Sheffield Teaching Hospitals NHS
NHS Foundation Trust

annual report 2004-2005





Annual Report and Accounts presented to Parliament pursuant to schedule 1, paragraph 25(4) of the Health and Social Care (Community Health and Standards) Act 2003.

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Welcome to the Sheffield Teaching Hospitals annual report

This report is different to most annual reports as it formally looks at the work of Sheffield Teaching Hospitals NHS Foundation Trust over the first nine months of its existence rather than a full year.

This was because Sheffield Teaching Hospitals was in the second group of the first wave of NHS Foundation Trusts and moved to the new status in July 2004.

As well as covering the period from July 2004 to March 2005, this report does include a brief summary of some of the activity that took place from April to June 2004.

A summary annual report looking at the closure of the Sheffield Teaching Hospitals NHS Trust is also available at www.sth.nhs.uk

NHS Foundation Trust status

On July 1st 2004 the Independent Regulator of NHS Foundation Trusts announced that Sheffield Teaching Hospitals had been given the go-ahead to become one of the first NHS foundation trusts in the country

From that date 19 patient and public governors, five elected staff governors and nominated representatives from 13 partner organisations the Trust works with (such as Primary Care Trusts, universities and the voluntary sector) formed the new Governors Council of Sheffield Teaching Hospitals NHS Foundation Trust.

The Trust now has greater freedom from central government control and is able to invest more in patient care, set local health targets, and look to play a greater role in the economic regeneration of Sheffield and South Yorkshire.

Foundation Trusts remain part of the NHS, providing care free of charge to those who need it. The main differences they bring are:

- greater involvement of local people in the development of local hospitals and the services they provide - with public, patient and staff membership and hospital governors elected to work with managers;
- less national Government control - with the ability for the hospitals to set local health targets designed around the needs of local people in the future;
- the power to retain financial surpluses and use them for future improvements to services and to borrow money to finance new buildings and initiatives;
- the ability to play a new role in the regeneration of Sheffield and South Yorkshire, and to look at new opportunities for bringing in money to the city and increasing employment opportunities in areas of deprivation.

Sheffield Teaching Hospitals was initially formed on April 1st 2001 through the merger of the Central Sheffield University Hospitals and Northern General Hospital NHS Trust.

The Governors Council represents the views of patients and the public in the setting of local priorities for the hospitals and works with the existing Trust Board of Directors to take the hospitals forward and set local targets and priorities. The hospitals are now accountable to the public through the Governors rather than directly to central government. It's an exciting new way of working for the NHS and one that Sheffield Teaching Hospitals is proud to be part of.

The hospitals of Sheffield Teaching Hospitals NHS Foundation Trust

Charles Clifford Dental Hospital

Jessop Wing

Northern General Hospital

Royal Hallamshire Hospital

Weston Park Hospital

Board of Directors

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

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

Chairman

David Stone OBE - Chairman [A]

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

Executive Directors

Andrew Cash OBE [B]
Chief Executive

Andrew Cash was a graduate entrant to the NHS on the national management-training scheme. His early training took place at the Nuffield Centre for Health Service Studies at the University of Leeds. He has been an NHS chief executive for 17 years and has worked at regional and national level. Mr Cash was seconded to the Department of Health in 1999 to lead the Millennium Executive Team, which handled preparations for winter planning and the year 2000 date change. He was awarded the OBE for services to healthcare in 2001 and is current chair of the national Foundation Trust Network.

Heather Tierney-Moore OBE [C]
Chief Nurse

Heather Tierney-Moore originally trained as a nurse in Sheffield working at both the Royal Hallamshire and Northern General Hospitals. She has held previous posts in executive management and clinical services.

Mrs Tierney-Moore was a member of the NHS's National Modernisation Board and was awarded the OBE for services to healthcare in 2002. She is lead Director responsible for the introduction and development of the NHS Foundation Trust model at the Trust.

Chris Linacre [D]
Director of Service Development

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

Neil Priestley [E]
Director of Finance

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

John Watts [F]
Director of Human Resources

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

Professor Chris Welsh [G]
Medical Director

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

Non-Executive Directors

Ony Bright [H]

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


A


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John Donnelley [I]

John Donnelley was a Chief Superintendent with South Yorkshire Police and commander for the district that covers the Trust's hospitals before retiring during the course of this year. He joined the Police as a cadet in 1966 at the age of sixteen and has headed up the Force's Research & Development, Community Relations, and Police Traffic Departments.

Vickie Ferres [J]

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

Vic Powell [K]

Victor Powell is an accountant by profession and worked for KPMG in Sheffield throughout his professional career. He was involved in the management of the North-East Region in general and the Sheffield office in particular where he was Business Unit Managing Partner for nine years until retiring in December 1999.

John Stoddart CBE [L]

Trust Vice Chairman John Stoddart has a background in higher education and was Vice Chancellor of Sheffield Hallam University until his retirement in 1998. He was appointed a CBE in 1995 for services to higher education and holds honorary degrees from both the University of Sheffield and Sheffield Hallam University. He is a Director of Sheffield Assay Office. Mr Stoddart was previously a Non-Executive Director at the Northern General Hospital NHS Trust.

Professor Tony Weetman [M]

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

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

1st July 2006
John Donnelly and John Stoddart

1st July 2007
David Stone, Vic Powell and Ony Bright

1st July 2009
Vickie Ferres and Tony Weetman

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

Remuneration of Executive Directors is carried out through the Trust Board's Remuneration Committee.

Our Governors Council

The Governors Council is a new body made up of and elected by the Foundation Trust members.

It aims to give everyday people who use the hospitals a big say in their running. The Governors Council holds the Board of Directors to account and seeks to ensure the continued success of the Trust through effective management, partnership working and maintaining NHS values and principles.

There are 37 Governors in total. 12 represent the public of Sheffield, seven represent patients who have used services at the hospitals, five represent staff at the hospitals and there are 13 partner governors appointed from key organisations that we work with. Further information on the constituencies is given in the Membership section on page 5.

The Governors Council meets formally three times a year, but their work involves more than that. Individual Governors are involved in trust committees and working groups and also input into specific projects where their particular expertise or perspective is valuable. Individual Governors are expected to seek views of the members. This will be to enable them to canvass views on significant issues and report back on decisions made.

Other statutory duties of the Governors Council include:

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

Governor elections will take place each year on a rolling annual basis to ensure that there are opportunities for new members to stand for election. To determine their initial term of office the Trust looked at the number of votes each Governor received in the election so that one place in each public constituency and two places in the patient constituency would come up for election each year. This means that Governors will have an initial term of office between one and three years. Staff Governor elections will take place every two years. Elections take place via a postal ballot and are run by the Electoral Reform Society.

