

During this year the Trust will have performed almost 175,000 inpatient episodes and day cases and around 840,000 outpatient appointments totalling over a million patient episodes. Each year, our patient services plan builds on our vision and priorities to ensure we provide high quality health services to our patients and create an environment where staff are empowered to explore new, creative ways of working for the benefit of patients.

Chairman's Statement

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

David Stone
Chairman

Once again it has been a successful year which reached a pinnacle when we were awarded a double excellent for quality of services and use of resources in this year's Annual Health Check conducted by the Healthcare Commission.

This was achieved not least, through the dedication and determination of staff to improve patient services, whilst at the same time working hard to ensure that the services offered, constitute value for money. We were one of only 19 trusts to be awarded a double excellent which puts us in the top five percent of NHS trusts in the country.

We succeeded in meeting our key targets for cancer; 95 per cent of suspected cancer patients who were referred by their GP for urgent diagnosis were treated within 62 days of referral and 100 per cent of all patients found to have cancer started their treatment within 31 days of agreeing to a treatment plan. No patients waited more than six weeks for diagnostic tests and MRI scans. In fact we went one step further and introduced a system of imaging on demand where patients attending outpatients have the option of having their x-ray or scan on the spot without the need to return for a further appointment.

The 18 week referral to treatment target has been challenging with both clinical directorates and central teams working hard throughout 2007/08 on the new standards for treatment within 18 weeks. The March 2008 milestones were that 90 per cent of outpatients and 85 per cent of inpatients would start treatment within 18 weeks of being referred to hospital. Our actual results were 93 and 89 per cent respectively, which meant that we exceeded these milestones, providing a very high quality of access to our services for patients, which is a considerable achievement for us.

Infection prevention and control has been one of our highest priorities this year, which is reflected in a continued excellent performance in this area. For the past three years we have been the most successful teaching trust in the country in the challenge to reduce healthcare associated infections. Since 2003/04 we achieved a 65 per cent reduction in MRSA infections far exceeding the Government target. We also met our locally agreed target for Clostridium difficile. However, the challenge is great and we continue to invest in new technologies such as hydrogen peroxide vapour machines and steam cleaners.

Recognition should also be given to the large number of wards that achieved high standards in infection control practice through their participation in the Trust's Ward Accreditation Scheme. The scheme has been crucial in giving ward teams the tools they need to tackle cleanliness and infection control issues. The scheme sets out clear standards and demands high levels of compliance in key areas of infection control practice such as hand hygiene and environmental cleanliness. The scheme also includes regular audits on clinical practice.

The ward accreditation scheme has been the lynch pin in enabling us to drive down infection rates, giving patients greater confidence in their local health services.

Despite sustained pressure particularly around the number of emergency admissions, the Trust has continued to produce an impressive array of developments and achievements within an environment of testing financial demands. Delays in the transfer of care, where we are reliant on the services of other health and social care providers, remain a risk for us. Consequently, we are working with our colleagues in the Primary Care Trust and Social Services to ensure timely discharge for patients.

The floods in Sheffield during June posed particular challenges with over 200 people seeking refuge at the hospitals. I am proud that we were able to offer those people food, shelter and medication for the night and the community spirit that ensued was really quite moving. On the subject of emergency planning and business continuity, the Trust has appointed a new emergency planning manager who is working with directorates to ensure that a risk based approach is taken in addressing emergency planning and business continuity issues. To support this programme of work, during March, the Trust undertook an'Emergotrain' tabletop emergency planning simulation which aimed to exercise our Major Incident Plan. The day was a great success and was instrumental in further informing our future plans in this area.

Our foundation status will see us engaging with our local community in a more proactive way through our membership and Governors' Council.

We have increasing numbers of people attracted to foundation trust membership and I have been excited and encouraged to see more younger people joining us as members.

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

During October we were honoured to welcome HRH Duke of Kent KG to open the new Sir Robert Hadfield Wing, the state of the art medical wing, which replaced the wards on the Vickers corridor. His Royal Highness was impressed with the style and design of the building and spent time speaking with patients and staff about their experiences.

Midwives Dorothy Smith and Julie Walsh were recognised at the annual Royal College of Midwives Awards for their work in developing midwifery services specifically tailored towards the needs of asylum seekers and homeless women. Word has spread throughout the community meaning that even more women are now accessing this unique service.

During the ceremony of our own Thank you Awards, Karen Dolling, Nurse Specialist for the visually impaired, scooped the award in the patient care category for the passion she shows in her work caring for visually impaired patients. Karen has single-handedly raised the profile of these patients both in the Trust, across the city and nationally. Among many other initiatives, Karen has implemented large print menus, colour contrast feeding utensils, and has given many educational talks to help staff understand the needs of these patients.

Glenys Wasteney, who recently retired as a matron in the care of the elderly wards, won the coveted Chief Executive's Award for Excellence for her work in the care of elderly patients and in particular, the role she played in the development of the new medical block, the Sir Robert Hadfield Wing.

Sheffield Hospitals Charitable Trust, the umbrella charity, which supports health services across Sheffield, embarked on its first major appeal for Sheffield Teaching Hospitals. The Sheffield Leukaemia and Blood Disorders Appeal, which was launched by film actor Sean Bean, aims to raise £150,000 to fund new equipment needed to complement the extensive refurbishments taking place on floors 0 and P at the Royal Hallamshire hospital. We are grateful for the ongoing support from the charity.

Neurocare is another of our proactive charities that had a very successful year. Income grew significantly and two new SonoWand brain scanners were purchased for use at the Royal Hallamshire and Sheffield Children's hospitals.

Weston Park Hospital Cancer Appeal continues to go from strength to strength thanks to the generosity of the public. The Cancer Appeal, which supports research, treatment and care at the Trust's dedicated cancer hospital, has achieved its major fundraising target of £1 million to enhance a new state-of-the-art chemotherapy suite and day case unit. The new unit, on the first floor of the hospital, is now spacious, bright and pleasant which is always a bonus for anyone having to endure chemotherapy as part of their cancer treatment.

In addition to this major capital appeal, the charity has continued to provide core funding to the Weston Park Cancer Research Centre, which acts as a hub for a multimillion-pound programme of research across the cancer spectrum. The Cancer Appeal has also provided specific funding for a number of vital research projects that have national and international significance.

This year has also seen the continuing growth of the work of the Cancer Support and Information Centre on Northumberland Road in Sheffield. This relatively new facility, funded by the Cancer Appeal, offers crucial additional support to patients, their carers and anyone who needs help and information coping with cancer and its effects. Complementary therapies are also being provided at the centre courtesy of the Cancer Appeal. We would like to thank everyone who has given so generously to the Weston Park Hospital Cancer Appeal for making a real difference to people living with cancer in this region.

We have large number of charitable organisations working with us and I would like to take this opportunity to thank each and every one of them for their continued support.

This year, we said farewell to two of our non-executive directors, Ony Bright and Chris Suddes. As well as her background in mental health

Actor Sean Bean was pleased to launch the Leukaemia and Blood Disorders Appeal.

Providing state of the art patient facilities.

nursing, Ony gave us invaluable expertise in the needs of our black and minority ethnic communities. Chris had joined us as a governor and we subsequently benefited from his skills as a non-executive director. However, personal circumstances meant a premature departure. We thank them both for their time with us and wish them well in the future.

Two new appointments Jane Norbron and Shirley Harrison joined us late in the year. Jane is a management consultant and Shirley has a background in public relations and marketing and I am confident that both will bring their unique skills and experience to the Board.

Our foundation status will see us engaging with our local community in a more proactive way through our membership and Governors' Council.

The work of the Governors is making a positive impact on services with representation on many of our committees and boards. Joe Abson has been a Patient Governor since 2007 and is a member of the Trust's Patient Representative Group tasked with listening to patients concerns and feeding back positive comments to wards and departments. Joe's expertise brings a unique perspective to the decision making process, which adds a valuable dimension to the Trust's work.

Other Governors are involved in issues such as cleanliness and infection control, nutrition, health informatics and work around the bereaved. We have increasing numbers of people attracted to foundation trust membership and I have been excited and encouraged to see more younger people joining us as members.

We look forward to the coming year when we will be launching our new corporate strategy. The strategy consists of three main pillars; clinical excellence, patient centred and engaging our workforce. Key areas of work include options to reconfigure services to better meet the needs of patients, developing integrated care pathways to improve the management of long term conditions and developing new and formal partnerships in academia, research and commercial enterprise. The latter will ensure that Sheffield Teaching Hospitals is well and truly on the map when it comes to research and development.

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

David Stone OBE
Chairman

Directors' Report

Infection control was a top priority for us with almost £4 million spent on a variety of infection prevention and control projects.

Andrew Cash
Chief Execuive

The year 2007/08 was a key year for us. I returned from my spell at the Department of Health to take over the reins from Acting Chief Executive, Chris Welsh.

Chris did a sterling job and I would like to take this opportunity to thank him for the valuable expertise and wisdom he brought to the role of Acting Chief Executive. Indeed all of our staff deserve recognition for their contribution to ensuring that we provide the highest possible standards for patients.

We have already mentioned our most prominent achievement in the Chairman's' forward; the Healthcare Commission's Annual Health Check, where we scored 'excellent' for quality and 'excellent' for use of resources. Sheffield Teaching Hospitals was one of only nineteen trusts throughout the country to achieve the highest rating. The Trust actively welcomes independent scrutiny. It helps to keep us focused on what matters most to patients, and the valued feedback ensures that we make improvements year on year.

We are now at the end of the second year of our three-year change programme, which focuses on improved patient care and better value for money for the taxpayer. There are many strands to the programme but essentially it is about cutting out unnecessary waste. This includes the amount of time patients spend waiting for clinic appointments and treatments. The 18-week referral to treatment programme has signalled the way ahead and the Trust is on course to meet this ambitious target. Staff are at the forefront of this work as it is they who make the difference between a patient having to wait and receiving their treatment promptly. Staff agree that unnecessary waits are unacceptable.

One of the key challenges concerns reducing the patient's length of stay. We continue to work closely with primary care and social services to look at more effective ways of managing complex patient discharges. The amount of paperwork at times reduces efficiency but with improved team working we are solving the issues one by one. The intelligent messenger service, which was established as a pilot at the Northern General, where hospital referrals to social services are collected from the wards and channelled through a process of checking, has led to a 20-30 per cent reduction in inappropriate referrals to social services. This has produced a more efficient way of working with less unnecessary paperwork for staff and a more responsive service for patients. The original pilot was run by the Discharge Liaison Team but has now been taken on by the Hospital Social Work Department. There are plans to roll out the service to the rest of the wards at Northern General and then at the Royal Hallamshire hospital.

Infection control was a top priority for us with almost £4 million spent on a variety of infection prevention and control projects. Having invested millions of pounds in new capital builds over recent years, we felt our focus should turn towards the existing ward accommodation. The ward upgrade and deep cleaning programme was a major piece of work but has succeeded in improving the ward environment for patients across the Trust. Steam cleaners and hydrogen peroxide vapour machines were purchased and additional funding was put into the ward accreditation programme, which the chairman has already mentioned. Campaigns to improve compliance with hand hygiene and a new uniform policy also helped to drive MRSA cases down to the lowest rate of any teaching trust.

This year saw further work to implement a risk-based approach to the prevention and management of deep vein thrombosis. Every patient admitted to hospital is now assessed against their risk of contracting a deep vein thrombosis (DVT) and offered prophylactic treatment where necessary. It is too early to say whether this will reduce the incidence of DVT but audit and monitoring against NICE guidance will give us the information we need to develop the service further.

We have made several notable appointments over the year. A Mental Capacity Act facilitator was appointed to ensure that staff across the organisation are proficient in working within the guidance laid down in the Act. The Trust also appointed a new patient information manager, the UK's first ataxia nurse specialist and a new head of chaplaincy. These people along with all the other staff and new appointees will make a valuable contribution to patient care over the coming months.

Externally, Professor Sir Gordon Duff, honorary consultant has been appointed as Chair of the Department of Health Scientific Advisory Group on Pandemic Influenza. Professor Duff also holds the positions of Florey Professor of Molecular Medicine at Sheffield University, Chair of the Commission on Human Medicines and the Chair of the National Biological Standards Board.

Sheffield is at the forefront of Lord Ara Darzi's wide ranging review of the NHS; Our NHS, Our Future, with Professor Chris Welsh taking the role of lead clinician for the Yorkshire and Humber region. The review focuses on quality and safety, access and reducing inequalities and looks at eight different patient pathways. Head of Midwifery, Dotty Watkins, is leading on the birth pathway and Consultant Oncologist David Levy is leading on the review of end of life care in our region. A&E Clinical Director Francis Morris will be co-leading the region's review of the Acute Episode pathway. Lord Darzi's review will be instrumental in shaping NHS services for the next decade.

Another area of progress was in our Leadership Development programme. Managers across the Trust have been involved in further learning to improve their understanding of business objectives, build effective relationships and enhance their existing skills and knowledge. The 'Guest Lecture Series' during which the Trust welcomed prestigious speakers, such as BBC journalist Fergal Keane and Paralympion Tanni Grey-Thompson, who provided invaluable insight into leadership within their particular spheres, complemented this work.

This year saw us develop our independence as a foundation trust as we ventured into a number of commercial partnerships. Matthew Edwards, consultant in ophthalmology, has led work to develop a fee-paying laser eye surgery centre within an NHS setting. The Sheffield Vision Centre, situated at the Royal Hallamshire hospital, will specialise in refractive laser surgery. It is envisaged that it will bridge a gap in the local market by providing expert private ophthalmic care delivered by an NHS consultant.

During the year, the Trust has been successful in securing a Healthcare Technology Co-operative contract called Design for Dignity (D4D). D4D is a Department of Health initiative involving the Trust as the host, other NHS 'nodes', such as Leeds and North Bristol NHS Trusts, academic and commercial partners. It aims to address the unmet needs of patients in less high profile areas of medicine such as urinary dysfunction and renal care, and assisted technologies such as communication aids. In essence it links clinical need with commercial capability and will reap benefits for patients across the NHS.

At the end of the year, the Trust was successful in being awarded Biomedical Research Unit (BRU) status in cardiovascular, and musculoskeletal disease following joint bids with the University of Sheffield.

We hope that the developments in the prevention, diagnosis and treatment of these diseases, made as a result of the work of the units will be translated into significant benefits for patients. A major success, this places both the Trust and the city at the forefront of biomedical research and will enhance our reputation nationally and internationally.

In January 2008 we also put in a bid to the National Institute of Health Research, on behalf of both commissioners and providers across South Yorkshire, to become an applied health research and care consortium. The aim of the consortium is to develop the self-management and self-care of long-term conditions through applied research and innovations in health technology, which can then be translated into quality patient care. This bid has been successful and the consortium's work will start in earnest in October 2008.

The Trust is now entering the final year of the three year performance and efficiency programme where we need to make a further £30 million saving if we are to remain financially stable. This is a major challenge for us, but with the determination and dependability of our staff, we know that we can achieve and potentially exceed this in the coming years.

Andrew Cash.

Andrew Cash OBE
Chief Executive
on behalf of the Directors

Celebrating Foundation Trust Status

Sheffield Teaching Hospitals is the largest NHS foundation trust in England. Now entering our fourth year since gaining foundation trust status, we continue to achieve financial balance and make positive progress towards improving the services and the quality of the care we provide for patients.

One of our key strengths has been the involvement of people, who live locally or who have received treatment at one of our hospitals, in our Governors' Council.

The Council is made up of 37 foundation trust governors who oversee and advise on the Trust's strategic direction and help to make sure that we are accountable to the people we serve. It holds the Board of Directors to account and seeks to ensure the continued success of the Trust through effective management, partnership working and maintaining the values and principles of the NHS.

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

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

The council appoints the Trust's non-executive directors, including the Chair and determines their remuneration.

Previously these functions were carried out through appointments and remuneration committees. However, a joint meeting of these committees agreed to recommend acceptance of a proposal to establish a nomination committee to undertake both functions. The Governors' Council accepted the proposal and the new Nomination Committee held its first meeting in September 2007. It has subsequently made two appointments, of one non-executive director and the Chair. (See also Public Interest Disclosure page 42)

The Council also approves the appointment or removal of the Trust's auditors following a recommendation from a nominated sub-group of the Board of Directors.

The Governors' Council

All the public and patient governors are elected for a three-year term of office, while governors representing partner organisations are nominated by their employer for a negotiable term.

At least one third of governors must be present, with each constituency represented by at least one member, for a meeting of the council to be quorate. During 2007/08 each meeting was attended by at least one member from every constituency while attendance varied between 48.5 per cent and 55.5 per cent.

At the end of March 2008, membership of the full Governors' Council was as shown opposite.

The governors have an important role to play in shaping our services. They do this not only by contributing to council meetings, but also by their involvement in a range of groups looking at different aspects our work.

The Good Food Group is responsible for helping us to maintain high standards in the purchase of ingredients and in the preparation and delivery of patient meals across the hospital sites. Governors regularly take part in 'snap inspections' visiting wards at meal times to ensure that food is presented well, tastes good and is still hot when served. For the Patient Environment Action Team (PEAT), the emphasis is on cleanliness. Their inspections often prove more rigorous and critical than those of the national external assessors, ensuring that standards are not simply maintained, but improved.

Other groups include the Patient Representative Group (see also Working With Our Communities, page 35) and one that looks at the way in which we communicate with our patients. Visiting wards and departments provides governors with the opportunity to talk to patients and staff. This helps governors to develop an understanding of both public expectations and the complexities of the services we provide, placing them in a unique position to make a valuable contribution to the work and future development of the Trust.

A tour of the Central Production Unit helped governors see for themselves the complexities of food preparation.

Constituency	Elected Governors	Expiration of term of office
Patient	Joe Abson Diana Chadwick Susan Coldwell Heather Gordon John Holden Kenneth Murta Clare Rawding	1st July 2010 1st July 2008 9th June 2009 1st June 2008 9th June 2009 1st July 2008 1st July 2009
Public Sheffield North	Kaye Meegan Julie Otter Sharon Tabberer	16th October 2009 1st July 2010 1st July 2008
Public Sheffield South West	Charlie Khan Philip Seager Susan Wilson	1st July 2010 1st July 2008 9th June 2009
Public Sheffield West	Martin Colclough Anne Eckford Beryl Wilson	1st July 2008 1st July 2010 9th June 2009
Public Sheffield South East	Richard Chapman Elaine Hill John Hulse	1st July 2010 9th June 2009 9th June 2009
Staff Medical & Dental	Mike Collins	9th June 2009
Staff Nursing & Midwifery	Rose Bollands	9th June 2009
Staff Allied Health Professionals, Scientists & Technicians	Stephen Westby	9th June 2009
Staff Managerial, Administrative & Clerical	Mark Hattersley	9th June 2009
Staff Ancillary, Works & Maintenance	Dave Weston	9th June 2009

goodhealth

The members' newsletter of Sheffield Teaching Hospitals NHS Foundation Trust

Winter 2007 Issue 14

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Operation Christmas Child

EXCELLENT and EXCELLENT!