A full Register of Interests for the Governors Council (including any company directorships where those companies may possibly seek to do business with the Trust) is available from Sue Coulson, Directorate of Legal and Corporate Affairs, Royal Hallamshire Hospital by ringing 0114 271 3071.

Governors Council (as at end March 2005)

Constituency	**Elected Governors**
Patient	Diana Chadwick Susan Coldwell John Holden Kenneth Murta David Symes Helen Wilde [One vacancy at year end]
Public - North Sheffield	Chris Suddes Sharon Tabberer Margaret Whiteley
Public - Sheffield South West	Sylvia Bennett Philip Seager Susan Wilson
Public - Sheffield West	Martin Colclough James Smith Beryl Wilson
Public - South East Sheffield	Richard Chapman Hazel Hughes Edwin Speight
Staff - Medical & Dental	Mike Collins
Staff - Nursing & Midwifery	Rose Bollands
Staff - Allied health professionals, scientists & technicians	Stephen Westby
Staff - managerial, administrative & clerical	Mark Hattersley
Staff - ancillary, works & maintenance	Dave Weston
Organisation	**Partner Governors**
North Sheffield Primary Care Trust	Paul Schatzberger
Sheffield South West Primary care Trust	Nicholas Steele
Sheffield West Primary Care Trust	Simon Gilby
South East Sheffield Primary Care Trust	Rosie Trainor
Sheffield City Council	Bob Kerslake Jan Wilson
South Yorkshire Strategic Health Authority	Alan Wittrick
South Yorkshire Public Health Network	Chris Bentley
Sheffield Hallam University	Diana Green
University of Sheffield	Bob Boucher
Sheffield First Partnership	Sylvia Yates
Voluntary Action Sheffield	Emily Morton
South Yorkshire, North Derbyshire & Bassetlaw Commissioning Consortium (NORCOM)	Cathy Edwards

Our Membership

Membership is one of the most important aspects of Foundation Trust status. Involving our local community in this new way was a major factor in the Trust expressing its interest in becoming a Foundation Trust.

Nearly 7,000 local people became members of Sheffield Teaching Hospitals NHS Foundation Trust before July 2004. Membership is open to people who have been a patient with our hospital, those who live locally and our staff. There are public, patient and staff constituencies of membership.

The public constituency splits Sheffield into four areas - North Sheffield, South East Sheffield, Sheffield South West and Sheffield West. These are based on the Primary Care Trust boundaries in the city and there are three Public Governors in each constituency. Anyone who lives in the boundaries of the Sheffield City Council area can join as a public member.

The patient constituency represents patients who have used our hospitals who come from outside the Sheffield area. However, Sheffield residents who have been patients can elect to join the patient constituency if they wish. The staff constituency is split into five staff groups. These are Medical and Dental; Nursing and Midwifery; Allied Health Professionals, Scientists and Technicians; Managerial, Administrative and Clerical and Ancillary, Works and Maintenance.

The Trust is keen to involve members and keep them informed about the hospital and its activity. A regular newsletter for members called GoodHealth was launched in July 2004 and has been published quarterly. It informs the membership about the Governors Council and also aims to bring health advice and information direct from staff at the hospitals to the members. Our first event for members was a Health Fair held in September 2004. Over 500 of the public and patient members took the time to visit the event and feedback was excellent.

The Trust is developing a strategy to enhance communication with members so that their views feed into our business planning process each year. The aim is to give Governors key information from members that can influence their work in the organisation and on the Governors Council. We also aim to double our public and patient membership over the next year.

Current membership levels at 31st March 2005 are:

Public Constituency	1873
Patient Constituency	3351
Staff Constituency	1281

[The staff constituency was set to grow to 12,625 members on May 1st 2005 as part of a change in constitution that saw an opt-out system of staff membership adopted.]

Chairman's statement

I always look forward to this time in the calendar, looking back over the year's achievements and thanking all our staff for their hard work and dedication to patient care that has made another successful year for the Trust.

It's all about local autonomy - giving the hospitals more freedoms from Government control and getting local people involved in saying how we use those freedoms to improve services.

We've been one of the NHS's top performing hospital trusts over the last three years and this year we have taken the next step in our development by becoming one of the first NHS Foundation Trusts.

It's all about local autonomy - giving the hospitals more freedoms from Government control and getting local people involved in saying how we use those freedoms to improve services. It's an exciting challenge and one that we feel is improving NHS care in the city and the region. Personally, I have been delighted to chair the new Governors Council alongside the Trust Board and feel that the Foundation Trust model is the right one for our Trust to develop further in the future.

The new governance arrangements, whereby members of the public, past and present patients and staff have a direct influence on how we plan and deliver out services has got to be the right way forward.

Sheffield Teaching Hospitals has taken a lead role in helping shape the development of Foundation Trusts and this is important. Our Chief Executive, Andrew Cash, is the chair of the Foundation Trust Network, which represents the interests of all Foundation Trusts at a national level. We've been able to help influence the policy across the UK that will benefit patients everywhere, including Sheffield.

This year in our Annual Report we have decided to follow the months of the year, highlighting some of the first-rate service developments and successes as they occurred. As usual, only a small sample of what truly goes on in the hospitals can be mentioned in detail. Every single member of staff plays their part in providing the best possible service to our patients and I would like to thank them for their professionalism and enthusiasm. This year, by working together, we have provided almost one million individual hospital appointments.

A number of teams and individuals have also received recognition for their work from outside the organisation. These include consultant surgeon Mr JAR Smith who has become President of the Royal College of Surgeons of Edinburgh and heads up their 500th anniversary celebrations; Chief Nurse Heather Tierney-Moore was asked to be the national clinical champion for the National Programme for Information Technology and Dr David Levy is now the country's deputy lead for cancer services. Staff Nurse Maggie Lean, who works on the Trust's Renal Unit, won the medical nursing category in the prestigious Nursing Standard 'Nurse of the Year Award' and the Trust's Mobility and Specialised Rehabilitation Centre won the important Disablement Services Centre of the Year Award. Finally I was delighted that Professor Sir James Underwood received his Knighthood during the course of the year.

This year we were also delighted to welcome the Duchess of Gloucester when she was able to visit and officially mark the opening of the Sheffield Macmillan Palliative Care Unit at the Northern General site. She was able to meet our staff and volunteers and the patients who are benefiting from the care provided.

This recognition and these high profile appointments help ensure that the name of Sheffield Teaching Hospitals is known across the country for the excellent services we provide, staff we employ and facilities we manage. As part of the new Foundation Trust movement we are in a position to help lead future national NHS reforms and system change and ensure that we see further benefits for our staff, patients and public.

We look forward to the coming year when will be working increasingly with our Governors and the local community to build on our excellent start as an NHS Foundation Trust and to tackle the challenges and real opportunities that lie ahead.

David Stone
Chairman

Chief Executive's statement

This year has been a year of contrasts at Sheffield Teaching Hospitals NHS Foundation Trust.

Our idea is that the responsibility for planning, managing and delivering services gradually moves from Whitehall control to Sheffield.

It has been a year of continued clinical success with more patients treated than ever before, but at the same time there has been a period of intense pressure for all the hospitals to cope with.

Looking back at my report for last year, I spoke of the forthcoming changes that we were preparing for. This year has indeed been a year of great change. Becoming one of the first and the largest of the new flagship NHS Foundation Trusts has given us the opportunity to look at new ways of working to tackle issues that face us and to make improvements patients want to see. As the region's second largest employer we are also beginning to play a bigger role in regeneration, which is something we've not looked at before. I feel we can make a big difference to the health of the city and the region as a Foundation Trust.

Change is also being seen around the hospitals. We have embarked on the biggest building programme in our history. Over £70 million worth of projects are now underway.

We will have new medical wards and expansions to cancer, heart and kidney facilities. Our buildings are being upgraded to meet the needs of the modern NHS. Over recent months earth moving equipment and cranes have become as common a sight as ambulances at the hospitals.

In some parts of the Trust the transformations have been incredible. In Accident and Emergency we have radically improved the services by ensuring that 98% of our patients get the treatment they need and a hospital bed within four hours of their arrival. In cardiac services, a five-year plus programme of work has culminated in no patient waiting more than three months for routine cardiac bypass graft surgery. These are remarkable changes. Only two years ago patients often waited on trolleys for hours in the corridors of the A&E department for a hospital bed to become available. Those waits are now a thing of the past. Only five years ago a patient could wait up to 18 months for a routine heart operation. Those waits are also now a thing of the past.

Not all of the change has been for the better. We saw a dramatic change on the demand for our services over the year and a major rise in the number of emergency admissions at the hospital - people who desperately need our care. Pressures on our services were greatest in the weeks after Christmas when admissions reached their highest ever-recorded levels and our priorities of treatment had to be changed. This led us to postpone a number of operations and open extra ward areas to provide care. Staff worked above and beyond the call of duty to ensure the hospitals could meet the needs of those patients.

The end result is how the patients who have received our care view us. This year saw important national surveys carried out looking at our services. The national outpatient survey saw the Trust rated by our patients as amongst the top performers in the country for informing and involving them in making decisions about their care, seeing them in a timely manner and for the trust and the courtesy of our doctors.

In the A&E Department survey the Trust again scored highly in most areas with waiting times improved and a high level of confidence in the doctors and nurses.

In 2004-2005 we were starting out on a new venture. Our idea is that the responsibility for planning, managing and delivering services gradually moves from Whitehall control to Sheffield. I believe that this is the right direction to take. We will do all in our power to maintain our overall objective of being one of the top performing NHS, academic and teaching centres in the United Kingdom.

Andrew Cash.

Andrew Cash
Chief Executive

Performance overview

In 2004-2005 the hospitals treated more patients than ever before and cut waiting times to new low levels.

At the same time there was a large and unpredicted rise in emergency admission in the later part of the year that added extra pressure to the hospitals.

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

- In A&E we achieved our target of 98% of patients being treated, admitted or discharged within four hours of their arrival.
- No patient waited over nine months for their inpatient or day case treatment, in fact 93.9% of patients were seen within six months.
- Only one patient waited more than six months for cardiothoracic surgery by March 2005 and 88% of patients received their operation within three months.
- There was a 10.2% reduction in the total number of patients waiting for inpatient treatment.
- The target for a maximum wait of two weeks for patients referred by their GP for an urgent appointment for a suspected cancer was achieved for 99% of referrals.

The table below provides a summary of the Trusts increase in activity in 2004-2005 in comparison with the previous year. The increase in activity for inpatients and day cases is impressive and has helped us meet our targets on keeping down waiting times. This was achieved against the background of sustained pressure in all wards and departments.

	Target 2004-2005	Actual Activity 2004-2005	Actual Activity 2003-2004	Percentage Activity Increase
Inpatient and day case episodes	159,524	165,070	164,667	**0.3%**
Outpatient attendances	728,586	766,586	747,295	**2.6%**

During 2004-2005 our total inpatient waiting list decreased significantly while the number of patients waiting over six months for inpatient treatments decreased by a huge 51.5%. Although the number of outpatients waiting over 13 weeks increased by 154 patients, this is out of a total of well over 766,000 patients and plans are already in place to rectify the situation.

	Target	31 March 2005	31 March 2004	Percentage Change
Total inpatient waiting list	11,759	11,727	13,057	**-10.2%**
Inpatients waiting six months and over	683	708	1,461	**-51.5%**
Outpatients waiting 13 weeks and over	549	703	549	**+22%**

Investing in our buildings and equipment

We are committed to developing our buildings and facilities across our hospitals with an ongoing programme of investment.

Total capital expenditure for the year was £29.6 million (£4.9 million in the three month period to June 2004 and £24.7 million in the nine month period to March 2005). Across both accounting periods, the key focus of expenditure continued to be support for initiatives on statutory compliance and infrastructure improvements, new and replacement medical equipment, waiting list and access improvements and new service developments associated with the Trust's Service Development Strategy.

The 2004-2005 capital expenditure is analysed as shown opposite.

Total capital income available to the Trust for the year was £35.3 million, including £3.2 million from donations and other contributions towards capital expenditure. The capital income is analysed as shown opposite.

CCDH - Charles Clifford Dental Hospital
JW - Jessop Wing
NGH - Northern General Hospital
RHH - Royal Hallamshire Hospital
WPH - Weston Park Hospital

Expenditure	Three months to June 2004 £000	Nine months to March 2005 £000
Medical Equipment	**1,237**	**4,172**
Replacement Computerised Tomography Scanner (WPH)	499	
Dual Headed Gamma Camera (NGH)		365
20 Renal Dialysis Machines (NGH)		236
Neurosciences Electroencephalogram Equipment (RHH)		190
Other	738	3,381
Statutory Compliance	**594**	**1,424**
Firecode	439	397
Asbestos		179
Bone & Tissue Bank (NGH)		319
Other (Health & Safety, Disability Discrimination, Legionella etc)	155	529
Information Technology	**78**	**771**
Theatre Computer System		201
Laboratory Computer System		100
Other	78	470
Infrastructure	**739**	**3,054**
RHH Tower Refurbishment re Science Research Investment Fund 2		727
Medical School Refurbishment (RHH)	491	609
Electrical Infrastructure (NGH)		376
Security Equipment/Systems		196
Other	248	1,146
Service Development	**2,289**	**15,258**
WPH Site Redevelopment	433	4,399
Cardiology Capacity Expansion (NGH)	70	1,706
Modifications to Urology OPD (RHH)	383	1,683
MRI Scanner (WPH)	4	1,437
Purchase Clinical Sciences Building (NGH)		1,000
Renal Expansion (NGH)	40	916
Theatre Admissions Unit (NGH)		723
Office Accommodation - Nurses Home (NGH), 12 Claremont Crescent and 12 Palmerston Road (RHH)	353	417
Replacement Dental Surgeries (CCDH)	7	262
Stem Cell Research Facility (JW)		242
Reconfiguration Phlebotomy/ Anticoagulation Accommodation (RHH)	152	200
Stereotactic Radiosurgery Expansion (RHH)	157	139
Other smaller schemes	690	2,134
Total Expenditure	**4,937**	**24,679**