Sheffield Teaching Hospitals NHS Foundation Trust is rated a 'double excellent' in the Annual Health Check 2006/07

Foundation Trust Membership - 31 March 2008

Public Constituency	2,643 members
Patient Constituency	3,353 members
Staff Constituency	12,670 members
Total Membership	**18,666 members**

Organisation	Partner Governors
Sheffield Primary Care Trust	Jeremy Wight Vacant
Sheffield City Council	Bob Kerslake Jan Wilson
NHS Yorkshire and the Humber Strategic Health Authority	Vacant
University of Sheffield	Keith Burnett
Sheffield Hallam University	Phil Jones
Sheffield College	Vacant
South Yorkshire Police	Jon House
Sheffield Care Trust	Martin Rosling
Sheffield First Partnership	Vacant
Voluntary Action Sheffield	Tim Plant
Non-Sheffield Primary Care Trust	Jayne Brown

Foundation Trust Membership

During 2007/08 the foundation trust membership database was revised to ensure that the register was as up to date as possible and membership now stands at over 18,600.

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

We also run a series of exclusive members' events. During 2007/8 these included lectures on:

- MRSA and *Clostridium difficile* - April 2007
- Diabetes - August 2007
- Antibiotics and their role in the fight against infection - November 2007
- Allergies - is this a 21st century affliction? - January 2008

Meeting our Targets

During the year the Trust's total inpatient waiting list decreased significantly. The reduction was the result of a combination of initiatives that are making the Trust more efficient leading to a decrease in the inpatient waiting list year on year.

The table below provides a summary of the Trust's activity in 2007/08 in comparison with the previous year.

	Target 2007/08	Actual Activity 2007/08	Actual Activity 2006/07	% Activity Change
Inpatient and day case episodes	173,998	174,958	175,566	**-0.3%**
Outpatient attendances	844,575	838,999	827,466	**+1.4%**

During the year the Trust's total inpatient waiting list decreased significantly. The reduction was the result of a combination of initiatives that are making the Trust more efficient leading to a decrease in the inpatient waiting list year on year.

	Target	31 March 2008	31 March 2007	% Change
Total inpatient waiting list	7,331	7,735	10,103	**-23%**
Inpatients waiting over 20 weeks	0	0	106	-
Outpatients waiting over 11 weeks	0	0	0	-

18 weeks

The Government's target of 18 weeks from referral to treatment comes into force in December 2008. To ensure compliance with the target the Government also set milestones for admitted and non admitted patients to be achieved by March 2008. As the table below shows, the Trust has not only achieved but also exceeded these milestones by a significant amount.

	Target	Actual	Variance
% Admitted patients less than 18 weeks	85% in March	89%	**+4%**
% Non admitted patients less than 18 weeks	89% in March	93%	**+3%**

We have a dedicated team of professionals working towards the single goal of improving patient care.

Diagnostic waits

No patient should have to wait longer than six weeks for a diagnostic procedure. This target, which covers a wide range procedures including: MRI and CT scans, ultrasound, echocardiography, respiratory physiology and sigmoidoscopy was a very challenging one for the Trust. At the beginning of the financial year nearly 20 per cent of patients, mainly those waiting for MRI scans, had to wait longer than six weeks for their investigations. However the target was achieved and currently nobody is waiting more than six weeks for a diagnostic scan, with the vast majority being seen within 3 weeks.

We are also looking to offer imaging on demand for scans such as MRI, CT and Ultrasound, which historically were booked on another day. Although currently in the pilot stage, by December 2007 approximately 20 per cent of outpatients were being scanned on the day they attended their clinic appointment. If preparation is required not every patient can be scanned on the same day, nor do some people choose to be. However, numbers continue to increase and we are confident that by December 2008 we will be able to offer all patients who want their scan the same day this opportunity.

Infection control

The Trust exceeded the Government's target to reduce cases of MRSA bacteraemia by 20 per cent, with 36 cases recorded during the year. This represents a 40 per cent reduction over the year and a 65.4 per cent reduction since the target was introduced in 2003/04, which equates to 0.5 cases per 10,000 bed days. We also achieved the local target, agreed with Sheffield Primary Care Trust, for incidence of *Clostridium difficile* (see also *Improving the Hospital Environment*, page 25).

Accident and emergency

The Trust achieved the Healthcare Commission assessment of the target for 2007/08 of assessing and admitting, treating or discharging 98 per cent of patients within 4 hours of their attendance in the accident and emergency department.

The Trust exceeded the Government's target to reduce cases of MRSA bacteraemia by 20 per cent.

Pulling your finger out - the Infection Control Team have been instrumental in driving up standards.

Investing in Buildings and Equipment

We believe that having the most appropriate hospital settings and facilities and the best equipment will help us to ensure patients have the highest possible quality of experience.

New outpatient facilities at Weston Park hospital

Over the last few years, we have invested heavily in Weston Park hospital and the final part of that investment programme was completed during the summer of 2007.

The outpatient department was completely re-designed and the outpatient consulting suite capacity extended by 50 per cent. The dignity and privacy of our patients is of the utmost importance and to ensure that it is respected the new outpatient suites have improved soundproofing and separate examination and consulting rooms.

A light and airy waiting area has been created close to all the outpatient facilities including the re-designed area where patients have their bloods taken prior to seeing the doctor and/or having chemotherapy.

The Weston Park Hospital Cancer Appeal provided additional funds to upgrade the refurbishment so that the finishes are of a high specification, improving the environment still further and creating a welcoming and relaxing atmosphere for patients.

Renal dialysis satellite unit

In December 2007 we opened a purpose built renal dialysis satellite unit in south Sheffield. This was done in partnership with Fresenius Medical Care Renal Services UK Ltd, who also manage and staff the unit, with medical cover, dietetic support and other support services provided by the Trust.

The unit, in Broadfields Business Park, has eighteen dialysis stations, isolation facilities and its own patient parking. It is able to dialyse ninety patients three times a week. As well as expanding our haemodialysis capacity, this has meant that suitable patients can have dialysis nearer to their homes, reducing the time they have to spend travelling to and from treatments and improving their quality of life.

Harmonising medical equipment

Our Medical Equipment Management Group oversees the procurement and training for medical equipment throughout the Trust. During the year it began a planned replacement programme to rationalise and standardise equipment and where possible to achieve better value in purchasing and usage.

The first major step was the replacement of over 1000 infusion devices. The new, more sophisticated devices have improved patient safeguards illustrating that better value and safety can go hand in hand!

Sir Robert Hadfield wing

In October 2007, the Trust welcomed HRH the Duke of Kent KG to perform the official opening of the new Sir Robert Hadfield wing at the Northern General hospital.

Brought into use during April 2007, this £30m medical ward development was designed with the needs of the elderly in mind. Half of the beds are provided in single rooms with en-suite facilities to give patients additional comfort and dignity. Specially designed 'assessment for daily living' rooms enable occupational therapists and physiotherapists to assess patients' abilities in simulated home environments, such as the kitchen or bathroom ensuring any assistance they require to live at home can be organised prior to their return.

Facilities also include 'barrier nursing' rooms to provide care for patients with infections such as MRSA or Clostridium difficile and overnight stay suites for relatives.

Operational Review

Improving our clinical services

We are always seeking ways to improve our services, whether by reassessing the way in which they are provided, making them more accessible, reducing waiting times, or by introducing new techniques and technological advances.

Pre-operative assessment

The Government's target of 18 weeks from referral to treatment by December 2008 has been the focus of much of our work during the year. One of the results of this work has been the development of a pathway for all patients coming to us for elective surgery. It provides a consistency of approach from decision to treat, through pre-operative assessment (POA) to surgery and will provide robust support to the 18 week pathway by ensuring patients are fit for surgery.

At the end of March 2008 we opened a centralised POA unit at the Northern General hospital. The unit is a purpose built 'one-stop-shop' for patients from general surgery, orthopaedics, plastics and vascular surgery. An innovative appointment process easily enables patients to access a multi-disciplinary team to assess their fitness for surgery. As well as bringing together expertise from anaesthetic, nursing and therapy staff, the unit will house innovative services such as cardio-pulmonary exercise testing, which has been shown to have a significant beneficial effect on predicting post-operative care requirements. We anticipate the unit will have a significant impact on reducing the amount of surgery that has to be cancelled due to medical unfitness, and will improve the experience patients have of the assessment process.

Critical care department

March also saw the opening of another state of the art facility at the Northern General hospital, this time for patients in need of critical care. The new critical care department has bed spaces for 36 patients and incorporates many design features to enhance the environment for both patients and staff. We have increased the amount of single room accommodation to improve privacy and infection control. In addition external plant rooms enable essential maintenance to be carried out without disturbing patient care and keeping noise levels to a minimum.

Currently we are also undertaking a major review of the location for the provision of level 2 (high dependency) and level 3 (intensive care) at the Royal Hallamshire hospital, the main objective of which is to provide safe care for patients in a quality environment.

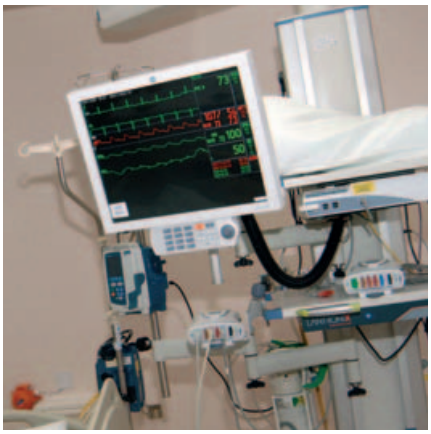
Improving services for heart failure patients

In July 2007, the Healthcare Commission published its Heart Failure Improvement Review, which looked at services provided by the Trust and Sheffield PCT. The findings highlighted a number of areas where the services in Sheffield provide good quality care. However, it indicated that further work was still needed in certain areas to provide even better care and support for people with heart failure.

In response to the review, we held a multidisciplinary heart failure service improvement session in October 2007 enabling stakeholders to contribute to the development of a service improvement plan. Building on the success of this event, a working group has developed a vision for a unique heart failure service with a high level patient pathway. This will involve:

- Establishing a heart failure management team with a lead clinician and two lead nurses
- Creating a lead directorate with responsibility for co-coordinating the service for heart failure patients across primary, secondary, tertiary and palliative care
- 'Designated heart failure beds to form an inpatient base
- Expanding the nurse specialist team - three new posts and administrative support has been approved for 2008
- Funding an audit data clerk post to support participation in the National Heart Failure Audit
- Purchasing new equipment to support the service

After its redevelopment, the service will be recognised as an important and high profile cross directorate sub-specialty at the Trust, delivering evidence-based care of a uniformly high standard regardless of the patient's 'port of entry'. Follow up care will be provided through a designated heart failure outpatient service, allowing easy transfer between primary and secondary care as required.



Caring for patients with dementia

It is now recognised that better care is needed for people with dementia whilst in acute services. We had already identified care of vulnerable adults as an educational priority and commissioned the University of Sheffield to run a short course enabling nurses to gain practical knowledge of caring for this group (See also, Governance and Healthcare Standards, Page 33). The course, which was run three times during 2007, looked at care for people with a learning disability, mental health problems, dementia and frail older people. It included helping participants to develop a brief action plan of how practice could be changed to enhance the care of one of these groups in their clinical area, and many chose to concentrate on dementia.

To help staff understand and respond to the needs of dementia patients in particular, we developed a number of initiatives looking at their care in the context of individual directorates. As well as providing staff with a greater understanding of the disease, study days were designed to enable them to see the experience of being in hospital from the point of view of the person with dementia. Staff were encouraged to have a more enabling relationship with the patients and to see their behaviour as 'difficult to understand' rather than 'challenging'. In some instances staff were given the opportunity to work with a small group of patients on the dementia ward.

Study days covering these kinds of topics were run for staff in both the Emergency Care and Surgical Services Directorates. A study day was also run for matrons and ward managers from both directorates to consider the management issues when caring for people with dementia, to provide an understanding of best practice for dementia care and to discuss future developments.

Mental Capacity Act

Closely associated with our work highlighting the needs of dementia patients, was training linked to the Mental Capacity Act 2005 (MCA), which came into force in two stages during 2007, in April and October. The Act affects everyone working with, or caring for, adults who lack the capacity to make decisions for themselves. To ensure staff were fully aware of and understand its implications, we seconded a trained nurse to the role of MCA Facilitator. As well as giving advice and providing information about MCA problems in clinical areas, the facilitator delivered presentations and workshops to over 800 staff from a wide range of disciplines. A Mental Capacity Act Resource Pack has been produced for managers and an e-learning course is now available for all STH staff, to give them a basic understanding of the Act and how it affects the Trust. In addition we are developing a policy, practice guidelines and preparing an MCA section for the intranet site, both of which should be available during Spring 2008.

Improving services for cancer patients

Haematology

In May 2007, in response to stricter national and international regulations for the provision of high quality haematological cancer services, we embarked on a £4.6 million expansion of our haematology services. It will improve facilities and further reduce the risk of infection for patients with acute leukaemia and aggressive lymphoma who are undergoing intensive chemotherapy or bone marrow transplantation.

The development, now nearing completion, will centralise all bone marrow stem cell transplant activity in the North Trent region into a single site clinical facility in the Royal Hallamshire hospital. It will also incorporate improved facilities for teenagers and young adults with haematological cancers.

Two wards at the Royal Hallamshire are being completely refurbished to include an additional six side rooms with en-suite bathroom facilities and clean air filtration systems. This will increase the number of separate rooms suitable for remission induction of acute leukaemia and bone marrow transplantation to eleven. The haematology day ward is moving floors so that it can expand to provide better facilities that will ensure patients receive a safe and timely service in the most appropriate setting.

At the same time Sheffield Hospitals Charitable Trust, ably assisted by actor Sean Bean, launched the leukaemia and blood disorders appeal. The appeal, to provide funding to improve the experience and comfort of patients undergoing prolonged treatments, often involving long periods of isolation, has already raised nearly £300,000. As well as raising money, we have also been successful in the local recruitment to clinical research trials in haematological cancer and have been commended by the National Cancer Research Institute for far exceeding national targets.

Other developments in this area of care have included a successful bid to host the network-wide diagnostic service for blood born cancers, as well as the introduction of an electronic prescribing service for chemotherapy, designed to improve patient safety.

Colorectal Cancer

The key development in this area of cancer care came in response to the implementation of cancer waiting times targets, which required us to treat suspected cancers within 62 days of GP referral and all cancers within 31 days of diagnosis. The colorectal cancer team, one of our largest, receiving in excess of 1600 referrals a year, draws its expertise from many different directorates, which made meeting these targets all the more challenging. In response, the service was redesigned utilising nurse practitioners to increase clinic capacity. This ensured that patients were seen within a few days and that the assessment process was streamlined to offer them a quality service. A 'surgical pool' was set up and a single point of entry encouraged enabling capacity to be matched against demand.

Every effort was made to put the skills of the team to best use, ensuring the right person was at the right place at the right time. Staff were increasingly involved in the new initiatives. To help to develop their understanding we implemented a 'pin yourself to a patient' system. This allowed a member of staff to follow one patient through their whole cancer journey, enabling them to gain an insight into the system from the patient's perspective. Whenever a patient did take longer than planned to complete their cancer pathway, we looked at why this had happened, learned from it and made changes where possible.

This work highlighted the benefits of multi-disciplinary team working. It enabled us to successfully transform services, ensuring through staff engagement that patients were seen rapidly and given access to the right investigations and treatment, whilst at the same time making sure no patient got left behind. By the end of March 2007 no patients exceeded their planned pathway, unless by clinical exception, enabling the Trust to meet the government cancer target one year early.

Managing Trust Business

We work to manage the Trust efficiently and effectively enabling us to provide the highest quality of care in a safe setting, ensuring that we are prepared to handle any eventuality and at the same time, reducing our impact on the wider environment.

Adding Value Programme

Delivery of high quality patient care is our top priority. By cutting out unnecessary steps in the patient pathway, we can reduce the number of attendances, making the system better for the patient, and more efficient and cost effective. Equally, we seek to improve efficiency in the corporate support services and cross-organisational ways of working.

The Adding Value Programme is an operational improvement programme that was launched in 2006/07 to deliver productivity and efficiency savings over three years to 2008/09. It has two key aims, to:

- Put the Trust on a stable financial footing, at minimum delivering £90m of savings and ideally generating surpluses to invest in improving patient services
- Ensure directorates have the necessary information, capabilities, corporate support and process mapping/redesign to drive efficiency and service improvement on a continuous basis.

The program provides a structured framework within which a range of productivity and efficiency projects can be coordinated and managed. During the two years since the programme began there have been improvements in length of stay across a number of specialties compared to the Dr Foster national benchmarks. Additional case managers have been appointed in orthopaedics and acute medicine to improve the management of patient discharge in these key areas. Work is also ongoing to reduce the number of delayed discharges and improve the patient experience.

We have improved peri-operative care through increased provision of pre-operative assessment. This, and plans for the development of a theatre admission unit at the central campus are all helping to ensure that surgical systems are effective.

Early in 2008, we embarked on '*The Productive Ward - releasing time to care*', a programme from the NHS Institute of Innovation and Improvement. This sets out the way in which wards and the delivery of care are organised to cut out unnecessary waste, create an environment that is calm and tidy and make the ward a more enjoyable place to work. Ultimately the programme aims to increase the amount of time ward staff spend with patients.

We are working to maximise benefits from the introduction of information technology across the Trust (See *New Technology*, page 27).

Considerable effort has also gone into seeking savings from better procurement of goods and services, optimising use of drugs, minimising bank agency and over-time costs and many similar initiatives.

We are committed to building capability and capacity in leadership and were successful in our bid to become a pilot site for the NHS Productive Leadership Team - Making Time to Lead - with the Institute of Innovation and Improvement. This project aims to release leadership time by working with the Trust Executive Group and their support staff in the use of tools and techniques including the effective use of email and meetings and diary management.

The Trust faces a significant challenge in 2008/09 and beyond to deliver financial balance and achieve the 18-week target as well as maintain other existing local and national access and quality objectives and to make our contribution to reducing health inequalities and improving the health of the community.

The size of the challenge and change agenda cannot be underestimated, but there are many good ideas to improve efficiency and so invest in patient care. To capitalise on these and re-energise the Adding Value Programme, we engaged external support to work with the Executive Group to develop a strong corporate productivity and efficiency plan for 2008/09. The plan aims to deliver sustainable recurrent financial benefit consistent with the 'Adding Value' principle of being good for patient care. The essence of this work is to make things happen 'because we can' with a clear focus on leadership, ownership, ensuring the engagement of our staff and delivering the benefits to improve service performance.

The Sheffield floods of 2007 posed a particular challenge.

Battle boxes are provided to all clinical areas in case of emergency.

Emergency Preparedness

A significant part of managing our business is to ensure that we are able to cope with any eventuality, like the flooding that occurred in Sheffield in June 2007, in line with the NHS Emergency Planning Guidance 2005. This sets out the responsibilities of NHS Trusts to ensure they have plans in place to respond to a major incident or serious internal event such as electricity failure or loss of other utilities.

The Executive Director with responsibility for emergency preparedness is the Chief Operating Officer. We have also appointed an Emergency Planning Manager to ensure that the Trust is in a state of readiness should a serious incident occur. In addition, a member of staff has been seconded until September 2008, as the Flu Pandemic Project Manager.

An Emergency Preparedness Operational Group (EPOG) has been established to take this work forward and check the resilience of our major incident plans. The group, which meets bi-monthly, will ensure communication and co-ordination of incident planning across the Trust. Membership is drawn from all the clinical groups and relevant corporate departments. Individual directorates have also identified business continuity leads to manage, risk assess and plan for critical internal events to ensure that should services be interrupted for whatever reason, we can continue to provide key services as far as is reasonably practicable.

This planning enables directorates to recover from an interruption and get things back to normal, minimising inconvenience to patients. Key action cards for use in the event of incidents such as electricity failure, loss or contamination of water supply, interruption to the medical gases supply and loss of the telephone and bleep systems have been developed for wards and departments.