Income	Three months to June 2004 £000	Nine months to March 2005 £000
Resources available from the Department of Health/Internally Generated	3,688	28,459
Sheffield University investment in Medical School Refurbishment	491	609
Other Donations/Contributions	759	1,311
Total Income	**4,938**	**30,379**

Operating Review 2004-2005

This report provides an insight into some of the achievements, milestones and activities of a year in the life of Sheffield Teaching Hospitals





April, May & June 2004

The three months before moving to NHS Foundation Trust saw the hospital hit by election fever, a major study into the effectiveness of heart attack treatments and a new team established.

April 2004 saw the results for our first ever elections for hospital governors announced. Five staff governors and 19 patient and public governors were elected to join the Governors Council to represent the public and patients in service development planning.

The Governors Council also includes representatives of partner organisations including Sheffield City Council and Primary Care Trusts. Nearly 7,000 local people signed up to become members of the NHS Foundation Trust and were eligible to vote in these first elections. The governors work with the membership and seek their views to make sure that the views of staff, public and patients are represented.

We were in the first wave of NHS Trusts looking at moving towards NHS Foundation Trust status that allows establishment of Governors Councils involving local people in running the NHS.

In May, experts in the Trust undertook a study that led to improvement in the safety and effectiveness of life-saving treatments given to heart attack patients. The £50,000 project - funded by the Sheffield Hospitals Charitable Trust - involved monitoring patients who have been admitted to the hospital with unstable angina (threatened heart attack) or myocardial infarction (heart attack).

These patients are given a combination of blood thinning (antithrombotic) drugs which stops blood cells (platelets) clotting together in the arteries supplying the heart. They are also given aspirin to minimise the risk of a heart attack. The antithrombotic drugs used are very effective at reducing the overall risk of a patient having another heart attack but previous studies have shown they can lead to unpredictable and varying responses and can cause side effects.

Dr Rob Storey, Senior Lecturer and Honorary Consultant in Cardiology, ran the project:

"The aim of the study is to use a rapid monitoring system to see how patients are responding to the drugs we give them and in what way," says Dr Storey, "By looking at platelets in the blood we will be able to work out the most effective combination of antithrombotic drugs for our patients and improve the treatments we provide."

Heart attack study

Around 300-400 patients are expected to join the study. The study is purely a monitoring project and the patients' medication will be administered in the usual way.

The patients will give a maximum of six blood samples over a period of at least three days and will be contacted after 30 days to see if they have had any health problems or adverse reactions to the medication.

Blood transfusions are another key treatment for many of our patients. Very careful testing needs to take place before a patient is transfused and failure to carry out these tests can result in a severe immune reaction. A new team formed in June is helping to ensure that our standards are amongst the best.

The Specialist Practitioners of Transfusion (SPOT) are a new team made up of doctors, nurses and other professionals who promote the safe and effective use of blood. The Team has a responsibility to implement and monitor Government and National Directives ensuring that the Trust complies with the latest legislation and recommendations. There remain significant issues around blood sampling, patients receiving wrong or inappropriate blood products and around traceability and wastage.

The SPOT Team aim to provide resources and specialist advice for all staff involved in the prescribing, sampling, testing, collecting, appropriate use and administering of blood products. Many different groups of staff are involved in this transfusion process and play a vital role in achieving safe transfusion practice.

July

As summer arrived, three new services were introduced at the Trust that are making a real difference to patients.

Karen Dolling from the Ophthalmology Directorate was appointed as the Trust's Support Nurse for the Visually Impaired. Karen's role enables her to support staff and carers as well as the patients themselves in all aspects of life where visual impairment can cause difficulties. The role itself is not a counselling role, but means Karen can provide direction to the right information and support that someone might need. Most importantly she can offer support and advice on all aspects of visual impairment to staff.

The Ophthalmology Directorate also offers a specialised Low Vision Service in which all new patients receive an hour-long assessment. This enables the patient and therapist to fully explore the impact of the visual impairment. Strategies can then be developed on an individual basis to help each patient cope with their loss of vision. No one is ever discharged from the service and continued support is available through an open appointment system enabling people to be reviewed when they need further help and support.

The Trust is committed to bringing new recruits into NHS professions in Sheffield and is looking at targeting younger people to help create the NHS workforce of the future. 22 Nursing Cadets successfully completed their course in July. After two years and four placements in the hospitals they are ready to take on the challenges of modern-day nursing.

Visual impairment

Visual impairment affects many people, with over 3300 people in Sheffield being registered as partially sighted or blind. However recent figures releases by the RNIB suggesting that only 1 in 3 of those that are eligible are actually registered, meaning that visual impairment is probably a problem for far more people than these figures indicate. Low vision is any level of visual loss or impairment, which is not resolved by correction of a need for glasses or by medical treatment, and which causes any level of disability

Cadets are recruited straight from GCSE education and the scheme gives them a route into full-time nursing. The cadets have had a wide range of experiences from seeing open heart surgery to caesarean sections and working with patients who have experienced the joys of childbirth through to those who have suffered loss and bereavement. They've also put in plenty of elbow grease, making beds, helping patients to wash themselves and taking blood pressure readings, plus much more. They become a part of the ward team.

Head of Student Education, **Sue Hopkins**, said: "We're all very proud of our cadets. They've worked so hard and it's a joy for us to see them heading on into their nurse training. We've really appreciated all the help and support from frontline staff on the wards and departments where our cadets have spent their placements learning the ropes. It's because of our cadets that there is such a positive attitude to young learners in our hospitals."

The Neuro Day Care Unit opened up in July at the Royal Hallamshire. Previously called the Planned Investigation Unit (PIU), the facilities and the service provided to patients has undergone a significant change.

Patients on the Neuro Day Care Unit might not even see a doctor - as the service is now led by nurses on the unit with the support from doctors when required. The Unit used to consist of three beds and a few chairs along with four outpatient-consulting rooms. Now, thanks to increased demand, around 50 patients a week are referred to the unit's nine brand new consulting rooms with separate examination rooms to ensure the patient is taken care of in a relaxing environment.

Senior nurses have undertaken full training to enable them to take on some of the jobs traditionally carried out by doctors. This makes them one of the few teams in the country to be able to offer this high level of nurse-led service. They can now perform procedures including lumbar punctures and botox injections. A day room has also been transformed into a research area for nurses on the unit to undertake studies and trials into multiple sclerosis and other neurological conditions.

The satellite units see the expertise of Sheffield Teaching Hospitals being brought closer to our patients across South Yorkshire

Reaching out with our services

Sheffield Teaching Hospitals NHS Foundation Trust teamed up with Doncaster and Bassetlaw Hospitals NHS Foundation Trust to open a new satellite Renal Dialysis Centre that will treat up to sixty patients per year needing kidney dialysis.

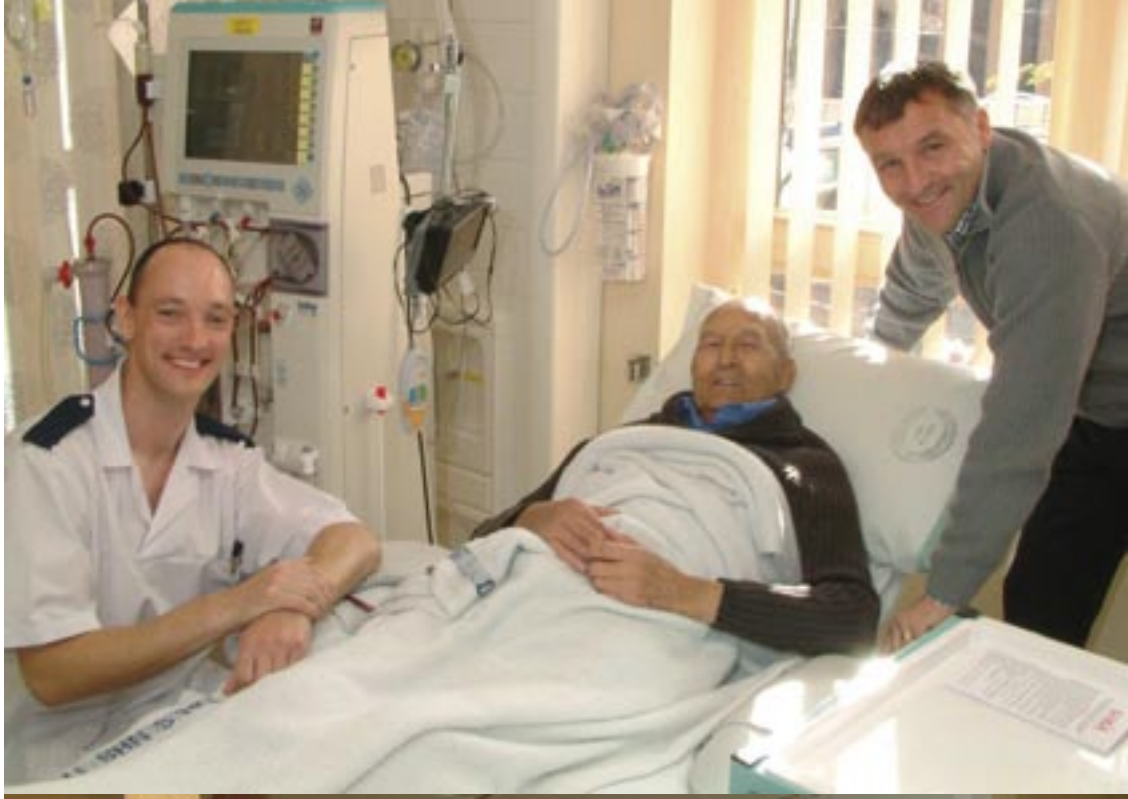
The £1.1 million Doncaster Renal Dialysis Centre is the fourth satellite centre to be opened by us. It aims to cut the time patients spend travelling to hospital for kidney dialysis.

Presently, around 60 patients travel from the Bassetlaw and Doncaster areas to the Northern General Hospital's Renal Unit - the main dialysis centre for the North Trent region -for haemodialysis treatment up to three times a week. Now most of these patients will be able to have dialysis at their local hospital, in some cases dramatically cutting the distance travelled to and from hospital by around 130 miles per week. Patients with more complicated conditions and those who are attending for their first dialysis session will continue to travel to Sheffield for more specialised treatment.

The new Renal Dialysis Centre has twelve dialysis stations - like hospital bed bays - where a patient goes for their treatment. Each station is fully equipped with the latest dialysis machines to ensure the best possible care for patients. Staff from Sheffield Teaching Hospitals will have responsibility for managing the clinical side of the Doncaster Renal Dialysis Centre: our doctors and nurses will treat patients and support will be provided in the form of dieticians and biomedical engineering services.

"By working in partnership with Doncaster we are now able to offer the highest quality health care services to our kidney dialysis patients from that area," says **Dr David Throssell**, Clinical Director of Renal Services, "It gives them their care in a local setting, under the guidance of Sheffield Teaching Hospitals. We use our expertise in this particular clinical area in a practical way closer to their homes."

The others satellite units are at Barnsley District General Hospital, Royal Chesterfield Hospital and Rotherham District General Hospital.



August

August saw the new consultant contract come into place in the NHS and schemes introduced to provide greater managerial opportunities for staff from black and minority ethnic backgrounds and an increased role for radiographers.

The new consultant contract aims to properly reward consultants so that more NHS patients benefit from their time and skills. It also sets out to ensure investment brings with it new ways of delivering patient care.

Following completion of negotiations between the Department of Health and the British Medical Association in 2003, a new national contract for Consultant Medical and Dental Staff in England was put forward for implementation. The new contract has been very successfully implemented within the Trust with a total of 321 Consultant Medical and Dental Staff transferred to the new contract. In addition, job plans have been agreed with all consultants, which will be subject to annual review. Under the terms of the new contract, new arrangements have been put in place, dealing with on-call availability and on-call work, including work undertaken in the evening and at night and at weekends, together with new arrangements for pay progression.

The Trust is committed to providing equal opportunities to all staff and a new project launched in August is aiming to ensure our workforce is representative of the community we serve. It aims to increase the opportunities for staff from black and minority ethnic backgrounds (BME) to gain the skills to help move into management positions in the Trust. This is one strand of the Trust's work towards the national Improving Working Lives Standard.

The Trust's profile suggests that only 3% of senior managers are from BME backgrounds and it's an issue that we are now addressing. An equalities framework from the Department of Health called 'The Vital Connection' has set targets for better representation within the health service and suggests we should be striving for a workforce that has 7% BME staff at senior level by 2005.