We have also addressed a number of issues that arose directly from the flood, and an electricity failure in November 2007. As a result we have:

- Ensured that essential equipment has an uninterruptible power supply
- Increased the resilience of the medical gases supply to the Jessop Wing
- Increased the number of portable laedal suction units
- Ordered battle boxes containing wind up headlamps, torches and lanterns, for distribution to wards
- Ensured key staff have access to all site areas during an incident

Environmental Policy

The Trust is committed to reducing its carbon emissions and the impact it has on the environment. Towards the end of 2007, we undertook a thorough review, with the help of external consultants, to measure precisely what that impact was. The review highlighted good practice as well as areas for further improvement, producing detailed recommendations.

Our recycling programme is a key area of our environmental activity. It forms an integral part of our waste management strategy with around 18 per cent of waste materials diverted to recycling and reuse processes. We have a number of recycling initiatives in operation, including one for cardboard that uses recently purchased baler machines to facilitate easier transportation. The Trust is home to a number of bottle banks with over 6000 tonnes recycled to date. We have collection systems for all waste metal and now for the first time, we are recycling items of clinical waste. These are segregated and sent to recycling centres to reduce our landfill impact still further. With around 90 points across the Trust, many staff are able to contribute towards our paper-recycling scheme. We have one main plastic recycling point, which is mainly used for bottles from our renal services. We are currently working on the introduction of a localised plastic recycling system and will be trialling this in certain departments during 2008 with a view to rolling it out across the Trust.

Due to new legislation that came in to force in 2007/08, the disposal of all electrical equipment is tightly controlled so it cannot be sent to landfill. The Trust operates an alternative system for dealing with this type of waste. All Waste Electronic and Electrical Equipment (WEEE) is either recycled or reused via a selling-on process now operated through the Supplies department. This enables us to comply with the law while at the same time reducing our environmental impact.

We also have and environmentally friendly transport policy, aspects of which are covered in *Our Staff* on page 24.

Our recycling programme forms an integral part of our waste management strategy with around 18 per cent of waste materials diverted to recycling and reuse processes.

Our Staff

Sheffield Teaching Hospitals employs around 13,500 people - they are our most important resource. So we must make sure that we are a responsible employer, providing opportunities for career and personal development for all our staff and that we find ways of saying thank you for their hard work and dedication.

A responsible employer

In 2007, we were re-awarded the 'Two Ticks' disability symbol. This reflects our continued commitment to promoting equality and eliminating discrimination in all its forms, whether affecting staff or people using our services. Similarly, we are committed to meeting our obligations under the new Gender Equality Duty, part of the Equality Act 2006 and produced a Gender Equality scheme and action plan. The new scheme, joins those covering disability and race equality, on our website at www.sth.nhs.uk

We continued to develop relationships with the local community, working with Burngreave New Deal, local schools and Sheffield College to ensure that we recruit a diverse workforce. Through the Regional Employability Scheme, which provides successful participants with training and the offer of a permanent job, we employed over forty-five people. The majority were previously unemployed and forty per cent were from black and minority ethnic groups. As well as providing employment opportunities, the scheme also develops confidence; allowing participants to unlock their potential. This is evidenced by those on the scheme who have gained promotion.

However, the year was not without its problems. A new method of appointing junior doctors, through a national electronic application service, the Medical Training Application System (MTAS), to support Modernising Medical Careers (MMC) presented us with many challenges. Although the overall objective was achieved and the majority of posts were filled by August 2007, the new system had to be suspended. Poor functionality, lack of technical support and issues of data security resulted in our having to reintroduce the old manual system. What should have been a more efficient method of recruitment turned out to be a more cumbersome and time consuming process than that previously used and MMC became the subject of a national independent enquiry.

Meeting the European Challenge

From 1 August 2009, new European legislation, the European Working Time Directive 2009 (EWTD 2009), will reduce the maximum average hours of work for all training grade doctors from 58 to 48 hours a week.

As the largest NHS foundation trust in England achieving EWTD 2009 will be a challenge for us which will be made more difficult by the complex nature of the Trust.

The new legislation will have an impact across the Trust and will incorporate risk management and clinical governance issues. In July 2007, Dr Jane Fitch was appointed to help prioritise, organise and implement the changes required for us to comply with the directive. Since then, we have carried out a detailed audit of the current working hours of training grade doctors, producing an organisational chart highlighting those directorates that need to make the largest or most significant changes. Discussions have been held with all clinical directors, general managers and EWTD leads. Detailed audits of workload and activity have taken place in those directorates likely to be most effected and an audit of the financial implications for the Trust has also been completed.

The changes required by the Directive must be implemented if we are to continue lawfully to employ training grade doctors after 1 August 2009, and work will continue throughout 2008 to ensure that we are compliant. Additional directorate meetings and targeted activity exercises have already been planned and an integrated project plan for EWTD 2009 will be produced.

Developing our staff

We want to make it easier for all staff to access training and development opportunities. To facilitate this a new study leave policy has been introduced. At the same time, we have been developing new ways of accessing learning and, as a result have launched several e-learning packages this year, covering areas such as diversity.

The Trust was also awarded more than £20,000, from the White Rose Health Improvement Partnership and Medipex, to develop an innovative training package that will help doctors, nurses and allied health professionals to improve their ECG (Electrocardiogram) interpretation skills. The interactive, online learning tool will provide clinicians with access to a vast library of ECGs helping them to learn how to recognise common and uncommon

Glenys Wasteney (centre) receiving her Thank you award from Andrew Cash and ITV presenter Carolyn Hodgson.

conditions from ECG patterns and correctly diagnose a wide range of heart conditions.

Over 250 staff took the opportunity to improve their literacy and numeracy skills through the 'Skills for Life' assessments. These are now available to all staff, as is a wide range of NVQs. Programmes to help staff access professional health care training are also provided. At the same time, we have continued to implement the NHS Knowledge and Skills Framework, which will ensure that everyone receives training and development appropriate to their job. With the introduction of local mandatory training plans, more relevant, timely and appropriate mandatory training is now being provided and more than 6000 staff have trained in conflict resolution techniques.

We are implementing the Leadership and Management Development Framework. The first senior managers and clinicians joint programme was developed and run in conjunction with Sheffield Hallam University. This year's Leaders Conference, entitled 'would you like to wait 18 weeks?' was held in September 2007. It examined how transformational leadership and 'doing things differently' would help to deliver the 18-week patient journey. The guest lecture series continued in June 2007 with a talk by BBC special correspondent, Fergal Keene OBE, who spoke on the theme of transformational change.

This was followed in January 2008, with a lecture on team leadership given by paralypian Dame Tanni Grey-Thompson DBE.

Providing benefits

We continued to negotiate benefits for staff from a range of suppliers. We joined the national car share database 'Liftshare.com'. This service allows people to form car share arrangements but can also be used to find walking or cycling buddies.

Staff who register can access the on-line scheme from work or home choosing to search for lifts with colleagues or from the whole database. They reduce their travel costs, meet new people and often having an easier journey to work. At the same time, they are contributing to a reduction in congestion, pollution and carbon dioxide emissions in the city, so helping to reduce global warming.

Working with South Yorkshire Passenger Transport Executive and other partners the park and ride Service 505, running from Tesco on Abbeydale Road to Sheffield University that serves the Royal Hallamshire hospital on the way was extended. Previously only running during core commuting hours, there are now 18 bus services running every half hour at peak times and hourly for the rest of the day. More flexible ticketing, such as a 10-day ticket booklet for £9.50 without an expiry date, has also been introduced. We are also introducing a salary sacrifice scheme for staff wishing to purchase monthly/annual bus tickets.

Cyclists have not been forgotten. Free cycle training was offered to all staff during the summer and will be repeated in 2008. The secure cycling provision at the Northern General hospital was increased considerably and we are currently looking to do the same at the Royal Hallamshire. We are also in the process of introducing the 'Cycle to Work' initiative.

The Trust added reduced gym membership to its list of staff benefits. Various departments also became involved in a pilot study, run by Leeds University and the Health and Safety Laboratory, designed to promote physical activity in the workplace. Participating staff were given free health checks, advice on physical activity and encouraged to get active through lunchtime walks, group challenges etc. Follow-ups after twelve months will assess how many people have continued with their new exercise regimes and the benefits they have derived from it.

Saying thank you

We recognise and celebrate the dedication and achievements of individuals and teams who work for us through our annual Thank You Awards. Presented in October 2007 they illustrated how staff had worked above and beyond the call of duty to ensure that patients, colleagues and visitors received the very best service. The winners and highly commended nominees highlighted the very best examples of team working, commitment, dedication, leadership and innovation.

Improving the Hospital Environment

Improving the environment in our hospitals is a priority for us and we have invested in a wide range of schemes to upgrade facilities and ensure the highest levels of cleanliness throughout the Trust.

Infection Control

As a reflection of the fact that Infection Prevention and Control (IPC) is one of the Trusts highest priorities we have committed significant financial resources to improve ward and department areas and support enhanced cleanliness. This has included major capital schemes, full ward upgrades and refurbishments, small upgrade schemes, equipment purchase and replacement programmes.

However, improved facilities are not the only developments in IPC and cleanliness. The Trust has rolled out a locally developed accreditation scheme that sets standards of expected practice and monitors that these standards are being met. Over 90 per cent of wards have now completed their assessment and the project is being extended to cover outpatient areas. This particular piece of work has attracted a lot of national interest; the infection control team was awarded third place in a national competition for their work on the accreditation programme and it was highly commended by the Department of Health's MRSA/ Cleaner Hospitals Team when they assessed the Trust in August 2007. In addition to their comments about the accreditation scheme, the national team was very pleased with the Trust's progress and provided a very positive assessment of our current practices and plans for the future.

Raising the profile of infection prevention and control through the accreditation scheme is one of the reasons we achieved outstanding results in reducing MRSA bacteraemias. The number of patients who have developed an MRSA bacteraemia continued to fall and the Trust exceeded the 60 per cent reduction target set by the Department of Health. Hospital acquisition colonisation also continued to fall. This was related to the Trust's early adoption of screening. We currently screen over 60 per cent of all admissions and are well placed to achieve 100 per cent screening ahead of the Department of Health's 2011 deadline.

Although *Clostridium difficile* (C.diff) is more of a health community issue, we are beginning to get good results and see a reduction in the number of patients affected by C.diff. The winter saw the lowest level of infection for three years and we have achieved the local target agreed with Sheffield Primary Care Trust. The local health community has implemented a number of measures, including the agreement of Sheffield Care Trust and Sheffield PCT to fund an additional consultant microbiologist to ensure that general practitioners and Care Trust staff have access to expert advice.

This cross community work will begin to help us achieve the Department of Health's target for reducing C.diff infections and within the Trust we have put in place several strategies to speed progress. We have appointed antibiotic prescribing pharmacists to ensure patients receive the right antibiotic, but for as short a time as possible. The prolonged use of antibiotics, particularly broad-spectrum antibiotics (those used to treat an infection which may be caused by a number of different infections) is a major cause of C.diff. We invested heavily in new technologies, steam cleaners and hydrogen peroxide vapour (HPV) machines. HPV machines use a safe 'bleach based' mist that settles on all surfaces killing the micro-organisms that can lead to infections. A specialist team of staff was appointed to ensure that this is available as soon as a ward or bed area needs to be deep cleaned.

Over the course of the next year we plan to continue with our ward refurbishment and deep clean programmes, revise and update the accreditation programme, and introduce an e-learning package across the health community. These measures will all help to reduce the number of patients who are affected by MRSA and C.diff. We will also be introducing an enhanced care facility for affected patients, which will provide isolation facilities, improved cleanliness and enhanced nursing and medical care and treatment.

Genito-urinary medicine clinic rebuild

The high rate of teenage pregnancies, the rising incidence of sexually transmitted infections, and the growing impact of HIV/AIDS raised the profile of sexual health services in the UK. The impact has been particularly felt in large cities. In Sheffield this resulted in us seeing 17000 patients a year in a clinic built to accommodate less than one quarter of that number, rendering it no longer fit for purpose. Concern about the effects of unacceptably long waiting times for clinic appointments on individuals and of the inevitable delay in treatment on public health prompted the Government to set a priority national target that all patients should be seen within 48 hours of their first contact with the clinic.

To enable us to meet this target, towards the end of 2006 we began a programme to improve our clinical facilities the first phase of which, a new £1 million male clinic, opened in February 2007. A further investment of £2.5 million has enabled us to rebuild the remaining clinic facilities and we opened a new female clinic in November 2007. Patient records, administration, and a new clinical psychology suite were moved into the old clinical floor and opened in January 2008. The final phase of the rebuild, a reconstructed new ground floor consisting of HIV, research and teaching facilities will be completed in April 2008.

The new facilities have considerably improved the environment for both patients and staff and have already had a positive impact on patient throughput enabling us to achieve the 48-hour target while increasing the number of patients being seen.

Charles Clifford Dental hospital

In response to the projected shortfall in the number of dentists in the UK, which indications suggest could be worse in South Yorkshire than the national average; we embarked on a programme to increase dental student numbers from 250 in 2005 to 435 by 2010. For us to accommodate this increase and the increased volume of patients meant expanding the Charles Clifford Dental hospital and dental school. So, in June 2007 we began a development programme that included:

- Building a new wing for the hospital and dental school
- Enlarging the hospital's clinics
- £800,000 worth of improvement to the clinical skills facility
- Enlarging the dental practice unit

When the work is completed, which we hope will be by the end of 2008, it will not only increase capacity safeguarding the future of both the Charles Clifford and the dental school, but will also attract increased funding for dental training, new buildings and equipment, as well as improving service provision.

Charles Clifford Dental hospital providing adult and paediatric care.

New Technology

We are constantly striving to be at the forefront of technological advances, whether by improving existing systems or introducing new ones, to help us provide the best possible services for our patients.

Radiology information system

A new radiology information system (RIS) was introduced at the end of the last financial year and has modernised our existing technology, providing a unified system across the Trust. This was essential for the new picture archiving and communications system (PACS), which was implemented some months later. Despite a number of difficulties, RIS has been in daily use enabling consultant radiologists to report on numerous images much faster than previous systems.

The core infrastructure for PACS, which enables images to be stored digitally rather than on film, went live in October 2007. It is already beginning to revolutionise the way in which clinical staff view and share images, such as X-rays and scans. As our hospitals carry out over 450,000 imaging examinations each year, including more than 28,000 CT scans, 13,000 MRI scans and 90,000 ultrasound scans, this has considerable potential to deliver real benefits for patient care.

Nearly 1,000 new personal computers and monitors have been installed to provide PACS access and, although the rollout is still continuing, many directorates are now benefiting from the faster workflow and improved imaging. Ultimately PACS will make clinical consultations easier for the clinician and quicker for patients, improving the quality and speed of diagnosis and treatment. As well as reducing the length of time patients stay in hospital, their exposure to radiation will decrease, as they will not have to undergo as many tests or repeat tests. In addition the system will enable us to provide more information to patients about their care and improve confidentiality.

Theatre management system

During the year we introduced a new theatre management system. The software supports electronic theatre bookings and allows patients to be tracked through the theatre suite, from reception, to theatre and through the recovery area, creating clinical records for each patient. Theatres can now be used more efficiently, reducing last minute cancellations and providing shared access to records of a patient's clinical care. Web-based views of the data have been developed allowing staff to access up-to-date information, supporting a busy operational environment.

ICE

We are also in the process of implementing ICE, a new web-based order (requesting) and results reporting system. It replaces the manual and electronic reporting systems in radiology and pathology. During the year ICE was established for radiology reporting while interfaces for pathology reporting were implemented and tested.

A requesting pilot in communicable diseases began in February 2008 and radiology and pathology results are scheduled to be available in ICE from April 2008. A trust-wide implementation plan for requesting will be developed after the pilot is reviewed in June 2008. Eventually, ICE may also enable other services, such as neurology, to benefit from electronic results reporting, as well as supporting discharge communications and GP requests and results reporting.

Digital dictation

In February 2008, after a successful pilot sponsored by the 'Adding Value Programme' (See *Managing Trust Business*, page 19), we began to rollout a new digital dictation system. For use by staff providing administrative support to our medical consultants, it allows a much faster turnaround of letters and documents for patients. The system enables secretaries to manage their workload more effectively, avoiding peaks and troughs and ensuring priority dictation is done first. The superior sound quality means there are fewer mistakes and less redrafting. Since tapes cannot be broken and all dictations are backed up and cannot be deleted, it is impossible for them to be lost. The general improvement in efficiency has also had the knock on effect of reducing the spend on private agency staff by 40 per cent. As well as being more efficient, digital dictation has improved administrative turnaround times contributing towards meeting the 18-week referral to treatment target.

69690 - speech recognition

There was another technological development during the year, this time in telecommunications. By ringing a single number, 69690, staff ask to be connected to other members of staff, wards or departments without the need to go via the switchboard or look up numbers in a directory. The system also connects to local GP practices, hospitals and other listed organisations. The system is about to be extended for use by the general public.

Our new theatre management system supports electronic theatre bookings and allows patients to be tracked through the theatre suite, from reception, to theatre and through the recovery area, creating clinical records for each patient.

Improving the Patient Experience

We are always trying to improve our patients' experience whether by changing the way we provide services, improving accessibility or simply making information about what we do easier to understand.

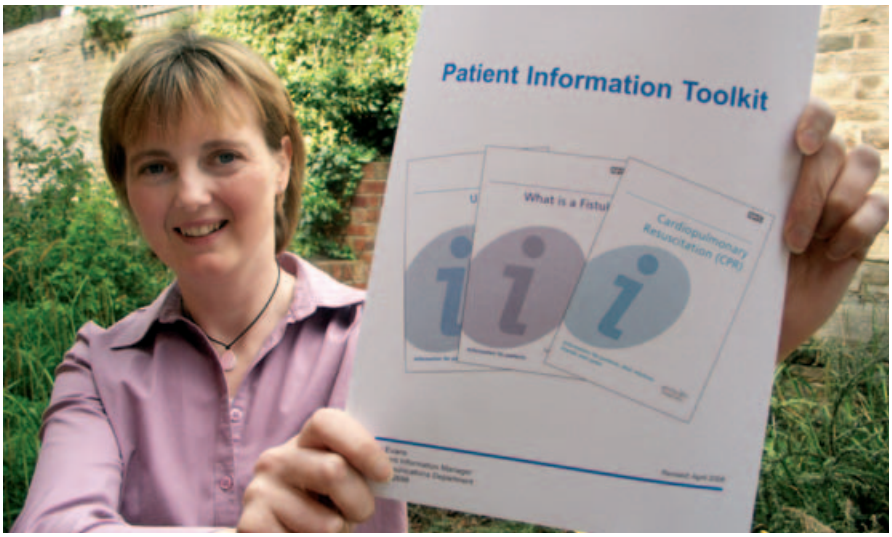
OHPAT service

Providing services in an outpatient rather than an inpatient setting is nearly always better for patients. An example of this is the Outpatient and Home Parenteral Antimicrobial Therapy service (OHPAT). The service enables patients who are well enough not to be in hospital, to receive intravenous antibiotics as outpatients or be taught to self-administer so they can give themselves the antibiotics at home. Since it was set up in 2006, the service has treated 299 patients, saving the equivalent of 3808 bed days. However, success has been limited by lack of capacity. This changed thanks to a larger, purpose-built unit on E floor of the Royal Hallamshire hospital, which became fully operational in March 2008.