Trust Chief Executive Andrew Cash and the Trust's Diversity Manager Millie Douglas are encouraging all managers to volunteer to become mentors to members of staff from BME backgrounds. Mentorship has been proven as an effective way to help staff gain the confidence and knowledge of what is required to become an effective manager. It is a great way of developing staff and is beneficial to both the mentor and mentee alike.

Millie is matching up managers with mentees looking to develop their careers with several partnerships already in place. Taking forward the scheme has seen Andrew Cash mentoring for Millie. The idea of the mentoring scheme has been driven by the Trust's diversity steering group, which is meeting regularly to take forward actions that will help ensure our workforce is properly reflective of the local community.

We're also always looking at new ways of working so we can develop the skills of our workforce and make sure that they are providing maximum benefit to our patients. At Weston Park Hospital it had been recognised that some of the tasks performed by doctors could be safely carried out by appropriately trained radiographers. To address this issue radiographers have undertaken training and competency assessments to allow them to extend their roles.

Radiographers are now carrying out routine clinical and image reviews, consenting for certain radiotherapy treatments, and performing radiographer led breast simulation for treatment. Doctors are available at all times for advice and support if required.

This role extension has resulted in an easier and quicker patients' journey, has reduced waiting times, released doctors' time for other duties and made the radiographers' job much more satisfying and fulfilling.

"I have been carrying out role extension for over 12 months and it is an area that is constantly developing," said **Pete Mitchell**, Superintendent Radiographer who undertakes role extension in areas of patient consent and patient review, "This provides a challenge for me as a professional and allows me to offer a more efficient service to our patients. I feel that I can also act as a role model for the more junior members of staff and encourage them to see the possibilities that are opening up in skill mix and personal development."

case study

Shaping national stroke services

Around 130,000 people in England and Wales suffer a stroke each year. The effects on not only the person who suffers the stroke, but also on their carers or family members, can be devastating and lead to major life-changes.

Over the past five years, there have been many developments in the stroke services in Sheffield, and we are fortunate to have stroke units in both acute hospital sites, ensuring that stroke patients receive specialist care from a multidisciplinary team who are both trained and motivated to deal with the individual needs of both patients and carers. The stroke service in Sheffield has been nationally recognised.

A major factor in developments in stroke care, has been the publication of the National Clinical Guidelines for Stroke (Royal College of Physicians). In August, our Stroke Nurse Consultant, **Amanda Jones**, was invited to join the working party of the 2nd edition of the guidelines, to provide expert advice from a nursing perspective. The guidelines provide recommendations based on best evidence, on the management and treatment and secondary prevention of stroke.

In the 2nd edition of the guidelines, as well as highlighting the medical treatment of stroke, there is now more emphasis on the psychological aspects of stroke, emphasising that the emotional recovery from stroke is just as important as the physical recovery and that more should be done in this area. There is also more emphasis on younger stroke patients.

"Many people lose their role in society," says Amanda, "Their social life suffers and they can have many psychological difficulties as well as physical problems to cope with.

"Work is already underway on the 3rd edition of the guidelines, and the Stroke Association is about to launch a national campaign for the general public, which will further raise the profile of stroke, and help people to recognise the symptoms of stroke and what they should do, and also inform people of how to help prevent the stroke happening in the first place, which is great news"

Occupational therapist Hannah Knox, physiotherapist Nicola Havenhand and staff nurse Fiona Mackenzie with Amanda Jones. Good stroke care is about professions working together for the patient.

September

A month that saw good news for heart services, Trust involvement in national work for improving spinal injuries care and new ways of delivering vital chemotherapy.

The Trust announced the go-ahead for a £10 million project that will revolutionise heart services for South Yorkshire patients. Cardiology services at the Northern General Hospital's Chesterman Wing - which serves people with heart disease from across South Yorkshire and parts of North Derbyshire - will be completely transformed by September 2005 thanks to extra facilities being built with the money.

The number of patients undergoing vital procedures to clear blocked arteries will be doubled and waiting times halved under the new plans.

The new patient-centred service will mean that waiting times during pre-admission appointments will be reduced and patients will experience faster treatment times and more one-on-one patient care from specially trained staff. A new pre-admission lounge with three test rooms will be developed where specialist staff will perform all of a patient's pre-admission checks in around 45 minutes - cutting the time spent waiting for tests by as much as three hours.

Thanks to new day case facilities, eligible patients will be able to undergo a balloon angioplasty procedure - which can clear blocked arteries - and many will return home on the same day, avoiding the need for an overnight stay in hospital and helping to free up beds that can be used for other emergency admissions.

Dr Chris Newman, Senior Lecturer in Cardiology, said:

"The new developments in heart services will allow us to treat more patients, cut waiting times and significantly improve our patients' experiences. Staff are genuinely excited by the new plans which will allow us to provide the very best care to patients from across the region. We are already doing well in tackling coronary heart diseases in Sheffield but we want to double the number of patients being treated whilst halving our existing waiting times."

Experts from the Trust's Spinal Injuries Unit joined forces with the National Patient Safety Agency (NPSA) to announce new national advice on improving the safety of patients with established spinal cord injuries during hospital stays.

The advice was issued in response to a request from the Spinal Injuries Association (SIA) who revealed to the NPSA the high numbers of spinal cord injuries patients admitted to NHS hospitals who are not being offered an important method of bowel management.

Clinical Development Officer, **Paul Harrison** and Staff Nurse, **Andrea Day**, from the Northern General Hospital's Princess Royal Spinal Injuries Unit were invited to join representatives of the SIA to make recommendations to the NPSA based on the expert care given at Sheffield's spinal cord injuries centre.

Other hospitals and spinal cord injuries centres across the country will now use these guidelines to ensure there are correct policies in place for providing appropriate personal care procedures for these kind for patients, making sure staff are aware of the consequences of not giving this care and ensuring appropriate training for staff.

The PICC (Peripherally Inserted Central Catheter) line service at Weston Park Hospital completed its first year in practice. A PICC is a soft, flexible plastic tube which is inserted into a vein in the arm and then moved along the vein until the tip reaches a large vein in the chest.

Once the line is in place its position is checked by X-ray, taped in place and a clear dressing applied to keep it clean. The line can then be used straight away to give patients fluids, medication - including chemotherapy - and to take blood samples, thus avoiding the need for repeated injections.

One of the main benefits of the service is the reduced waiting time for having the line inserted compared to that of a Hickman line. Some patients have had their line inserted on the same day as referral meaning they can continue their treatment without delay. PICC line placement is a less invasive and traumatic procedure for the patient, with a much lower complication rate. There is no waiting list for removal of the PICC and lines are usually taken out on the day the patient completes treatment. This is not only more convenient for the patient but further reduces the risk of complications from having a line that is no longer required. To date nearly 200 patients have benefited from this service and there has been a very positive response from both patients and staff.