Involving our patients and the public

Whatever we do, we need to listen to the views of patients and the public and we work hard to involve them in developing, monitoring and evaluating services. Twice during 2007/08 we held events bringing patients and members of the public together with health, social care and voluntary sector organisations to help us shape and streamline our involvement strategy.

We called on service users with a disability to help us identify and prioritise improvements to access. As a result we opened the first Changing Places toilet in the city at the Royal Hallamshire hospital.



Patient Information Manager Jo Evans with the new patient information toolkit.

This purpose built facility is fully equipped with an electronic hoist and height adjustable bench to enable people with profound or multiple disabilities and their carers to use an accessible toilet. It has received national recognition from the Changing Places campaign and we are now looking to open a second at the Northern General hospital. We have also provided thirteen additional disabled parking spaces and an accessible ticket machine at the Royal Hallamshire.

Among the initiatives being considered for 2008/09 is a system to allow patients to give on-the-spot comments about the care they receive. We are also working with patient groups to design and implement a 'mystery shopper' programme to provide detailed feedback on services that have a high impact on patients' overall experience and satisfaction.

Differing needs

Not everyone's needs are the same, which is why we have a number of multi-disciplinary groups looking at areas of care or particular patient groups. The Nutrition Steering Group addresses aspects of feeding from a patient's admission to hospital throughout their stay. This has led to the introduction of nutrition screening and assessment, helping nurses to identify problems and develop a nutrition care plan for each patient.

Nutrition is often a problem for older people, who are major users of our services, and also forms part of the work of the Older People's Task Group.

During the year the group has also focused on mental health, falls and end of life needs. An orthogeriatric service is being introduced to ensure elderly trauma patients are placed under the care of geriatricians. Here the emphasis is on optimising medical status, nutrition, pressure and pain relief, communication, rehabilitation and discharge planning

The End of Life Pathway Group, set up in 2005, produced a care pathway to provide better quality care for dying patients. Our aim is to make the patient more comfortable, helping staff to focus on good symptom control, comfort and maintaining dignity. The end of life care pathway has now been piloted on several wards and will be introduced throughout the Trust. We have also published a leaflet for relatives and friends designed to help them understand the care we will be providing. It also describes some of the more common symptoms that can occur at this time and explains how we can manage them.

Patient information

For some, the first contact with the Trust is through our literature, so we take patient information very seriously. Following the appointment of a new patient information manager in September 2007 work began on a new database to allow staff and eventually patients to view leaflets online. During the year we developed a number of key documents outlining the standards and procedures for producing information. These have included a revised 'Code of Practice for Producing, Publishing and Managing Patient Information Materials' and a Patient Information Toolkit, a practical document, providing a step by step guide to producing information.

Forums held at both the Northern General and the Royal Hallamshire hospitals early in 2008 enabled us to share our vision for patient information with patient information leads and coordinators, while a monthly newsletter, 'Patient Information News' was introduced to keep them up-dated.

Interpreter services

English is not the first language for everyone who uses our services and we began to introduce telephone interpreting in key areas to meet this need. The new facility, due to be completed in April 2008, offers patients speedy and confidential access to interpreters. A new contract to provide in-person interpreting is also due to begin in April.

Research and Innovation

We pride ourselves on being at the cutting edge of innovation and healthcare research, which helps us to continually improve the care we provide to our patients. 2007/08 was a particularly productive year, with a number of prestigious projects being initiated or coming to fruition.

Clinical Research Facility

In April 2007 Sheffield MP, Nick Clegg opened our new Clinical Research Facility (CRF) at the Royal Hallamshire hospital. The CRF, a joint venture with the University of Sheffield, provides a dedicated unit for investigators undertaking all types of clinical research involving adult patients and healthy volunteers.

The new facility allows us to offer investigators the highest standard of research expertise from the development of a protocol, through gaining ethics and governance approval, to completion of the project with high quality data. Spacious and well equipped, the CRF also enables us to provide excellent nursing and medical care to the healthy volunteers and patients who participate in research studies.

Devices for Dignity

'Devices for Dignity' Award

The Trust was selected as one of only two in England to pilot a Department of Health initiative to create healthcare technology co-operatives (HTCs). This innovative project, which brings together NHS organisations, universities, healthcare industries, patients and the public, is intended to develop new technologies for patients with long term conditions. Selection of the Trust as the lead, or host organisation was a reflection of our research and innovation capabilities, as well as our track record in bringing medical devices to the marketplace.

We are supported by five other 'node' trusts:

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

with the Universities of Cambridge, Coventry and Sheffield providing academic support.

'Devices for Dignity' (D4D), the name chosen for the HTC, will focus on the design, development and evaluation of medical devices that address dignity and independence of patients with long-term conditions. These factors are critical to a patient's feeling of well-being and quality of life, but are often overlooked by technology developers. The close collaboration with industry will enable devices, which meet patients' needs to be turned into commercially viable products. We hope D4D will become a national resource, acting as an exemplar for the national HTC programme.

Professor Wendy Tindale,
Clinical Director, Devices for Dignity

Biomedical Research Units

During the year the Trust made two bids, in conjunction with Sheffield University, to establish Biomedical Research Units in cardiovascular, and musculoskeletal disease. These bids were made under the aegis of 'Best Research for Best Health' the five year research and development strategy for the NHS in England. The strategy included the establishment of specialist National Institute for Health Research Biomedical Research Units (NIHR BRU), intended to drive innovation in the prevention, diagnosis and treatment of ill health and translate advances in biomedical research into benefits for patients.

Bids were invited from NHS/University partnerships where there was already a strong track record of partnership and research excellence. Both our bids were short-listed and, just after the end of the financial year, in early April 2008, we heard that both had been successful. Each unit will receive funding for four years with the first year drawing in £750k and £1m per year for the remaining three years.

This success is a major coup for the Trust and for Sheffield. It places us at the forefront of research, enhancing our reputation both nationally and internationally. It will increase our capacity to translate biomedical research into excellent clinical research to benefit patients as well as our scope to develop new external collaborations and attract additional investment. We will also be able to apply the lessons we learn from BRU status to the development of an Academic Health Science Centre.

Collaboration for Leadership in Applied Health Research and Care

In January 2008 we also put in a bid to the National Institute of Health Research, on behalf of our partners in South Yorkshire, to become an applied health research and care consortium. The South Yorkshire Consortium, which has been short listed by the Institute, aims to develop the self-management and self-care of long term conditions through applied research, health technology innovations and the translation of knowledge into quality patient care. If successful, the planned five-year activity would lead to step changes in:

- The amount and way in which applied research is undertaken in South Yorkshire
- The design, evaluation and delivery of services across the region
- How individuals within the participating organisations use research evidence provided by the consortium to improve the quality of the care they provide
- How we inform and respond to practice-based and joint strategic commissioning
- Partnership working between universities and health and social care providers in the region.

We heard that the bid was successful just after the year end and the work of the consortium will begin in October 2008.

Governance and Healthcare Standards

We want our patients to receive the highest quality care and are always working to achieve this, looking at our own internal systems and learning from national assessments, which examine our services and the way we handle our resources.

Annual Health Check

The Annual Health Check, carried out by the Healthcare Commission, uses a complex set of standards to assess trusts and provide patients with a detailed view of how NHS organisations are performing. The results of the 2006/07 health check were published in October 2007. We were one of only three NHS trusts in the region and 19 nationally to receive two overall ratings of 'excellent' for delivering quality patient care and making the best use of resources, placing us in the top 5 per cent of trusts in the country.

In its report, The Healthcare Commission stated that based on its assessment, the Trust "provided an excellent quality of service to patients, having made improvements compared to the previous year" and "continued to be excellent at managing its finances". We:

- Achieved all of the 24 core standards (made up of 44 components) relating to the quality of patient care such as safety, responding to patient's needs and standards of care
- Maintained performance on existing targets such as waiting times, and made significant progress on new national targets
- Met all the standards relating to patient dignity and respect
- Significantly reduced the number of reported MRSA bacteraemia cases
- Provided excellent value for money, making the best use of available resources

A new structure for clinical governance

We are committed to making sure we have processes in place to identify and handle potential risks to the safety and well-being of our patients. For this reason, a new department, Patient and Healthcare Governance was set up to oversee all matters of clinical governance, health and safety and clinical risk. A clear structure for reporting clinical healthcare issues was established through committees via the Healthcare Governance Committee to the Board of Directors. The committee is responsible for ensuring that all clinical areas are systematically reviewed. A 'clinical governance dashboard' has also been introduced to monitor the governance performance of clinical directorates.

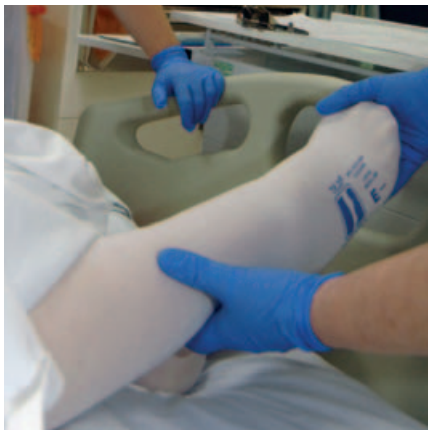
Clinical Assurance Toolkit

Beneath this overarching structure, we have introduced a wide range of measures to ensure patients are appropriately and safely cared for. The Clinical Assurance Toolkit (CAT) was developed by the Trust to provide a consistent, co-ordinated approach for assessing the quality of care we provide. The CAT brings together all the assessments and other clinical data currently gathered, into one user-friendly document. This ensures consistent Trust-wide standards, a multi professional approach and prioritisation of action planning. After consultation and training, the CAT for inpatient areas was launched in the summer of 2007 and a version for outpatient areas has also been developed.

The toolkit employs a traffic light scoring system to highlight areas of good practice and areas for improvement. A blue category, identifying excellence, has also been included and encourages staff to share good practice. Evaluations from the first wave of assessments have been influential in developing the web-based version of the toolkit to provide faster, more consistent assessments.

Practice development

The toolkit is one of a number of Trust-wide practice development initiatives that came into operation during the year. An invest and save project, 'dispensing for discharge' was successfully trialed at Weston Park hospital and went live in November 2007. Training began at the Royal Hallamshire hospital in January 2008 and the Northern General the following month, part of a roll out plan for all wards that meet the minimum requirement. The Trust's Evidence Based Council (EBC) undertook two projects during 2007, 'Breaking bad news' and 'Intravenous Access Project (IVAP)', the results from which will be disseminated in the spring of 2008. A new project 'Promoting a restful night's sleep' is planned for 2008. Work continued to support the implementation of 'A New Ambition for Old Age - The Next Steps in Implementing the National Framework for Older People', including the introduction of the single assessment process.



Our efforts to ensure the consistency of clinical practice across the Trust progressed during the year. Work continued to centralise nursing care guidelines and by January 2008, 53 out of a potential 196 guidelines were available on the intranet site. Clinical competencies and proficiencies were developed in a number of different formats for various topic areas and again every effort was made to ensure a consistent approach. Similarly we made progress in the standardisation of record keeping. Support and funding was provided for the creation of an inter-professional patient record and it is anticipated that a new member of staff will be appointed in April 2008 to lead its development and implementation.

Sharing good practice

One way of making sure our clinical practice is of a uniformly high standard is to share examples of good practice across the Trust. One way of doing so is through our practice development database, which during 2008, we plan to link with other databases including clinical audit and sections of the research department. However, we are constantly trying to find new ways of highlighting excellence. In July 2007 we successfully introduced a 'sharing good practice festival day' at which 22 people showcased their work and a second is planned for July 2008.

Caring for vulnerable people

We are particularly committed to ensuring that the most vulnerable members of society, whether children or adults, receive care that is safe and appropriate to their needs.

Work concerning vulnerable adults included the development of a learning disability resource pack for clinical areas and a suicide risk assessment as well as citywide initiatives looking at dementia and depression. We also commissioned the University of Sheffield to provide a course enabling nurses to look at the practical aspects of caring for vulnerable adults.

An audit of the care we provide for children was initiated, with a view to ensuring that it is child-centred, safe, effective, and meets the standards for a young person. Four care groups: head and neck services, specialised medicine and rehabilitation, specialised cancer services and emergency care were audited during the year with the five remaining groups due to be audited in 2008/09.

Reducing the risk of deep vein thrombosis for patients in hospital

The introduction of new procedures can have a very obvious and practical impact on the quality of patient care. According to new guidelines from the National Institute for Health and Clinical Excellence (NICE), patients being admitted for surgery should be assessed for their risk of developing a deep vein thrombosis (DVT or blood clot). In December 2007 we rolled out the risk assessment process to all hospital inpatients except day surgery and obstetrics as these patients have a different set of risk factors. Almost complete, this work will enable every patient to benefit from a risk assessment and for us to provide them with appropriate preventative treatment where necessary.

We received two overall ratings of 'excellent' for delivering quality patient care and making the best use of resources, placing us in the top 5 per cent of trusts in the country.

Working with our Communities

We are always looking for ways in which we can work with, or involve, members of the communities we serve. We value feedback from patients and service users and are grateful for the contributions made by our volunteers.

Mental health

As the largest provider of mental health inpatient care in Sheffield, many of our patients have mental health needs and these must be addressed if we are to achieve high quality care and good clinical outcomes. To enable us to do this, we produced our first mental health strategy during 2007/08.

Working with colleagues from Sheffield Care Trust we organised a mental health stakeholder event in June. This brought staff from both trusts together with service users as well as colleagues from Sheffield PCT and the voluntary sector. The event provided an opportunity for them to become involved and collaborate in the development of the strategy by helping us to identify the key issues.

The strategy, which is currently out to consultation, is a clear recognition of the inter-relationship between the physical and mental aspects of health. It aims to focus services on the mental health needs of patients, support a positive approach to mental health promotion and care, and provide a clear direction for service development. It also recognises that we cannot achieve these aims alone building upon the collaborative work already underway between services users, carers and health and social care professionals.

Developing stroke care

A new national stroke strategy was launched by the Department of Health in December 2007. It placed considerable emphasis on stroke being treated as a medical emergency. This involves patients being seen urgently by a specialist stroke team, and assessed for new treatments such as thrombolysis, which needs to be given within three hours of the onset of a stroke.

The Trust is well on the way to addressing much of this strategy. We are one of the top thrombolysing centres in the country, having introduced the treatment about four years ago. We have also set up five clinics to help people who have had transient ischemic attacks preventing them from progressing to a full-blown stroke. The results of the National Sentinel Stroke Audit showed us to be in the top 25 per cent of hospital stroke services. However, there is still work to do. We are currently carrying out an option appraisal to determine a single point of entry for all patients who have suffered an acute stroke and are developing a comprehensive ambulance protocol. We are working with a new stroke group to develop a commissioning strategy that addresses primary prevention, public and professional awareness and hospital, community and long-term specialist services, to help us improve services for patients and carers still further in the future. We are also involved in developing a stroke network similar to the current cardiac networks to improve stroke services regionally.

Expert Patient Programme

We have continued to work with our local communities through the Expert Patient Programme (EPP), which is designed to help people with long-term conditions to gradually self-manage their health. The EPP Steering Group, which has now developed a five-year plan of activity, ran 10 generic courses during the year. The Supporting Parents course proved successful and a further two were planned through special schools. A learning disabilities course was run in conjunction with Crown Hill Employment Services. This also proved so successful that a second course was planned for April 2008. A tutor-training event in March enabled us to train tutors from Sheffield, Chesterfield, Rotherham and Doncaster. Links were made with the Pakistani Muslim Centre and Roshni, a project for South Asian women, to look at whether courses could be provided for them. Money was made available from the Enhanced Public Health Programme for innovative work in the Lowedges, Batemoor and Jordanthorpe communities.

The future of the Expert Patient Programme relies on people self-referring into the programme. Experience has shown that those who would benefit most from learning about self-care are least likely to self-refer. Therefore GPs were asked to use their local knowledge and chronic disease registers to identify appropriate patients and encourage them to attend. As a result, the Richmond

practice asked for a course to be run and we hope that other practices will also consider offering courses. The Steering Group plans to extend the number of events held during 2008/09 and already has two further generic courses planned for June and September.

Volunteers

The Trust is fortunate in attracting a large number of volunteers willing to help and support our work. We make every effort to ensure that their valuable contribution does not go unrecognised. We must also provide a sound structure for managing them, backed up by policies and protocols to guarantee their health and safety, and make sure they are supported and given opportunities to develop during the time they spend with us. In August 2007, our work in this area was recognised when we were awarded 'Investing in Volunteers' - the UK quality standard for organisations that involve volunteers in their work. Presented by ITV's Emmerdale star Verity Rushworth, the award demonstrates our commitment to ensuring that each and every one of our 700 volunteers is fully supported in their role, that they feel valued and appreciated and have access to training and personal development opportunities.

Joyride!

We are always looking for new ways to engage or involve members of the local community. Towards the end of 2007, students from Longley Park Sixth Form College visited the Northern General hospital to carry out some filming in the now demolished Vickers 11. Entitled 'Joyride', the film was commissioned by South Yorkshire Police and Sheffield Futures to show teenagers and young people the consequences of car-crime. It was distributed to schools across the region at the beginning of 2008 and, if successful, may be rolled out to schools across the country.

Learning from our Patients

We are committed to delivering hospital services that are patient-focused, and make a real difference to the care we provide. To help us achieve this we make every effort to learn from the results of surveys and the views of our patients.

Inpatient survey

In November 2007, we completed the national inpatient survey, receiving almost 500 responses from a total of 850 questionnaires. The survey looked at topics such as hospital food, cleanliness and levels of privacy. The Trust achieved 61 out of a possible 62 green and orange scores denoting very good or good results and puts the Trust among the top performing hospitals across the country in significant aspects of care. There was only one red score which relates to the percentage of patients offered choice of hospital for their first hospital appointment, which is not entirely within the control of the Trust.

53% of patients scored the Trust as excellent in the question relating to overall satisfaction with care which ranked us as the second best acute teaching trust in the country.

Areas where the Trust scored in the best 20 per cent of trusts in the country included;

- Doctors and nurses washing their hands
- Confidence and trust in treatment
- Privacy during discussions, examinations or treatment
- The way in which doctors and nurses work together
- Patients who felt they were admitted to hospital as soon as necessary

Maternity care survey

Nearly 280 women who gave birth in Sheffield during February 2007 responded to the first national survey of maternity care.

The Trust scored highly in a number of areas and overall ratings of care were consistently higher than the national average. In particular, 87 per cent of women stated that they were always spoken to in a way they could understand during their antenatal care, compared to 81 per cent nationally. Women also felt they were treated with dignity and respect, were given information about birthing choices and were involved in decisions about their care.

Other key results showed:

- **97 per cent** reported having the name and telephone number of the midwife to contact if they were worried during their pregnancy (90 per cent nationally)
- **72 per cent** saw the same midwife for every or most antenatal checks (57 per cent nationally)
- **77 per cent** were always involved enough in decisions about their care (67 per cent nationally)
- **82 per cent** were always treated with kindness and understanding during labour and the birth (77 per cent nationally)
- **69 per cent** definitely received sufficient pain relief (64 per cent nationally)
- **96 per cent** felt the labour/delivery room was very clean or fairly clean
- **84 per cent** said a midwife discussed infant feeding with them and 78 per cent subsequently tried breastfeeding
- **100 per cent** had been visited at home by a midwife since the birth of their baby

Feedback from both surveys is being used to improve services still further. We are addressing ways to ensure patients are asked for their views on the quality of care whilst in hospital and we are looking at a variety of other ways of collecting patients' opinions, such as interactive questionnaires on the Patientline bedside entertainment system and the Internet.

Whilst the overall results of the maternity survey were positive, we identified some areas where improvements need to be made to bring the service up to national standards and are developing action plans to address these. In other areas, such as providing information on where women can have their babies, where the Trust actually scored higher than the national average, we have set up a task group to make further improvements, enabling us to provide a better standard of care overall.

We continue to use feedback from surveys to improve the quality of our care. Results from the 2007 inpatient survey will be available in spring 2008, while a national survey of emergency departments will also begin around the same time.

Complaints

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

During the year, the Trust received 661 complaints of which 94 per cent were responded to within the target of 25 working days. The comments and suggestions we received enabled us to take action to improve the services we provide to our patients. These included:

- Fitting new taps and sinks in both male and female toilets on ward N2 as the result of a complaint that the taps were too difficult to turn
- Updating information sheets for vascular day surgery patients, and identifying an individual nurse to coordinate patient enquiries post discharge
- Developing a flow-chart within South Yorkshire Regional Services to streamline communication between secretarial staff and patients making it more effective
- Replacing antibacterial hand gel holders on the wards with ones without sharp edges.

The Trust also receives many compliments via letters, cards and emails from patients and their relatives regarding their treatment, and the professionalism and care shown by our staff. Many have been treated by the Trust for some years and remain pleased with their care. The following are a few comments posted on the NHS Choices and Patient Opinion websites:

I would like to bring to your attention the excellent care and attention I received from my consultant and the dental nurses who were involved in my care at the Charles Clifford Dental Hospital. I previously visited the hospital over 30 years ago and it is still an excellent place and it is reassuring to know we have such a valuable facility in Sheffield.

Patient, Charles Clifford

I had to have a Caesarean section and everything regarding the procedure was explained well. The service and treatment that I received was good. I would like to thank the team on the labour ward, in the theatre and all of the staff on the Concord ward.

Patient on Concord Ward, Jessop Wing

I was recently admitted to ward J2 of the Royal Hallamshire Hospital in Sheffield for the treatment of breast cancer. The best thing was that the staff kept me well informed about everything that was going to happen to me. I don't think that anything could have been any better than it was. I would like to thank all staff on ward J2.

Patient on J2, Royal Hallamshire

Just like to say how good the staff were on Ward 3 when my wife had to go in overnight because of problems with her chemo. The whole place was thoughtful and supportive. The Ward Sister in particular (don't know her name) ran the place with calm kindness, which all the other staff seemed to take their lead from.

Relative of patient treated on Ward 3, Weston Park

The ward I was admitted to was kept scrupulously clean, the floors washed daily and surfaces cleaned rigorously. Nurses observed the highest standards in washing hands and using plastic gloves and I felt safe in their hands. A very busy ward, the staff was, nonetheless, caring helpful and extremely pleasant.

Patient on Firth 2, Northern General

Finance Director's Review

Whilst the Trust has achieved financial balance in every year since its creation on 1 April 2001, initially as an NHS Trust and latterly as an NHS Foundation Trust, the Income and Expenditure (I&E) Account surplus for 2007/08 of £6.9m is the largest.

The Trust is very mindful of the tensions associated with delivering surpluses in an organisation where the primary aims are to deliver excellent healthcare, teaching and research rather than profits for investors.

However, even in such an organisation a modest surplus brings a level of strength and stability and also gives the opportunity for further much needed capital investment in subsequent years. At just less than 1 per cent of turnover for the year, and equivalent to just 3.7 days' worth of expenditure, the surplus can be reasonably described as modest and beneficial.

The Trust's income grew significantly again in 2007/08 as shown in the table below.

However, after adjusting for inflation and national NHS cost pressures, the real terms income growth is much smaller.

Within the Trust's income there was around £19m of non-recurrent transitional funding to offset losses from the introduction of the Payment by Results (PbR) and new NHS Research and Development (R&D) funding systems.

The need to plan for a future without this funding was a major reason for the Trust's 2007/08 surplus.

Pay costs rose by 3.8 per cent in the year which, given a very small increase in the number of staff in post, largely reflects pay awards and ongoing NHS pay reform costs. Other significant cost increases in 2007/08 were in respect of drugs, premises, depreciation/impairments and purchase of healthcare from non-NHS providers.

2007/08 was the second year of the Trust's three year programme to deliver total productivity and efficiency savings of £90m. The Adding Value Programme has remained the vehicle for driving such efficiency gains and the plan for the year for £29.3m of savings was virtually delivered. However, several clinical directorates have found it very difficult to deliver such savings and also address historic budget deficits and this remains a key issue for the Trust in the coming years.

Total capital expenditure for the year amounted to £54.5m. Whilst slippage on schemes caused a £4.8m underspend, this still represents a major level of investment in the Trust's asset base.

The key focus of expenditure was to continue investment in new and replacement medical equipment, undertake initiatives to advance information technology, support new service developments associated with the Trust's service development plans and statutory compliance needs, and improve the infrastructure to enhance the patient experience. The 2007/08 capital expenditure is analysed overleaf.

	£M	% Increase over 2006/07
Income from Patient Services Activities	570.0	6.5
Total Income	691.9	7.0

	£000	£000
Medical Equipment	**9,361**	
Digital X-ray Equipment		3,363
Multi-slice CT Scanner (NGH)		927
Fluroscopy X-ray Equipment (NGH & RHH)		849
Ultrasound Equipment		835
Image Guided Radiotherapy System (WPH)		340
Other		3,047
Statutory Compliance	**950**	
Infection Control/Deep Cleaning Equipment		266
Decontamination Equipment		131
Other Firecode Works		255
Other (e.g. Disability Discrimination, Legionella etc)		298
Information Technology	**7,697**	
Picture Archiving and Communications System		6,662
Digital Dictation System		123
Pathology Order Communications System		111
Other		801
Infrastructure	**5,721**	
Ward Refurbishments		2,163
Lift Refurbishments		864
Upgrade Medical Gases System (RHH)		533
Upgrade NGH Theatre Chillers/Air Handling Plant		474
PET/CT Substation (NGH)		469
Other		1,218
Service Development	**30,817**	
NGH Critical Care Expansion		14,024
Charles Clifford Dental School Expansion		3,289
Expansion Haematology / Bone Marrow Transplant Facilities		2,363
Genito-Urinary Medicine Expansion, Phase 2		2,198
Social Work and Anaesthetic Office Accommodation		1,014
Expansion NGH Endoscopy Facilities		1,012
Centralisation Pre-Operative Assessment Facilities		849
Clinical Decisions Unit, A&E		841
WPH Site Redevelopment		738
Infectious Diseases Outpatient Facilities		537
Ophthalmology Vision Centre		364
Other smaller schemes		3,588
Total Expenditure	**54,546**	

A key development in 2007/08 was the new Critical Care department at the Northern General hospital which was largely funded by an £18.3m 20 year loan. The first part of the loan was drawn in 2007/08 with the balance drawn in April 2008. Interest payments and loan repayments commence in earnest from 2008/09 and have to be financed by the income earned from use of the facility.

Cash balances at 31 March 2008 were £54.8m. Of this, £30m related to commitments in respect of pay provisions, largely Agenda for Change pay assimilation costs, and capital. The Trust believes that it needs to retain £15m of uncommitted cash balances, the equivalent of around 8 days of expenditure, in order to maintain a satisfactory working capital position and to provide a degree of financial resilience. This, therefore, leaves a balance of £10m, equivalent to the I&E surpluses in the last two years, which will be used for additional capital expenditure in the coming years.

Overall the Trust had net assets of £514.7m at 31 March 2008 and net current assets of £29.9m. However, the latter would have been much reduced, but still positive, if the pay provisions and capital underspend referred to above had become liabilities.

On Monitor's financial risk rating of one to five, where one represents very high risk and five very low risk, the Trust was assessed as a four rating at both plan and outturn stages for the year. It was at all times compliant with the Prudential Borrowing Limit, as set by Monitor, and income from private patients was, at 0.6% of patient related income, well within the Statutory Cap of 0.9%.

Overall, therefore, the Trust's 2007/08 financial results are very satisfactory, particularly so given the very challenging environment and the excellent service achievements in the year. However, there are many challenges facing the Trust in

Total capital income available to the Trust for the year was £59.3m.
The breakdown of capital expenditure for 2007/08 is as follows:

	£000
Resources available from the Department of Health / Internally Generated	56,814
Sale proceeds from disposed assets	445
Other Donations/Contributions	2,064
Total Income	**59,323**

2008/09 and beyond which must temper any complacency on financial management.

These include:

- The need to deliver over £27m of further productivity and efficiency savings in 2008/09 to meet corporate targets.
- The need for even greater productivity and efficiency gains in several clinical directorates which carry underlying budget deficits into 2008/09.
- The expectation of further demanding national efficiency targets in 2009/10 and 2010/11.
- Inflationary pressures in the economy generally leading to cost increases and pressures on pay awards.
- Further income losses on the old NHS R&D Levy funding in 2008/09 and 2009/10, with some uncertainty over future funding levels for NHS Education and Training Contracts.
- Potential patient service income losses through demand management and patient choice initiatives, and also from reduced requirements following the achievement of the 18-week referral to treatment target during 2008.
- Ongoing demands to enhance the quality of services and the patient environment, frequently with no specific funding.

However, there are also reasons for some optimism looking ahead and these include:

- A much improved general NHS financial position during 2007/08, further assisted by a relatively favourable funding settlement for the NHS for the three years from 2008/09.
- Fundamental revisions to tariffs from 2009/10 which it is hoped will address some of the current inadequacies in fully reflecting case-mix differences and the inequity of the current Market Forces Factor at hospital level.
- Highly regarded services which will enable the Trust to compete very successfully in a competitive environment.
- A great commitment within the Trust to continue to develop services and to enhance facilities and the general patient experience.
- A constructive relationship with Yorkshire and the Humber Strategic Health Authority on NHS Education and Training services which it is hoped will enable the development of these services in a financially stable environment.
- Significant opportunities to attract new R&D funding from the new National Institute for Health Research arrangements.
- Ongoing major levels of capital investment enhanced by resources from I&E surpluses.

The Trust has for some time viewed 2008/09 as an extremely challenging year financially given the end of PbR Transitional Funding despite the promised fundamental revision to tariffs still being awaited; the cumulative effect of major productivity and efficiency requirements over three financial years; and the lack of certainty in respect of many funding streams.

However, the financial success in 2007/08, the financial and productivity and efficiency plans developed for 2008/09 and the continued imagination and commitment of the clinicians, managers and staff within the organisation all suggest that despite the major challenges, there is good reason to believe that the Trust can maintain its excellent track record on financial performance.

Neil Priestley
Director of Finance
11 June 2008

Public Interest Disclosure

The Board of Directors comprises the chairman, six non-executive directors and six executive directors. Together they bring a wide range of different skills and experience to the Trust, enabling it to achieve balance and completeness at the highest level.

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

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

The Board of Directors can be contacted by writing to:
Trust Secretary
Sheffield Teaching Hospitals
NHS Foundation Trust
8 Beech Hill Road
Sheffield S10 2SB.

Senior Independent Director

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

The Chairman

David Stone OBE
Chairman

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

Other Interests

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

The Executive Directors

Andrew Cash OBE
Chief Executive

(Returned from secondment to Department of Health 1st July 2007)

Andrew Cash was a graduate entrant to the NHS on the national management-training scheme. He has been an NHS chief executive for 18 years and has worked at regional and national level. Mr Cash was seconded to the Department of Health as Director General for Provider Development in July 2006, returning to the Trust a year later.

Other Interests

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

Professor Chris Welsh
Medical Director

(Acting Chief Executive
1st July 2006 - 30th June 2007)

Professor Chris Welsh trained as a Vascular Surgeon and was appointed to a consultant post at the Northern General Hospital in 1984. Before becoming Medical Director in 2001, Professor Welsh held the post of Regional Postgraduate Dean for the NHS Trent Region for six years. He was seconded to the post of Acting Chief Executive for one year from July 2006.

Other Interests

- In Private Medical Practice based at Claremont Hospital
- Tutor Medical Leadership Programme - NHS Leadership Centre and Keele University, Centre for Health Planning and Management
- Part owner and Director of C. L. Welsh and Company Ltd

Hilary Scholefield
Chief Nurse

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

Other Interests

- Associate Fellow, Warwick University
- Nurse Advisor to Engaging Quality, part of the Health Foundation Member, Professor Sir Ara Darzi's Sounding Board
- Member, SDO Programme Board
- Member, NIHR Board

Chris Linacre
Director of Service Development
Deputy Chief Executive

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

Other Interests:

- Non Executive Director of Medipex Ltd.
- Non Executive Director of EPAQ Ltd (a company in which the Trust has a shareholding)
- Non Executive Director of Aperio Diagnostic (a company in which the Trust has a shareholding)

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. He was appointed to the post of Director of Finance upon the merger of the trusts in 2001. Mr Priestley is a Fellow of the Chartered Association of Certified Accountants.

Other Interests: None

John Watts
Director of Human Resources

John Watts has a 35-year career in NHS personnel and executive management and has held senior posts in NHS organisations around the country. Prior to joining the team at Sheffield Teaching Hospitals, Mr Watts was Director of Human Resources at the Northern General Hospital.

Other Interests: None

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

Dr Graham Davies
Deputy Medical Director

(Acting Medical Director 1st July 2006 - 30th June 2007)

Graham Davies has been a Deputy Medical Director at the Trust since its formation in 2001 and he held a similar post at the Northern General prior to the merger. Dr Davies was appointed as a consultant cardiothoracic anaesthetist in 1981. He has also worked in the chronic pain service and palliative care.

Dr Davies took on the role of Acting Medical Director in July 2006.

Other Interests: None

Phil Brennan
Acting Director of Estates Management (1st April 2007 - 27th March 2008)

Director of Estates Management (from 28th March 2008)

Phil Brennan was appointed as Estates Director, following a period in an acting position.

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

- Member of the Chartered Institute of Building Services Engineers (CIBSE
- Member, British Institute of Facilities Managers

Neil Riley
Trust Secretary

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

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

Other Interests

- Visiting Professor, Faculty of Health and Well Being, Sheffield Hallam University
- Associate, PACT consultancy
- Vice Chairman of the FTN Company Secretary Network

The Non-Executive Directors

Ony Bright
(Until 30th June 2007)

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 Central Sheffield University Hospitals NHS Trust.

Other Interests: None

John Donnelly

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

Other Interests

- Trustee - Sheffield Hospitals Charitable Trust
- Lay Panellist - General Medical Council Fitness to Practice Panel

Vickie Ferres

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

Other Interests

- Chief Executive, Age Concern Doncaster

Shirley Harrison

(Since 1st November 2007)

Shirley Harrison's professional career has been in marketing and public relations, both as a practitioner and an academic. She was formerly the Director of Public Relations at Sheffield City Council and has written a number of books and papers on the subject of communications. Until March 2007 she was chair of the South Yorkshire Probation Board. She is a former chair of the Human Fertilisation and Embryology Authority and is the current chair of the Human Tissue Authority.

Other Interests

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

Jane Norbron

(Since 1st July 2007)

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

Other Interests

- Company Director, Jane Norbron Limited
- International Women of Excellence

Vic Powell

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

Other Interests

- Member of the Department of Health Foundation Trust Finance Facility

Chris Suddes

(Resigned 30th September 2007)

Chris Suddes has an MBA from the University of Sheffield and over 20 years experience in contract logistics organisations, most recently as Operations & IT director for Bibby Distribution. Chris has previously held a Non-executive Director post at North Sheffield Primary Care Trust. He was also one of the first Public Governors to be appointed to the Sheffield Teaching Hospitals NHS Foundation Trust in 2004. Chris was appointed as a Non-executive Director in July 2006.

Other Interests

- Director, Antipas Designworks Ltd
- Non-executive Director, Patient Opinion Ltd
- Bibby Line Group
- Associate Director, Prism Associates business consultancy
- Communications and Media Officer, British Disabled Flying Association

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 Board of Directors. 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.

Other Interests

- University Representative
- Medical Advisor and Trustee, British Thyroid Foundation
- Private Medial Practice at Thornbury Hospital

Appointments

Non-executive directors are appointed via an open advertisement and formal interview process, which the NHS Appointments Commission manages on behalf of the Trust. The final appointment of non-executive directors, including that of the Chair is made by a committee of the Governors' Council, which also determine their remuneration. Previously these functions were carried out through appointments and remuneration committees. However, during 2007 the Council agreed to establish a nomination committee to undertake both functions. The first meeting of that committee was held in September 2007. It has subsequently made two appointments of one non-executive director and the chairman. (See also Celebrating Foundation Trust Status page 8)

Terms of Office

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

Name	Position	Term of Office Commenced	Term of Office Ends
David Stone	Chairman	Reappointment commenced 1st July 2008	30th June 2012
Ony Bright	Non-executive director		June 2007
John Donnelly	Non-executive director	Reappointment commenced 1st July 2006	30th June 2010
Vickie Ferres	Non-executive director	Reappointment commenced 1st July 2005	30th June 2009
Shirley Harrison	Non-executive director	Appointment commenced 1st November 2007	30th October 2011
Jane Norbron	Non-executive director	Appointment commenced 1st July 2007	30th June 2011
Vic Powell	Non-executive director	Reappointed commenced 1st July 2007	30th June 2011
Christopher Suddes	Non-executive director		Resigned September 2007
Anthony Weetman	Non-executive director	Reappointment commenced 1st July 2005	30th June 2009

Development of the Board

Following a review in January 2007 of the Trust's governance arrangements, the Board has overseen the implementation of the principal recommendations of the review. In particular, the Trust now has a single department of patient and healthcare governance as a key step in its journey towards integrated governance. Most recently, the Board has reviewed progress against the original recommendations and in order to continuously improve, has agreed to commission a further piece of work on Board development over the next year.