Building for the future

Cranes and building works are a usual part of the Sheffield city-centre skyline at the moment as new buildings transform the city's landscape.

A similar and just as important transformation is now well underway at the city's NHS hospitals. Work on the new £30 million state-of-the-art NHS wards at the Northern General Hospital - known as the Hadfield Wing - is just one part of a £60 million plus programme of building underway during the year.

Just a few hundred yards from the Hadfield Wing, work is nearing completion on a £10 million expansion to the hospital's Chesterman Wing. The number of heart patients undergoing vital procedures to clear blocked arteries will be doubled to 2,000 a year thanks to the new facilities.

At the other side of the hospital campus, a £9 million development has also just started to expand services at the Sheffield Kidney Institute.

This will give the hospital extra renal dialysis stations and 34 new inpatient beds making it one of the largest centres of its kind in Europe. The first developments will open at the end of 2005.

At the central campus new scanners and radiotherapy equipment were ready to move into a purpose built facility at Weston Park - called the Broomcross Building - and work began on re-developing vital research facilities and laboratories at the Royal Hallamshire.

"There's a huge programme of investment going on in the hospitals at the moment which are going to transform some of the services we provide," says **Andrew Cash**, Chief Executive, "It's an exciting time and we're making sure the facilities we have match the expertise of our staff and the needs of our patients. The long-term benefits are going to be fantastic."

Pauline Mackender, Sue Thorpe and Anne Pulfrey outside the new Broomcross Building. It houses extra linear accelerator radiotherapy equipment in a specially designed bunker.

October

New developments in predicting premature birth and the need for critical care were unveiled in the month that saw our annual staff awards event.

A prototype machine that could help obstetricians to identify women at risk of premature birth was developed at the Trust. Experts in the Trust's Medical Engineering Team - part of the Medical Physics Department - have designed a new kind of medical probe which will be used by doctors undertaking a two year study at the hospital's Jessop Wing to identify women who are more at risk of having a premature baby. If the technique is successful, the new probe will become a regular feature in clinical practice.

The new electrical impedance probe is about the size of a pencil and uses a small electrical current, which is too slight to be felt by the patient. It measures the resistance of the cervical tissue to electrical current, determining whether its 'soft' or 'hard'- the less resistance there is, the softer the tissue and the more likely a woman is to go into labour. This could help doctors to understand when and why changes take place in the cervix (neck of the womb) and will be key to developing interventions to prevent premature births.

An ongoing two-year preliminary survey of over 80 women has helped the team to finely tune the new equipment to ensure the most accurate measurement can be carried out.

National research has shown that the management of ward patients prior to Critical Care admission could be improved. A significant number of patients could benefit from earlier identification of problems with prompt medical intervention at ward level. This would improve the patient experience and outcome and may avoid the need for a move to critical care for extra monitoring and treatment.

Premature birth

Around 7% of babies in the UK are born prematurely (also known as pre-term, and usually defined as before 37 weeks of pregnancy). In Sheffield, premature babies are looked after in the Neonatal Unit at the Jessop Wing which has a range of intensive care and high dependency facilities. Most babies stay on the unit until roughly the time that they were due to be born, as if pregnancy had gone to full term.

October saw the launch of a new early warning system designed to standardise the care of ward patients across the Trust. Early warning systems are simple, easy-to use tools to help ward staff recognise a deteriorating patient, and ensure prompt and appropriate help is sought. The Critical Care Outreach Team have developed the new universal system - called SHEWS (Sheffield Hospitals Early Warning Score) which aims to improve patient care by standardising documentation and reducing clinical risk.

SHEWS is intended to assist good clinical judgement and early identification of 'deteriorating' patients. It isn't meant to replace existing good practice, but aims to support ward based teams. Training for ward staff is taking place to ensure everyone is ready to take forward the new system.

Sheffield Teaching Hospitals praised excellence in care above and beyond the call of duty at the 'Thank you' annual excellence awards in October.

Winners of the highly prestigious awards include a midwife, a diabetes nurse specialist and volunteers, who have all made an outstanding contribution to improving the patient experience at the city's adult hospitals.

The winners were:

- **The People Award**
  Vicki Brunt, Clerical Officer
- **The Patient Care Award**
  Vince Tucker, Staff Nurse
- **The Service Development Award**
  Cardiac Fast Track Team
- **The Patient Quality of Experience Award**
  Maria Barranco-Wadlow, Parent Education Co-ordinator
- **The Best Use of Resources Award**
  Pauline Mark, Staff Nurse
- **The WRVS Special Award**
  Trudie Watson and Friends of Weston Park Hospital Cancer Appeal Shop, Rawmarsh
- **The Chief Executive's Award for Excellence**
  Clare Collette-Blair, Staff Nurse
- **The Lifetime Achievement Award**
  Pam Sparkes, Diabetes Nurse Specialist

Palliative care services by Royal inspection

Palliative Care is a key part of any hospital service.

Her Royal Highness the Duchess of Gloucester visited the Northern General Hospital to officially open the Sheffield Macmillan Unit for Palliative Care in October. The Duchess spent time meeting patients, relatives and staff as well as inaugurating a special Book of Remembrance. The Unit has been open to patients for just over two years but has never been formally opened.

When the building was first completed in May 2002, members of the Sheffield public were invited to look around as a way of thanks for the £1.25 million they raised towards the Unit through the Macmillan Horizons Appeal. The 18-bed Unit and was jointly funded by Macmillan Cancer Relief, Sheffield Teaching Hospitals and the Sheffield Hospitals Charitable Trust. It is designed to provide the best possible care for people with cancer and life threatening illnesses away from the traditional hospital ward setting and provides care for around 400 patients each year.

The Trust's Palliative Care service stretches well beyond the unit though. The 60-strong team includes Macmillan nurses, doctors, pharmacists, a social worker, psychologist, therapy staff, administrative staff, ancillary staff and volunteers. The wider team includes Chaplaincy and community liaison nurses. Services are provided on the wards throughout the hospitals and also in special outpatient clinics. There are also very strong links with St Luke's hospice in Sheffield.

"The service is vital for the people of Sheffield," explains **Alison Reitz**, lead nurse on the Macmillan Palliative Care Unit, "We have designed a service that provides the different levels of care that a patient might need - whether it be as an inpatient or outpatient."

Some of the palliative care team - who provide such a vital service to patients each year - outside the Macmillan unit.

November

November saw the Trust working to raise awareness of infections, surveying its staff and improving services after feedback.

The Trust is committed to giving all patients high quality care and part of this includes reducing the risk of a patient getting an infection whilst in hospital.