Meetings of the Board

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

The individual attendance by Directors is noted at each meeting and reviewed by the Chairman. Attendance may be affected by sickness or annual leave. Individual attendance for 2007/08 is as follows:

Attendance at Board Meetings	
Board Members	**Attendance Rate (Out of 16 meetings unless otherwise stated)**
David Stone OBE, Chairman	16/16
Andrew Cash OBE, Chief Executive Returned from secondment 1st July 07	10/10 (after end of secondment)
Professor Chris Welsh, Medical Director Acting Chief Executive 1st July 06 - 30th June 07	14/16 (as both Acting Chief Executive and Medical Director)
Hilary Scholefield, Chief Nurse	16/16
Chris Linacre, Director of Service Development Deputy Chief Executive	15/16
Neil Priestley, Director of Finance	16/16
John Watts, Director of Human Resources	11/16
Dr Graham Davies Acting Medical Director 1st July 2006 - 30th June 2007	4/6 (before the end of secondment)
Phil Brennan, Director of Estates Management	14/16
Neil Riley, Trust Secretary	10/16
Ony Bright, Non-executive Director (until 30th June 2007)	4/6
John Donnelly, Non-executive Director	15/16
Vickie Ferres, Non-executive Director	14/16
Shirley Harrison, Non-executive Director (Appointed 1st November 2007)	4/5 (from commencement of post)
Jane Norbron, Non-executive Director (Appointed 1st July 2007)	9/10 (from commencement of post)
Vic Powell, Non-executive Director	15/16
Chris Suddes, Non-executive Director (Resigned 30th September 2007)	12/12 (before resignation)
Professor Anthony Weetman, Non-executive Director	15/16

Committees of the Board

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

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

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

Attendance at Management Audit Committee

Board Members	Attendance Rate (Out of five meetings unless otherwise stated)
John Donnelly, Non-executive Director	5/5
Shirley Harrison, Non-executive Director	1/1 (from commencement of post)
Vic Powell, Non-executive Director	5/5
Neil Priestley, Director of Finance	5/5
Neil Riley, Trust Secretary	5/5
Professor Anthony Weetman, Non-executive Director	4/5

Attendance at Finance Committee

Board Members	Attendance Rate (Out of eleven meetings unless otherwise stated)
David Stone, Chairman	10/11
John Donnelly, Non-executive Director	6/11
Vic Powell, Non-executive Director	9/11
Chris Linacre, Director of Service Development	8/11
Neil Priestley, Director of Finance	11/11
John Watts, Director of Human Resources	10/11
Chris Welsh, Acting Chief Executive	1/2 (until return of Chief Executive from secondment)
Andrew Cash, Chief Executive	9/9 (after end of secondment)

Attendance at Human Resources Committee

Board Members	Attendance Rate (Out of six meetings unless otherwise stated)
Ony Bright, Non-executive Director	1/3
Vickie Ferres, Non-executive Director	6/6
Jane Norbron, Non-executive Director	3/6 (from commencement of post)
Chris Suddes, Non-executive Director	4/6 (before resignation)
John Watts, Director of Human Resources	6/6

Attendance at Healthcare Governance Committee	
Board Members	**Attendance Rate** (Out of eight meetings unless otherwise stated)
Ony Bright, Non-executive Director	3/8
Graham Davies, Deputy Medical Director	6/8 (before return of Medical Director to substantive post)
Vickie Ferres, Non-executive Director	8/8
Chris Linacre, Director of Service Development	1/8
Hilary Scholefield, Chief Nurse	5/8
John Watts, Director of Human Resources	6/8
Professor Anthony Weetman, Non-executive Director	5/8
Phil Brennan, Director of Estates Management	5/8
Chris Welsh, Acting Chief Executive	1/8 (before return of Chief Executive from secondment)

Attendance at Remuneration Committee	
Board Members	**Attendance Rate** (Out of one meeting unless otherwise stated)
David Stone, Chairman	1/1
Andrew Cash, Chief Executive	0/1 (before return from secondment)
Ony Bright, Non-executive Director	0/1
John Donnelly, Non-executive Director	1/1
Vickie Ferres, Non-executive Director	1/1
Vic Powell, Non-executive Director	0/1
Neil Priestley, Director of Finance	1/1
Chris Suddes, Non-executive Director	1/1
John Watts, Director of Human Resources	0/1
Chris Welsh, Acting Chief Executive	1/1 (before return of Chief Executive from secondment)

Governance code

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

- The Trust has undertaken a formal review of its insurance liabilities. Having identified a gap in the arrangements, we resolved to take out cover from 1st April 2008.
- The Board does not believe that the re-appointment of executive directors at no more than five years is required, given the existence of robust annual appraisal arrangements for directors.

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

Remuneration

Further details of remuneration are given in the remuneration report on page 50. The accounting policies for pensions and other retirement benefits are set out in the accounts on page 60.

Countering fraud and corruption

The Trust works closely with colleagues in the Local Counter Fraud Service to ensure incidents of fraud and corruption are kept as low as possible. The local counter fraud specialist is responsible for investigating all allegations of fraud and where necessary, pursuing criminal, civil and disciplinary sanctions against anyone who commits fraud against the Trust. Improved communications, reporting and detection methods are helping to bring perpetrators to justice ensuring that NHS money is spent on NHS services.

Discrimination and equal opportunities

The Trust is committed to promoting equality and eliminating discrimination in all its forms, whether affecting staff or people using its services. The Trust's schemes and action plans relating to disability, race and gender equality can be accessed via the website at www.sth.nhs.uk. (See also *Our Staff* page 23)

Communication and consulting with staff

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

The Trust has a number of central communications mechanisms, which aim to inform staff about Trust business. The Link magazine is a quarterly publication largely driven by staff in the organisation in terms of content. The monthly Team Brief provides a template for managers to use in their own local staff briefings and the weekly Communications Update is an informal single page publication disseminated by email. Over the year, the Trust has employed several creative methods of communicating with staff including hand written letters from the Chief Executive and thank you cards to clinical staff for their efforts in infection prevention and control.

Health and safety

The Trust remains committed to ensuring that it protects the health and safety of its patients, staff, and visitors. During 2007/08 the Trust had a routine audit by the Health and Safety Executive and used the information from this audit to improve safety within the Trust.

Sheffield Occupational Health Service currently provides occupational health advice and support to 33,000 employees of 16 major employers.

Occupational Health

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

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

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

Consultation, communication and involvement

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

Examples during the year have included:

- A consultation on improving chronic pain services, which included centralising those services at the Northern General hospital. This was formally considered by the Overview and Scrutiny Committee in February 2007 and reviewed by that committee in February 2008. The response was positive, enabling the Trust to progress the implementation.
- A mental health stakeholder event organised jointly with Sheffield Care Trust in June 2007, which brought together service users, NHS and voluntary organisations to assist in the development of a mental health strategy.
- Two events bringing patients and members of the public together with representatives from health, social care and voluntary organisations to help the Trust further develop its involvement strategy.

For further details of the Trust's activities in relation to working with other organisations, groups, patients and the public see also *Improving the Patient Experience*, page 29, *Working with our Communities*, page 35, and *Learning from our Patients*, page 37.

Remuneration Report

Remuneration committee

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

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

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

Remuneration of chairman and non-executive directors

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

Remuneration of senior managers

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

Assessment of performance

All executive and non-executive directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 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 this there is a meeting between the chairman and each executive director to discuss their performance.

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

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

Performance pay

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

Duration of contracts

All executive directors have a substantive contract of employment with a 12 month notice provision in respect of termination.

This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the executive director.

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

Early termination liability

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

Other Information

Please refer to the notes in the 07/08 Accounts contained on pages 64-65 of this Annual Report in respect of the following:

- Salaries and Allowances
- Benefits in Kind
- Increases in Pension at age 60 during 07/08
- Value of the cash equivalent transfer value at the beginning of the year
- Increase in the cash equivalent transfer value during 07/08.

Andrew Cash OBE
Chief Executive

11 June 2008

Name	Designated	Expiry date
Mr. D.R. Stone	Chairman	30 June 2012
Mr V.G.W. Powell	Non-executive Director Sen Independent Director	30 June 2011
Mr J. Donnelly	Non-executive Director	30 June 2010
Ms. V. Ferres	Non-executive Director	30 June 2009
Mrs. S Harrison	Non-executive Director	31 October 2011
Mrs J. Norbron	Non-executive Director	30 June 2011
Professor A.P. Weetman	Non-executive Director	30 June 2009

Name	Date of Contract	Unexpired term at 31st March 2008
Andrew Cash	1st July 2004	13 years
Chris Welsh	1st July 2004	4 years
Hilary Scholefield	1st February 2006	21 years
Chris Linacre	1st July 2004	7 years
Neil Priestley	1st July 2004	19 years
John Watts	1st July 2004	5 years
Graham Davies	1st July 2006	30th June 2007

Independent Auditor's Report to the Governors Council of Sheffield Teaching Hospitals NHS Foundation Trust

I have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2008 under the National Health Service Act 2006.

The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

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

Respective responsibilities of the Accounting Officer and auditor

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

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

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information included in the Annual Report [which comprises: Welcome, Chairman's Statement, Directors' Report, Celebrating Foundation Trust status, Meeting our targets, Investing in buildings and equipment, Operational Review 2007/08, Finance Director's report, Public Interest Disclosures and the un-audited part of the Remuneration Report], is consistent with the financial statements.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2007/08. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. [This other information comprises: Welcome, Chairman's Statement, Directors' Report, Celebrating Foundation Trust status, Meeting our targets, Investing in buildings and equipment, Operational Review 2007/08, Finance Director's report, Public Interest Disclosures and the un-audited part of the Remuneration Report]. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

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

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

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

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information [which comprises: Welcome, Chairman's Statement, Directors' Report, Celebrating Foundation Trust status, Meeting our targets, Investing in buildings and equipment, Operational Review 2007/08, Finance Director's report, Public Interest Disclosures and the un-audited part of the Remuneration Report], included in the annual report, is consistent with the financial statements.

Certificate

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

J G Prentice FCCA

Officer of the Audit Commission
Littlemoor House, Littlemoor, Eckington, Sheffield S21 4EF

13 June 2008

Statement of Responsibilities

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

The National Health Service Act 2006 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 National Health Service Act 2006, 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 OBE
Chief Executive

11 June 2008

Foreword to the Accounts

These accounts for the year ended 31 March 2008 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed

Andrew Cash OBE
Chief Executive

11 June 2008

Income and expenditure account for the 12 months ended 31 March 2008

	NOTE	**2007/08 £000**	2006/07 £000
Income from activities	3	**570,006**	535,332
Other operating income	4	**121,925**	111,187
Operating expenses	5-7	**(673,828)**	(632,961)
OPERATING SURPLUS		**18,103**	13,558
Surplus on sale of fixed assets	8	**0**	0
SURPLUS BEFORE INTEREST		**18,103**	13,558
Finance Income	9	**3,170**	2,217
Finance Costs - interest expense	9	**(146)**	0
Net gain/loss on financial instruments		**0**	0
Other finance costs - unwinding of discount		**(58)**	(55)
SURPLUS FOR THE YEAR		**21,069**	15,720
Public Dividend Capital dividends payable		**(14,167)**	(12,753)
RETAINED SURPLUS FOR THE YEAR		**6,902**	2,967

The notes on pages 58 to 77 form part of these accounts.

All income and expenditure is derived from continuing operations.

Signed

Andrew Cash OBE
Chief Executive

11 June 2008

Balance sheet as at 31 March 2008

	NOTE	**31 March 2008** **£000**	31 March 2007 £000
FIXED ASSETS			
Intangible assets	10	**2,835**	764
Tangible assets	11	**514,732**	436,288
Investments	12	**0**	0
		517,567	437,052
CURRENT ASSETS			
Stocks	13	**8,287**	7,904
Debtors	14	**35,826**	30,880
Investment	15	**0**	0
Cash	19.3	**54,794**	37,568
		98,907	76,352
CREDITORS: Amounts falling due within one year	16	**(69,025)**	(47,830)
NET CURRENT ASSETS		**29,882**	28,522
TOTAL ASSETS LESS CURRENT LIABILITIES		**547,449**	465,574
CREDITORS: Amounts falling due after more than one year	16	**(9,039)**	(2,472)
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(23,727)**	(23,740)
TOTAL ASSETS EMPLOYED		**514,683**	439,362
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital	18.2	**314,279**	305,119
Revaluation reserve	18.3	**130,998**	82,524
Donated asset reserve	18.3	**42,855**	39,289
Income and expenditure reserve	18.3	**26,551**	12,430
TOTAL TAXPAYERS' EQUITY		**514,683**	439,362

Andrew Cash OBE
Chief Executive
11 June 2008

Statement of total recognised gains and losses for the 12 months ended 31 March 2008

	2007/08 **£000**	2006/07 £000
Surplus for the year before dividend payments	**21,069**	15,720
Fixed asset impairment losses	**0**	0
Unrealised surplus on fixed asset revaluations/indexation	**59,868**	170
Increases in the donated asset reserve due to receipt of donated assets	**2,064**	5,094
Reductions in the donated asset reserve due to depreciation, impairment, and / or disposal of donated assets	**(2,616)**	(2,131)
Other recognised gains and losses	**(57)**	(39)
Total recognised gains for the year	**80,328**	18,814
Prior Period Adjustment	**0**	(3,052)
Total gains and losses recognised since last annual report	**80,328**	15,762

Cash flow statement for the 12 months ended 31 March 2008

	NOTE	**2007/08** **£000**	2006/07 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	19.1	**56,033**	54,013
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**3,035**	2,244
Net cash inflow from returns on investments and servicing of finance		**3,035**	2,244
CAPITAL EXPENDITURE			
(Payments) to acquire tangible assets		**(45,094)**	(32,925)
Receipts from sale of Tangible Fixed Assets		**0**	0
(Payments) to acquire intangible assets		**(525)**	(170)
Net cash (outflow) from capital expenditure		**(45,619)**	(33,095)
DIVIDENDS PAID		**(14,167)**	(12,753)
Net cash (outflow) / inflow before management of liquid resources and financing		**(718)**	10,409
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of current asset investments		**(150,000)**	(165,000)
Sale of current asset investments		**150,000**	165,000
Net cash flow from management of liquid resources		**0**	0
Net cash (outflow) / inflow before financing		**(718)**	10,409
FINANCING			
Public dividend capital received		**9,160**	0
Loans received from Foundation Trust Financing Facility		**7,300**	0
Other capital receipts		**1,484**	5,104
Net cash inflow from financing		**17,944**	5,104
Increase in cash		**17,226**	15,513

Notes to the Accounts

1 Introduction

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2007/08 NHS Foundation Trust Financial Reporting Manual issued by Monitor, the body responsible for overseeing Foundation Trust activities. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

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

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

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

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

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

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

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided . Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

The NHS Foundation Trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology from 2004/05. To manage the financial impact of this change on the NHS Foundation Trust and its commissioners the Department of Health has implemented transitional gain and clawback arrangements. These are on a sliding scale, as the change is phased in over the four year period to 2008/09. Under these arrangements the Trust received income protection of £12,755,000 from the Department of Health during 2007/08 (2006-07 £20,511,000).

1.4 Expenditure

Expenditure is accounted for applying the accruals convention.

1.5 Intangible fixed assets

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

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

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

1.6 Tangible fixed assets

Capitalisation

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

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they 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 professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2007-08 as at the prospective valuation date of 1 April 2007 and were applied on 1 April 2007.

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

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

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

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

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value from the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

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

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

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

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

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

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

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

1.7 Donated fixed assets

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

1.8 Government Grants

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

1.9 Private Finance Initiative (PFI) transactions

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

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

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

1.10 Stocks and work-in-progress

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

1.11 Research and development

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

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

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

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

1.12 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 2007/08 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. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period. The total employer contributions payable in the 12 months to 31 March 2008 were £39,070,454 (31 March 2007 £37,344,418)

Employer's pension cost contributions are charged to operating expenses as and when they become due.

The Scheme is subject to a full actuarial investigation every four years, the main purpose of which is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and Scheme members. The last such investigation, on the conclusions of which Scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the Scheme liabilities for FRS 17 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary Report, which forms part of the NHS Pension Scheme (England and Wales) resource account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

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

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

1.14 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 NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.19 Public Dividend Capital (PDC) and PDC Dividend

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

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

1.20 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 Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Corporation Tax

The NHS Foundation Trust has carried out a review of Corporation Tax liability of its non healthcare activities. At present all activities are either ancillary to patient care activity or below the de-minimis level at which corporation tax is due.

1.22 Cash, Bank and Overdrafts

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

1.23 Financial instruments and financial liabilities

Recognition

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

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

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade Date.

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

De-recognition

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

Classification and Measurement

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

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

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

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise cash at bank and in hand and NHS back to back debtors. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Available-for-sale financial assets

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

Other financial liabilities

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

Determination of fair value

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

Impairment of financial assets

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

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

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

	2007/08	2006/07
	£'000	£'000
Elective income	**128,345**	119,569
Non Elective income	**152,688**	139,313
Outpatient income	**88,099**	83,020
Other NHS Clinical income	**175,359**	160,633
A&E Income	**9,269**	9,098
PBR transitional relief	**12,755**	20,511
Private Patient Income	**3,491**	3,188
TOTAL	**570,006**	535,332

3.2 Private patient income:

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

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

3.3 Income from Activities

	Total	
	2007/08	2006/07
	£'000	£'000
Primary Care Trusts	**527,357**	485,620
Local Authorities	**268**	201
Department of Health	**35,608**	43,213
NHS Other	**1,007**	1,253
Non NHS: Private patients	**2,312**	2,417
Non NHS: Overseas patients (non-reciprocal)	**1,179**	771
NHS injury scheme (was Road Traffic Act Scheme)	**2,206**	1,784
Non NHS: Other	**69**	73
TOTAL	**570,006**	535,332

4 Other Operating Income

	Total	
	2007/08	2006/07
	£'000	£'000
Research and Development	**8,170**	8,001
Education and Training	**56,792**	52,690
Transfers from the donated asset reserve in respect of depreciation, impairment, and disposal of donated assets	**2,616**	2,131
Non patient care services to other bodies	**41,083**	36,550
Other	**13,264**	11,815
TOTAL	**121,925**	111,187

5 Operating Expenses

5.1 Operating expenses comprise:

	2007/08	2006/07
	Total	Total
	£'000	£'000
Services from other NHS Foundation Trusts	**4,152**	3,770
Services from other NHS Trusts	**6,865**	6,667
Services from other NHS bodies	**6,142**	5,593
Purchase of healthcare from non NHS bodies	**8,581**	4,186
Directors' costs	**1,337**	1,142
Staff costs	**431,288**	415,450
Drugs costs	**61,408**	55,868
Supplies and services - clinical	**63,782**	62,221
Supplies and services - general	**7,657**	6,813
Establishment	**6,781**	6,807
Transport	**726**	778
Premises	**26,866**	21,562
Bad debts	**371**	61
Depreciation and amortisation	**29,446**	27,781
Fixed asset impairments and reversals	**3,779**	2,286
Audit fees	**89**	80
Other auditor's remuneration	**0**	3
Clinical negligence	**5,794**	5,757
Other	**8,764**	6,136
TOTAL	**673,828**	632,961

5.2 Operating leases

5.2/1 Operating expenses include:

	2007/08	2006/07
	£'000	£'000
Other operating lease rentals	**1,823**	1,800
TOTAL	**1,823**	1,800

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

	2007/08	2007/08	2006/07	2006/07
	Land and buildings	Other leases	Land and buildings	Other leases
	£'000	£'000	£'000	£'000
Operating leases which expire:				
Within 1 year	**13**	65	12	79
Between 1 and 5 years	**183**	744	223	574
After 5 years	**132**	466	158	549
TOTAL	**328**	1,275	393	1,202

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	**To 31 March 2008**		
	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000)	(bands of £5000)	Rounded to the nearest £100
	£000	£000	
Mr A J Cash, Chief Executive (from 1 July 2007)	**155-160**	-	-
Mr J Watts, Director of Human Resources	**125-130**	-	-
Mr N Priestley, Director of Finance	**140-145**	-	-
Mr G Davies, Acting Medical Director (until 30 June 2007)	**35-40**	5-10	-
Mrs H Scholefield, Chief Nurse	**125-130**	-	-
Mr C Welsh, Medical Director (Acting Chief Executive until 30 June 2007, Medical Director with effect from 1 July 2007)	**160-165**	-	-
Mr C C Linacre, Director of Service Development Deputy Chief Executive	**135-140**	-	-
Mr C Suddes, Non-Executive Director (resigned 31 December 2007)	**10-15**	-	-
Mr J P Donnelly, Non-executive Director	**10-15**	-	-
Ms V R Ferres, Non-executive Director	**10-15**	-	-
Mr V G W Powell, Non-executive Director	**10-15**	-	-
Mrs J Norbron, Non-executive Director (appointed 1 July 2007)	**10-15**	-	-
Ms S Harrison, Non-executive Diirector (appointed 1 November 2007)	**5-10**		
Professor A P Weetman, Non-executive Director	**10-15**	-	-
Ms O V Bright, Non-executive Director (until 30 June 2007)	**0-5**	-	-
Mr D Stone, Chairman	**50-55**	-	-

B) Pension Benefits

Name and title	**Real increase in pension and related lump sum at age 60 (bands of £2500)** £000	Total accrued pension and related lump sum at age 60 at 31 March 2008 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension £ (To nearest £100)
Mr A J Cash, Chief Executive (from 1 July 2007)	**20-22.5**	315-317.5	1,295	1,117	79	22,300
Mr J Watts, Director of Human Resources	**15-17.5**	225-227.5	n/a	946	n/a	17,500
Mr N Priestley, Director of Finance	**15-17.5**	175-177.5	604	519	50	20,200
Mr G Davies, Acting Medical Director (until 30 June 2007)	**0-2.5**	252.5-255	1,128	998	18	5,600
Mrs H Scholefield, Chief Nurse	**17.5-20**	172.5-175	565	472	57	17,500
Mr C Welsh, Medical Director (Acting Chief Executive until 30 June 2007, Medical Director with effect from 1 July 2007)	**7.5-10**	280-282.5	n/a	n/a	n/a	20,600
Mr C C Linacre, Director of Service Development Deputy Chief Executive	**17.5-20**	252.5-255	1,165	1,026	80	19,300

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

There are no CETV amounts for those directors aged 60 or over at the balance sheet date. This is because these directors are not permitted to transfer benefits, hence no value is disclosed under this note.

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

	2007/08 Total	2007/08 Permanently Employed	2007/08 Other	2006/07 Total	2006/07 Permanently Employed	2006/07 Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	**362,527**	357,698	4,829	349,869	346,177	3,692
Social Security Costs	**25,602**	25,602	0	24,875	24,875	
Employer contributions to NHSPA	**39,070**	39,070	0	37,344	37,344	
Other pension costs	**30**	30	0	33	33	
Agency/contract staff	**5,239**		5,239	4,326		4,326
TOTAL	**432,468**	422,400	10,068	416,447	408,429	8,018

The above figure of £432,468k is net of the amount of £1,160k (12 months to 31.3.2007, £1,062k) in respect of capitalised salary costs included in fixed asset additions (note 11.1).

6.2 Average number of persons employed

	2007/08 Total	2007/08 Permanently Employed	2007/08 Other	2006/07 Total	2006/07 Permanently Employed	2006/07 Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**1,471**	1,430	41	1,380	1,340	40
Administration and estates	**2,438**	2,260	178	2,418	2,306	112
Healthcare assistants and other support staff	**1,277**	1,277	0	1,269	1,269	0
Nursing, midwifery and health visiting staff	**4,785**	4,564	221	4,738	4,556	182
Scientific, therapeutic and technical staff	**1,886**	1,873	13	1,883	1,869	14
Total	**11,857**	11,404	453	11,689	11,340	348

6.3 Employee benefits

	2007/08	2006/07
	£000	£000
None	**0**	0
	0	0

6.4 Early retirements due to ill health

	2007/08	2007/08	2006/07	2006/07
	£'000	Number	£'000	Number
Number of early retirements agreed on the grounds of ill health		18		28
Cost of early retirements agreed on grounds of ill health	**683**		1,174	

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:

	2007/08	2006/07
Number of non NHS invoices paid	**141,269**	143,777
Number of non NHS invoices paid within 30 days	**135,251**	137,892
Percentage of invoices paid within 30 days	**95.74%**	95.91%

	£'000	£'000
Value of non NHS invoices paid	**231,542**	211,444
Value of non NHS invoices paid within 30 days	**215,982**	200,986
Percentage of invoices paid within 30 days	**93.28%**	95.05%
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:

	2007/08	2006/07
	Total	Total
	£000	£000
Profit on disposal of fixed asset investments	**0**	0
Loss on disposal of fixed asset investments	**0**	0
Profit on disposal of intangible fixed assets	**0**	0
Loss on disposal of intangible fixed assets	**0**	0
Profit on disposal of land and buildings	**0**	0
Loss on disposal of land and buildings	**0**	0
Profit on disposal of other tangible fixed assets	**0**	0
Loss on disposal of other tangible fixed assets	**0**	0
Profit on disposal of equipment	**0**	0
TOTAL	**0**	0

9.1 Finance Income

	2007/08	2006/07
	£000	£000
Interest on loans and receivables	**3,170**	2,217
Interest on available for sale financial assets	**0**	0
Interest on held-to-maturity financial assets	**0**	0
Other	**0**	0
TOTAL	**3,170**	2,217

9.2 Finance costs - interest expense

	2007/08	2006/07
	£000	£000
Loans from the Foundation Trust Financing Facility	**146**	0
Commercial loans	**0**	0
Overdrafts	**0**	0
Finance leases	**0**	0
Other	**0**	0
TOTAL	**146**	0

9.3. Other net gains / (losses) on financial instruments

Financial assets and liabilities held at fair value through income and expenditure account		
- fair value gains	**0**	0
- fair value losses	**0**	0
Net gains / (losses) on available for sale financial assets through income and expenditure	**0**	0
Other	**0**	
TOTAL	**0**	0

10.1 Intangible fixed assets:

	Total	Software licences
	£'000	£'000
Gross cost at 1 April 2007	**1602**	1602
Impairments	**0**	0
Reclassifications	**2218**	2218
Other revaluations	**0**	0
Additions - purchased	**217**	217
Additions - donated	**5**	5
Disposals	**(152)**	(152)
Gross cost at 31 March 2008	**3890**	3890
Amortisation at 1 April 2007	**838**	838
Provided during the year	**347**	347
Impairments	**22**	22
Reversal of impairments	**0**	0
Reclassifications	**0**	0
Other revaluations	**0**	0
Disposals	**(152)**	(152)
Amortisation at 31 March 2008	**1055**	1055
Net book value		
- Purchased at 1 April 2007	**756**	756
- Donated at 1 April 2007	**8**	8
Total at 1 April 2007	**764**	764
Net book value		
- Purchased at 31 March 2008	**2826**	2826
- Donated at 31 March 2008	**9**	9
Total at 31 March 2008	**2835**	2835

11 Tangible Fixed Assets

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

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under constr-uction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2007	**550,754**	25,849	370,612	2,601	15,983	101,195	875	14,866	18,773
Additions - purchased	**52,036**	0	4,132	41	42,508	4,338	58	400	559
Additions - donated	**2,059**	0	173	0	1,118	721	30	0	17
Impairments	**(4,323)**	0	(3,467)	0	(856)	0	0	0	0
Reclassifications	**(2,218)**	0	29,814	0	(41,218)	3,816	0	4,186	1,184
Other revaluations	**33,268**	3,026	26,997	(44)	33	2,672	23	41	520
Disposals	**(11,609)**	(144)	(301)	0	0	(9,696)	(11)	(1,410)	(47)
Cost or valuation at 31 March 2008	**619,967**	28,731	427,960	2,598	17,568	103,046	975	18,083	21,006
Depreciation at 1 April 2007	**114,466**	0	28,343	219	0	61,081	683	10,841	13,299
Provided during the year	**29,099**	0	18,005	114	0	8,152	52	1,512	1,264
Impairments	**181**	0	0	0	0	119	0	55	7
Reversal of impairments	**(747)**	0	(705)	0	0	0	0	(42)	0
Reclassifications	**0**	0	0	0	0	(26)	0	0	26
Other revaluations	**(26,600)**	0	(28,412)	(219)	0	1,614	18	42	357
Disposals	**(11,164)**	0	0	0	0	(9,696)	(11)	(1,410)	(47)
Depreciation at 31 March 2008	**105,235**	0	17,231	114	0	61,244	742	10,998	14,906
Net book value									
- Purchased at 1 April 2007	**397,008**	24,503	309,234	2,211	15,001	36,777	181	4,002	5,099
- Donated at 1 April 2007	**39,280**	1,346	33,035	171	982	3,337	11	23	375
Total at 1 April 2007	**436,288**	25,849	342,269	2,382	15,983	40,114	192	4,025	5,474
Net book value									
- Purchased at 31 March 2008	**471,887**	27,237	373,850	2,309	17,119	38,358	202	7,069	5,743
- Donated at 31 March 2008	**42,845**	1,494	36,879	175	449	3,444	31	16	357
Total at 31 March 2008	**514,732**	28,731	410,729	2,484	17,568	41,802	233	7,085	6,100

11.2 Analysis of tangible fixed assets:

Net book value									
- Protected assets at 31 March 2008	**441,944**	28,731	410,729	2,484	0	0	0	0	0
- Unprotected assets at 31 March 2008	**72,788**	0	0	0	17,568	41,802	233	7,085	6,100
Total at 31 March 2008	**514,732**	28,731	410,729	2,484	17,568	41,802	233	7,085	6,100

11.3 Assets held at open market value

There were no assets held at open market value at the Balance Sheet date or at 31 March 2007

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

No assets were held under finance leases or hire purchase contracts at the Balance Sheet Date or at 31 March 2007

11.5 The net book value of land, buildings and dwellings at 31 March 2008 comprises

		31 March 2008			31 March 2007	
	Total	Protected	Unprotected	Total	Protected	Unprotected
	£,000	£,000	£,000	£,000	£,000	£,000
Freehold	**441,944**	441,944	0	370,500	370,500	
Long leasehold	**0**	0	0	0		
Short leasehold	**0**	0	0	0		
TOTAL	**441,944**	441,944	0	370,500	370,500	0

11.6 Impairment of assets

	2007/08	2006/07
	£,000	£,000
Loss or damage from normal operations	**204**	285
Loss as a result of catastrophe	**0**	0
Abandonment of assets in course of construction	**855**	410
Unforeseen obsolescence	**0**	0
Over specification of assets	**0**	0
Other	**0**	0
Changes in market price	**3,467**	1,605
TOTAL	**4,526**	2,300

12 Fixed asset investments

The Trust has holdings in Aperio Diagnostics (32.37%) and Epaq (45.95%), companies commercially developing intellectual property. The trust holding in these companies carry a minimal value at the balance sheet date.

13 Stocks

	31 March 2008	31 March 2007
	£'000	£'000
Raw materials and consumables	**8,287**	7,904
TOTAL	**8,287**	7,904

14.1. Debtors

	31 March 2008	31 March 2007
	£'000	£'000
Amounts falling due within one year:		
NHS debtors	**18,236**	16,563
Provision for irrecoverable debts	**(1,303)**	(1,144)
Other prepayments and accrued income	**931**	1,396
Other debtors	**15,036**	11,702
Sub Total	**32,900**	28,517
Amounts falling due after more than one year:		
NHS debtors	**268**	272
Other debtors	**2,658**	2,091
Sub Total	**2,926**	2,363
TOTAL	**35,826**	30,880

14.2 Provision for impairment of NHS debtors

	£'000	£'000
At 1 April 2007	**204**	666
Provision for debtors impairment	**147**	174
Debtors written off during the year as uncollectable	**(16)**	(340)
Unused amounts reversed	**(90)**	(296)
At 31 March 2008	**245**	204

14.3 Analysis of impaired debtors

Ageing of impaired debtors	**£'000**	£'000
Up to three months	**24**	30
In three to six months	**9**	0
Over six months	**212**	174
Total	**245**	204
Ageing of non-impaired debtors past their due date		
Up to three months	**2,655**	1,056
In three to six months	**571**	1,278
Over six months	**2,128**	2,378
Total	**5,354**	4,712

15 Current asset investments

	2007/08	2006/07
	Total	Total
	£'000	£'000
Additions	**150,000**	165,000
Disposals	**(150,000)**	(165,000)
Cost or valuation at 31 March 2008	**0**	0

16 Creditors

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

	31 March 2008	31 March 2007
	£'000	£'000
Amounts falling due within one year:		
Loans	**311**	0
NHS creditors	**13,216**	9,457
Non-NHS trade creditors - revenue - other	**13,071**	11,044
Non-NHS trade creditors - capital	**14,078**	4,472
Tax and social security costs	**9,272**	8,855
Other creditors	**387**	491
Accruals and deferred income	**18,690**	13,511
TOTAL	**69,025**	47,830

Amounts falling due after one year:	31 March 2008	31 March 2007
	£'000	£'000
Loans	**6,989**	0
Accruals and deferred income	**2,050**	2,472
TOTAL	**9,039**	2,472

NHS creditors include;

£0k (31 March 2007, £0k) for payments due in future years under arrangements to buy out the liability for early retirements; and £4,976k (31 March 2007, £4,670k) outstanding pensions contributions at 31 March 2008.

16.2/1 Loans

	31 March 2008	31 March 07
	£'000	£'000
Payments of loan principal falling due:		
- within one year	**311**	0
- between one to two years	**311**	0
- between two and five years	**933**	0
- after five years	**5,745**	0
TOTAL	**7,300**	0

16.2/2 Of which:

	£'000	£'000
- wholly repayable within 5 years	**1,555**	0
- wholly repayable after 5 years, not by instalments	**0**	0
- wholly repayable after 5 years by instalments	**5,745**	0
TOTAL	**7,300**	0
Of which, wholly repayable after 5 years	**5,745**	0

16.3 Prudential borrowing limit

	2007/08 Limit	2007/08 Actual	2006/07 Limit	2006/07 Actual
	£'000	£'000	£'000	£'000
Total long term borrowing limit set by Monitor	**150,700**	**7,300**	146,700	0
Working capital facility agreed by Monitor	**46,000**	**0**	46,000	0
TOTAL PRUDENTIAL BORROWING LIMIT	**196,700**	**7,300**	192,700	0
Minimum Dividend Cover	**>1**	**3.83**	>1	3.41
Maximum Debt/ Assets Ratio	**25%**	**1.2%**	25%	0
Minimum Interest Cover	**>3**	**372.3**	>3	0
Minimum Debt Service Cover	**>2**	**372.3**	>2	0
Maximum Debt Service to Revenue	**<3%**	**0.02%**	<3%	0

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

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

Further information on the NHS Foundation Trust's Prudential Borrowing Code & Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The financial ratios for 2007/08 (2006/07) as published in the Prudential Borrowing Code are shown above with the actual level of achievement for the period.

During 2006-07 the trust received approval for an £18.3m long term loan to fund its critical care expansion scheme.

£7.3m of this facility was drawn in November 2007. The balance of this facility was drawn in April 2008.

17 Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Agenda For Change	Other	**31 March 2008 Total**	31 March 2007 Total
	£'000	£'000	£'000	£'000	**£'000**	£'000
At start of period	2,636	832	13,329	6,943	**23,740**	13,328
Arising during the year	155	497	7,428	3,810	**11,890**	13,159
Utilised during the year	(151)	(418)	(5,412)	(5,245)	**(11,226)**	(2,556)
Reversed unused	(199)	(360)	0	(176)	**(735)**	(246)
Unwinding of discount	58	0	0	0	**58**	55
At 31 March 2008	2,499	551	15,345	5,332	**23,727**	23,740
Expected timing of cashflows						
Within one year	156	551	15,345	5,332	**21,384**	21,259
Between one and five years	590	0	0	0	**590**	589
After five years	1,753	0	0	0	**1,753**	1,892

Pensions relating to other staff represents the liability relating to staff retiring before April 95 (£609k) and Injury benefit Liabilities (£1,889k).

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.

Agenda for Change provision relates to amounts that may become due to members of staff if they accept the new rates of pay under Agenda For Change. Consultation with individual members of staff on this issue is proceeding.

Other provisions relate to:

- Costs likely to be incurred under the trust workforce reduction scheme (£3,829k).
- Costs likely to be incurred due to equal pay claims (£1,503k).

The consultation with staff in respect of the pay awards and the staff reduction project is continuing.

Of the above total provision and related payments, some £286,797 has been covered by 'back-to-back' income arrangements with the Trust's major Purchasers (31.3.07, £330,652).

£34,255,112 is included in the provisions of the NHS Litigation Authority at 31/03/2008 in respect of clinical negligence liabilities of the Trust (31/3/2007, £25,614,737).

18 Reserves

18.1 Movement in taxpayers' equity:

	31 March 2008	31 March 2007
	£'000	£'000
Taxpayers' equity at start of period	**439,362**	433,301
Surplus for the financial year	**21,069**	15,720
Public dividend capital dividend	**(14,167)**	(12,753)
Surplus from revaluations of fixed assets and current asset investments	**55,693**	829
New public dividend capital received	**9,160**	0
Transfers from donated asset reserve	**3,566**	2,265
Closing Government Funds	**514,683**	439,362

18.2 Movements in public dividend capital:

	31 March 2008	31 March 2007
	£'000	£'000
Public Dividend Capital at start of period	**305,119**	305,119
New Public Dividend Capital received	**9,160**	0
Public Dividend Capital at 31 March 2008	**314,279**	305,119

18.3 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Available for sale investments reserve	Income and Expenditure Reserve	**2007/08 Total**
	£'000	£'000	£'000	£'000	**£'000**
At start of period	82,524	39,289	0	12,430	**134,243**
Transfer from the Income and Expenditure Account	0	0	0	6,902	**6,902**
Surplus on revaluations of fixed assets and current asset investments	55,750	4,118	0	0	**59,868**
Transfer of realised profits (losses) to the Income and Expenditure Reserve	(7,276)	0	0	7,219	**(57)***
Receipt of donated assets	0	2,064	0	0	**2,064**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	0	(2,616)	0	0	**(2,616)**
At 31 March 2008	130,998	42,855	0	26,551	**200,404**

* Note that £57k was transferred from Revaluation Reserve to the Government Grant Reserve in respect of realised surpluses.

19 Notes to the Cash Flow Statement

19.1 Reconciliation of operating surplus to net cash flow from operating activities:

	2007/08	2006/07
	£000	£'000
Total operating surplus	**18,103**	13,558
Depreciation and amortisation charge	**29,446**	27,781
Fixed asset impairments and reversals	**3,779**	2,286
Transfer from donated asset reserve	**(2,616)**	(2,131)
(Increase) / decrease in stocks	**(383)**	193
(Increase) / decrease in debtors	**(3,785)**	2,826
Increase / (decrease) in creditors	**11,705**	(857)
(Decrease) / Increase in provisions	**(216)**	10,357
Net cash inflow from operating activities	**56,033**	54,013

19.2 Reconciliation of net cash flow to movement in net funds

	2007/08	2006/07
	£000	£'000
Increase in cash in the period	**17,226**	15,513
Change in net debt resulting from cashflows	**17,226**	15,513
Net funds at start of period	**37,568**	22,055
Net funds at 31 March 2008	**54,794**	37,568

19.3 Analysis of changes in net funds

	At 1st April 2007	Cash changes in year	**At 31st March 2008**
	£'000	£'000	**£'000**
OPG cash at bank	19,095	35,463	**54,558**
Commercial cash at bank and in hand	18,473	(18,237)	**236**
TOTAL	37,568	17,226	**54,794**

	At 1st April 2007	**At 31st March 2008**
Third party assets held by the NHS Foundation Trust (note 26)	19	**18**

20 Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £7.6 million (31 March 2007, £21.4million).

The major components of these commitments are as follows:

Scheme	**£'000**
Dental School Expansion	**1,419**
RHH Lifts - Tower Block	**847**
Haematology Expansion	**690**
RHH Food / Disposals Lift	**586**
Anaesethetic Consultant Accommodation	**312**
Other Building & Engineering work	**1,172**
Equipment	**2,536**
TOTAL	**7,562**

21 Post Balance Sheet Events

There were no material Post Balance Sheet events.

22 Contingencies

	2007/08	2006/07
	£000	£000
Gross value	**(264)**	(313)
Amounts recoverable	**0**	0
Net contingent liability	**(264)**	(313)

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

23 Related Party Transactions

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

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

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

These entities are listed below:

	Income £'000	Expenditure £'000
Sheffield PCT	320,912	
Bassetlaw PCT	10,173	
Derby County PCT	35,853	
Barnsley PCT	75,139	
Rotherham PCT	29,838	
Doncaster PCT	25,404	
Yorkshire Ambulance Service		3,968
NHS Litigation Authority		5,794
National Blood Authority		1,493
NHS Blood and Transplant Agency		5,054
National Heath Service Logistics Authority		9,323
Doncaster and Bassetlaw NHS Foundation Trust		4,000
Sheffield Care Trust		1,616

Also received from the Department of Health and from the Trent and South Yorkshire Workforce Confederations during the year is £64,897k in respect of Education ,Training and Research Funding.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with the Department of Education and Skills in respect of The University of Sheffield, and with Sheffield City Council in respect of joint enterprises.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common control of Monitor.

During the year the Trust contracted with certain other Foundation Trusts and Trusts for the provision of clinical and non clinical support services.

Of the Trust's total debtors of £35,826k at 31 March 2008, (note 14.1) £18.5m was receivable from NHS bodies. This sum comprises, in the main, monies due from Commissioners in respect of health care services invoiced, but not paid for, at the Balance Sheet date.

The remainder of the balance comprises income from NHS Trusts in respect of clinical support services provided.

£3.8m was receivable from the University of Sheffield at 31 March 2008 in respect of clinical and estates support services provided.

Professor C Welsh and Professor A P Weetman have clinical commitments at Thornbury and Claremont private hospitals, both of which are sited in Sheffield. During the year the Trust purchased healthcare from these two hospitals in the sum of £2,259k and £456k respectively.

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company which manages healthcare provided at the above hospitals. This amounted to £4,376k during the year. Certain of the Trust's clinical employees have an interest in this company.

Creditors falling due within one year of £69,025k (note 16.1) include £13,216k owing to NHS bodies. This sum includes monies owing to the Department of Health in respect of pension contributions, and to other NHS Trusts for clinical support services received.

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

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

This representation on the Governors' Council gives important perspectives from these key organizations 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

	2007/08 £000	2006/07 £000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**2,457**	42
Amortisation of PFI deferred asset	**0**	0
Net charge to operating expenses	**2,457**	42

The Trust is committed to make the payment of £2,686k (at 2007/08 prices) during the next financial year.

Future annual payments will be increased by the Retail Prices Index on 1 April in each year.

	£000
Estimated capital value of the PFI scheme	24,705
Contract Start date:	December 2004
Contract Handover Date	March 2007
Length of project (years)	32
Number of years to end of project	28.75 Years
Contract end date	December 2036

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

The residual interest projected value at December 2036 is based on a projection from a professional valuer.

There are no deferred assets associated with this scheme.

Detail;	£,000
- value of deferred asset	0
- value of residual interest	12,457

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

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

25 Financial Instruments

25.1 Financial assets

	31 March 08 £,000	31 March 07 £,000
Denominated in £ Sterling	**55,080**	37,840
In other currencies, restated in £ sterling	**0**	0
Gross financial assets at 31 March 2008	**55,080**	37,840

25.2 Analysis of financial liabilities

Denominated in £ Sterling	**(27,977)**	(20,272)
In other currencies, restated in £ sterling	**0**	0
Gross financial assets at 31 March 2008	**(27,977)**	(20,272)

25.3a Financial assets by category

Assets as per balance sheet

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	**Total £000**
Fixed asset investments	0	0	0	0	**0**
NHS Debtors (net of provision for irrecoverable debts)	286	0	0	0	**286**
Accrued income	0	0	0	0	**0**
Other debtors	0	0	0	0	**0**
Current asset investments	0	0	0	0	**0**
Cash at bank and in hand	54794	0	0	0	**54794**
Total at 31 March 2008	55080	0	0	0	**55080**
Fixed asset investments	0	0	0	0	**0**
NHS Debtors (net of provision for irrecoverable debts)	272	0	0	0	**272**
Accrued income	0	0	0	0	**0**
Other debtors	0	0	0	0	**0**
Current asset investments	0	0	0	0	**0**
Cash at bank and in hand	37568	0	0	0	**37568**
Total at 31 March 2007	37840	0	0	0	**37840**

25.3b Financial liabilities by category

Liabilities as per balance sheet	Other financial liabilities £000	Liabilities at fair value through the I&E £000	**Total £000**
Bank overdrafts	0	0	**0**
Loans	(7,300)	0	**(7,300)**
Interest payable	0	0	**0**
NHS Creditors	0	0	**0**
Other creditors	(20,677)	0	**(20,677)**
Accruals	0	0	**0**
Finance lease obligations	0	0	**0**
Total at 31 March 2008	(27,977)	0	**(27,977)**
Bank overdrafts	0	0	**0**
Loans	0	0	**0**
Interest payable	0	0	**0**
NHS Creditors	0	0	**0**
Other creditors	(20,272)	0	**(20,272)**
Accruals	0	0	**0**
Finance lease obligations	0	0	**0**
Total at 31 March 2007	(20,272)	0	**(20,272)**

25.4a Fair values of financial assets at 31 March 2008

	Book Value £000	Fair value £000
Debtors over 1 year - Agreements with commissioners to cover creditors and provisions	286	286
Investments	0	0
Other	54,794	54,794
Total	55,080	55,080

25.4b Fair values of financial liabilities at 31 March 2008

	Book Value £000	Fair value £000
Provisions under contract	(20,677)	(20,677)
Loans	(7,300)	(7,300)
Total	(27,977)	(27,977)

25.5 Maturity of financial liabilities

	2007/08 £000	2006/07 £000
Less than one year	**(20,988)**	(20,272)
In more than one year but not more than two years	**(311)**	0
In more than two years but not more than five years	**(933)**	0
In more than five years	**(5,745)**	0
Total	**(27,977)**	(20,272)

Financial Instruments comprise assets of £55,080k and liabilities of £27,977k. The assets comprise cash of £54,794k and 'back-to-back' NHS debtors of £286k. The cash is held in the Paymaster General Account(£54,558k) and 3 other accounts with commercial high street banks (£236k). The credit risk to this asset is that the commercial banks may default on payment, either temporarily or permanently. Since they are all credit rated as 'A1' (Standard & Poor's) this risk is considered immaterial. The PGO is a Department of HM Government and is considered to have a zero credit risk. The cleared balances on these accounts attract interest calculated with reference to the Bank Of England's base rate. Note that the relative holdings of cash in the PGO/Commercial accounts will vary in the course of the year. The debtor is an undertaking by the major NHS purchasers of the Trust to pay for certain injury benefits payable to former trust staff. It is calculated by discounting the cash flows expected to occur over the expected lifetime of the recipient, as calculated by the Government Actuary at the assigned rate of 2.2%. Cash becomes payable by the PCT at the time the trust pays cash over to the NHS Pensions Authority, or earlier if the PCT so requests. The value of this asset is subject to variations in financial circumstances of the claimants, their actual longevity and the continued willingness of the Patient Care Trusts concerned to honour their liability under contract.

The liabilities comprise a loan from the Department of Health for £7,300k and £20,677k of sundry provisions. The loan was contracted with the Department of Health on 1/11/2007 in respect of the cost of the construction of critical care accommodation. It is repayable over 25 years at 4.8% interest. Since the loan is effectively provided by HM Government the risk of the lender defaulting is considered zero. The principal risk is that trust income might fail to cover the principal and interest. Considering the trusts annual income is currently £689m per annum and the total interest and principal amounts to £11.7m over the 25 year life of the loan, this risk is considered negligible.

The other liability represents provisions in respect of ongoing negotiations with individual members of staff in respect of their rates of pay or termination payments, either through the Agenda For Change scheme (£15,345k), Equal Pay claims (£1,503k) or the Staff Reduction program (£3,829k). The Agenda for Change and equal pay claims are subject to the wishes of the member of staff and to adjucation by the Trust, and the outcome and timing of such adjucation are the main variables in determining the value of the liability. In respect of the Staff reduction program, payments due to the individual as redundancy pay or the NHS Pensions Authority re pension consequences of redundancy or early retirement are set out in the rules of the pension scheme and staff national terms and conditions. In each case there was substantial intention to proceed with the redundancy/early retirement at the balance sheet date. The exact date of enacting the terminations are, however, to be determined, and this date will affect the amount payable. The value provided assumes that the effective date is 31 March 2008 and that staff continue in their intention to proceed with the redundancy / early retirement.

26 Third Party Assets

The Trust held £17,570 (31 March 2007, £18,587) at bank and in hand at 31 March 2008 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 530 (366 in the year to 31 March 2007) cases of losses and special payments totalling £412k (12 months to 31 March 2007, £327k) approved during the financial year.

There were no cases (12 months to 31. March 2007- 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 accounts which are prepared on an accruals basis.

28 Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £14,167k (12 months to 31 March 2007 £12,753k) bear to the average net relevant assets during the twelve month period of £417,270k (12 months to 31 March 2007 £378,033k), that is 3.5% (2006-07 - 3.4%).

This is calculated as follows:

	31 March 2008	31 March 2007
	£'000	£'000
Total Capital and Reserves	**514,683**	439,362
Less - Donated Asset Reserve	**(42,855)**	(39,289)
Less - Cash held at Office of the Paymaster General	**(54,558)**	(19,095)
Net Relevant Assets	**417,270**	380,978
Average Net Relevant Assets	**399,124**	378,033
Dividend paid per Cash Flow statement	**14,167**	12,753
Percentage	**3.5%**	3.4%

The Trust's actual rate of return in 2007/2008 of 3.5% (12 months to 31.3.2007 3.4%) is no different from its forecast rate of 3.5%.

Statement on Internal Control

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2008 and up to the date of approval of the annual report and accounts.

As an employer, with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

Capacity to handle risk

I recognise that risk management is pivotal to developing and maintaining robust systems of internal control required to manage risks associated with the achievement of organisational objectives and compliance with Terms of Authorisation as a Foundation Trust.

The leadership and accountability arrangements concerning risk management are included in the Trust's Risk Management Strategy and Policy, job descriptions and identified risk-related objectives.

The Board of Directors is collectively and individually responsible for ensuring sound risk management systems are in place. The Board of Directors is supported by a number of formal sub-committees with a remit to oversee and monitor the effectiveness of risk management, internal control and assurance arrangements including:

- Management Audit Committee
- Healthcare Governance Committee
- Finance Committee
- Human Resources Committee
- Remuneration Committee

The committees are chaired by non-executives and minutes and relevant reports are submitted to the Board of Directors.

As Chief Executive, I am accountable for risk management and my office, through the Trust Secretary, has an overarching responsibility for the development and maintenance of a cohesive and integrated framework and shared processes for the management of all risk.

Operationally, risk management is delegated to the Trust Executive Group which reports through the chief executive to the Board of Directors. Executive directors are responsible for specific categories of risk, (as detailed in the Risk Management Strategy and Policy).

In addition to the corporate responsibilities outlined above, clinical directors, directorate managers and departmental heads have devolved responsibility for ensuring effective risk management in accordance with the Trust's Risk Management Strategy and Policy within their own areas.

The Risk Management Strategy and Policy indicates the level of training for all grades of staff commensurate with their responsibility for risk management. Training is determined by the personal development process at an individual level and by training needs analyses at a strategic level. Advice on generic and specific risk management training, either internally or externally delivered, is available to staff and managers via the Training and Organisational Development Department.

Health and safety training and information governance are core topics in the mandatory training programme. All directorates are required to produce a risk-based induction and update plan for mandatory training.

The Patient and Healthcare Governance Team provide support and expert advice and guidance.

Incidents, claims, patient feedback and risks assessments are reviewed as part of a scheduled programme. The results of audits, national surveys, external agency visits and accreditations reports and external reports are also routinely reviewed. Issues raised by such reviews are used to ensure lessons are learnt and to improve practice. In addition, the Trust is continuing to develop expertise and capacity to undertake root cause analysis.

The risk and control framework

The Risk Management Strategy and Policy was approved by the Board in July 2006. It is maintained by the Department of Patient and Healthcare Governance and is regularly reviewed.

It has been widely promoted across the organisation and is available to all staff on the Trust intranet.

The strategy and policy sets out the organisation's approach to risk which aims to strike a balance between innovation, opportunity and risk, seeking to enhance performance and quality whilst minimising adverse consequence. It clarifies accountability arrangements and individual and collective roles and responsibilities for risk management at all levels across the organisation. It outlines the structures and processes for effective risk management within the Trust. It provides instructions on how to register the risk on the Trust's electronic Risk Register, (Datix Risk Management System).

The policy and strategy clearly defines risk and includes guidance on the systematic identification, assessment and scoring of risk using a standard likelihood and consequence matrix. The score enables risks to be prioritised and identifies at what level in the organisation risk should be managed and when the management of a risk should be escalated within the organisation. This is an indication of the Trust's general approach to risk appetite but it should be acknowledged that decisions regarding acceptable or unacceptable levels of risk in relation to specific risk issues are also affected by financial capacity, the need to maintain service provision, and assessment of potential harm to patients, staff or public, together with the Trust's obligations in relation to legislation, regulation, standards or targets. At a corporate level, the Board of Directors utilise risk reports and other sources of information to consider their risk appetite.

The Assurance Framework identifies the Trust's principal objectives and the high level risks to their achievement along with key controls and sources of assurance. Underpinning the Assurance Framework is the Trust's Risk Register which includes those strategic risks identified by the Trust Executive Group and reported via the Top Risk Report and operational risks identified by clinical and corporate directorates. The annual review of the Assurance Framework and the quarterly Top Risk reports inform and update the Board of Directors and the Trust Executive Group on key strategic risks and allow progress against director-led action plans to be effectively monitored.

The integration of the Assurance Framework and the Risk Register into the business planning process ensures that risk-based decisions can be made in relation to service developments and capital allocation.

Risk management is firmly embedded into the activity of the organisation and operational responsibility is delegated to the individual directorates' management teams. Each directorate is responsible for identifying, assessing, scoring and registering its own risks. It is also responsible for maintaining the local risk register and for developing and monitoring plans to mitigate unacceptable risks or escalating the risk management within the organisation.

Supplementing the work of the Board and its committees, there are a number of specialised committees within the Trust with a remit to oversee specific risks: Blood Transfusion Committee, Control of Infection Committee, Emergency Preparedness Operational Group, Health and Safety Committee, Information Governance Committee, Medical Equipment Management Group, Medicines Safety Committee and Radiation Safety Steering Group,

There are well established and effective arrangements in place for working with public stakeholders across the local health economy:

- Sheffield PCT
- Yorkshire and Humber Specialised Commissioning Group (South)
- Yorkshire and Humber Strategic Health Authority
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- Neighbouring trusts in South Yorkshire and North Derbyshire
- Sheffield City Council
- Sheffield and South Yorkshire Overview and Scrutiny Committees
- Sheffield First and more specifically Sheffield First for Health

The Trust is also represented on various national forums such as Foundation Trust Network and NHS Confederation and is able to help influence national policies

Information risks and controls

There are robust and effective systems, procedures and practices to identify, manage and control information risks. Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Committee which is accountable to the Healthcare Governance Committee, a committee of the Board. For 2007-08 the Information Governance Committee was chaired by the chief nurse who was also the Caldicott Guardian. From June 2008, the medical director will take over these roles as the Board's senior information risk owner.

The Information Governance Strategy (approved by the Board in April 2005) outlines a framework which brings together all the statutory requirements, standards and best practice in information governance. Underpinning the strategy is the Information Governance Policy (approved by the Board in June 2005) and a risk-based Annual Plan which is used to drive continuous improvement in information governance. The development of the Annual Plan is informed by the results from the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Programme.

Responding to concerns about public sector data protection and security, the Trust has recently issued guidance on the transfer of personal identifiable data and sensitive data. This guidance has been widely promoted across the Trust and complements the Trust's Information Security Policy and Confidentiality Code.

Work is underway to further strengthen information security relating to removable and portable devices.

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 organisational-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 income assumed from national tariffs and local prices agreed with commissioners. Financial plans are approved by the Board, supported by its Finance Committee. An Annual Plan is submitted to Monitor, reflecting financial, service and governance aspects, each of which is ascribed a risk rating by Monitor. This plan incorporates projections for the following two years, which facilitates forward planning by the Trust.

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

The Trust's Adding Value Programme continues to drive enhanced productivity and efficiency through better information, targeting areas for improvement and developing capability and capacity. A key element of the programme is to seek improvements to patient care alongside productivity and efficiency gains.

The Trust employs a number of approaches to ensure best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service re-design leading to improvements in the quality of services and patient experience as well as financial performance. External consultants are commissioned to undertake reviews where the Trust believes economy, efficiency and effectiveness can be improved. In its drive to service improvement, the Trust works closely the NHS Institute for Innovation and Improvement. As mentioned below, the Board receives assurance on the use of resources from a number of external agencies for example, Monitor's Financial and Governance risk rating and the Healthcare Commission's Annual Healthcheck. Such reviews are reported to the Board of Directors or its committees.

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

The Trust also makes use of both Internal and External Audit functions to ensure the controls are operating effectively and to advise on areas for improvement. In addition to financially related audits the Internal Audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed thereby assisting prioritised action plans which are agreed with management for implementation. All action plans agreed are monitored and implementation is reviewed regularly and reported to Management Audit Committee as appropriate.

Review of effectiveness

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

The Assurance Framework and the Top Risk report provide me with evidence that the effectiveness of controls that manage the risks to the organization achieving its principal objectives have been reviewed.

The Management Audit Committee continues to receive and monitor relevant audit reports and the Assurance Framework. It has recently reviewed and revised its terms of reference in line with latest guidance to provide an overarching review of the effectiveness of systems of integrated governance, risk management and internal control across the organisation.

The Trust is continually reviewing risk management and assurance processes to ensure continuous improvement of the systems and processes in place. Governance arrangements have been reconfigured in the past year following an external review. The appointments of Head of Patient and Healthcare Governance and Assurance Manager have been key to strengthening the effectiveness of risk management, internal controls and assurance in the Trust.

My review is also informed by:

- Opinion and reports by Internal Audit who work to a risk-based plan. Of specific value have been internal audit reviews of Risk Management, the Board Assurance Framework, Emergency Planning, Sudden and Unexpected Incidents and Standards for Better Health.
- Opinion and reports by our external auditors (Audit Commission) and specifically the annual audit letter.
- Quarterly performance management reports by Monitor.
- DH reports such as Performance Indicators and Cleaner Hospitals Visit.
- Healthcare Commission reports.
- The Board of Directors' declaration of compliance against Core Standards for Better Health and supporting third party comments from Yorkshire and the Humberside Strategic Health Authority, Governors' Council, Safeguarding Children's Board, South Yorkshire Health Scrutiny Committee, Patient and Public Involvement Forum.
- Achievement of Improving Working Lives - Practice Plus.
- NHSLA assessments against Risk Management Standards and CNST for Maternity.
- Information Governance Assurance Programme and the Information Governance Toolkit
- Results of national patient surveys and the national staff survey.
- Investigation reports and action plans following serious untoward incidents.
- User feedback such as PALS reports, complaints and claims.
- Patient and Public Involvement Forum and Governor Council reports.
- Clinical Audit reports.

Conclusion

As Accounting Officer and based on the review process outlined above, I am assured that there are no significant internal control issues.

Andrew Cash OBE
Chief Executive

11 June 2008

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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