During the week staff worked to inform and educate patients and visitors about Infection Control Issues and how they can help. Staff sought to reassure patients by giving them clear information and helping to bust some of the myths around MRSA.

MRSA

The full name of MRSA is Methicillin Resistant Staphylococcus Aureus. Staphylococcus Aureus is a very common type of bacteria. In fact, the Staphylococcus Aureus lives on the skin and in the nose of around a third of us without causing infection or doing any harm at all. Like many bacteria, MRSA only usually becomes a problem if you are run down, ill, injured or have had surgery. It can cause serious infections if it enters the body through wounds or tubes following surgery or serious illness.

The Trust has relatively low rates of infection compared to other similar hospitals. However, MRSA is a key issue for all hospitals and infection control is seen as one of our key priorities.

In a bid to tackle the global problem of MRSA and other infection issues the Trust:

- Has dedicated infection control teams in each hospital. They educate staff and check the levels of infection within the hospitals.
- Teach all health care workers good infection control practice from the time they start working in the hospitals.
- Provide good hand hygiene facilities for staff and visitors including germ-killing hand rubs.
- Has domestic services teams who also play a key role through striving to make sure the wards and departments are kept clean.

The results of the 2004 Staff Attitude Survey were received. Measuring the attitudes of our 12,000 plus staff is vital so we can address issues and make improvements to the way the hospitals are structured. It forms a key part in achieving the Improving Working Lives Practice Plus level of the standard, which the Trust is working towards. Representatives from teams across the Trust, together with Staff side and Human Resources representatives take the results and then work on producing detailed action plans to address issues that arise.

Generally the results were positive. Over 80% of staff said that that the Trust was a good employer, 85% of staff get satisfaction from working for the Trust and well over 60% of staff regularly receive the Trust Communication Updates, LINK newsletters and Security Bulletins. The surveys also give us information to learn from and there were areas for further development identified within the results. These included ensuring more staff receive a regular appraisal and feedback from their manager, better awareness of training & development opportunities and the need to better manage staffing/workload issues.

The Trust is committed to addressing complaints raised by patients. During the year the Trust received 843 complaints of which 87% were resolved within our target of 20 working days.

The Independent Review process changed this year with the Healthcare Commission taking over the process in July. 13 requests for independent review were received this year with two being accepted.

We always try to learn and improve our services in response to complaints and this year improvements have included:

- There are now two Pharmacists in post on the NGH site taking responsibility for discharge medications. It is hoped this will improve the accuracy of prescriptions for patients on discharge.
- A formalised daily routine has been introduced to all the Orthopaedic wards and to facilitate a more systematic approach and assist staff in prioritising care.
- The Diagnostic and Therapeutic Services have created a new phlebotomy suite on the Central Campus.
- Head and Neck Service have made changes to their PAS system to allow letters to patients attending the Low Vision Clinic to be printed in a larger print.

Caring for our environment as well as our patients

Sheffield Teaching Hospitals NHS Foundation Trust is taking health care to new heights by helping to clean up South Yorkshire's air.

The Trust won a prestigious regional award - Care4Air - for its work to improve air quality in the region by reducing the amount of Carbon Dioxide (CO_2) that the organisation emits and encouraging its employees to do the same at home.

Each year the Trust's hospitals produce in the region of 52,500 tonnes of CO_2. That's the equivalent of 7,500 Sheffield family homes. CO_2 is one of a number of gases that contribute to air pollution. Many people in Sheffield suffer from existing respiratory conditions such as asthma, bronchitis, emphysema and lung disease. Pollution can aggravate these conditions and could lead to hospital admission in severe cases.

To help reduce Sheffield's levels of CO_2 , the hospitals teamed up with the Carbon Trust to launch a three-year Earthcare and Energy Campaign aimed at encouraging staff to help to safely reduce the amount of gas, electricity, oil and water used by the hospitals on a daily basis. It is linked to a national NHS campaign to reduce carbon emissions by 15% between the years 2000 and 2010.

"We were the first public sector organisation in the country to secure a Carbon Trust partnership agreement to fund the entire Earthcare and Energy Campaign so we're really pleased that our project has been recognised by the Care4Air initiative," says **Jonny Cole**, the Trust's Deputy Head of Estates for Environmental & Specialist Services, who is managing the campaign, "As a major employer we feel we can set an example to others by helping to preserve finite energy sources and reduce carbon emissions in Sheffield."

Mark Braden and Jonny Cole have led the Earthcare campaign that is resulting in a more environmentally friendly NHS in Sheffield

December

The hospitals don't stop for the festive period and December saw the launch of a major research project into heart disease, a major push to protect staff from the threat of violence and aggression and preparations for the new Freedom of Information legislation.

A £300,000 research project, which medical experts hope could help them to treat patients who have suffered heart attacks was launched at the end of the year. The three-year laboratory-based project is being funded using a grant from the Medical Research Council. It will help heart specialists to understand how adult stem cells are distributed around blood vessels to areas of arterial injury.

What is a stem cell?

A cell is the basic unit of life. Human bodies are made up of more than 300 different types of 'cell', which make up every single part of the body from hearts to brains to hair and fingernails. Stem cells are special cells that have the ability to develop into virtually every other type of cell in the body. They are 'master' cells that haven't yet differentiated into more specialised cells such as brain, heart or nerve cells. Adult stem cells can be found in a person's bone marrow where they maintain the body by helping to produce replacement blood cells.

The team running the project, led by **David Crossman**, Professor in Clinical Cardiology, are based at the Clinical Sciences Centre at the Northern General site. They aim to find out more about a certain type of molecule that 'grabs' the adult stem cells and directs them to the damaged areas of blood vessels so they can develop into 'endothelial cells'. Endothelial cells form the lining of the blood vessels and are vital for helping to reduce the risk of narrowing and blood clotting.

An unfortunate part of life on the frontline of the NHS is the threat of violence and aggression from a small minority of patients and the public. December saw the Trust delivering a strong message to would be troublemakers by launching a new policy for the management of violence and aggression.

We have a legal and moral duty to ensure that staff, patients and the public are protected from any acts of physical or verbal abuse. This includes making threats, swearing and intimidation.

The policy clearly sets out a legal framework the Trust can use to deal fairly with deliberately violent or aggressive patients, visitors or staff members. It also clearly states behaviours that the Trust finds unacceptable. Each department has carried out a risk assessment and developed its own local action plan that will help to minimise risks of violence by identifying improvements that need to be made to working practices, departmental layouts and even small but important things such as ensuring there is adequate lighting.

Two new Personal Safety and Health Training Advisors are leading a mandatory in-house training programme for frontline staff, enabling them to use negotiating skills to diffuse potentially abusive or aggressive situations.

The key points of the violence and aggression policy are:

- **Training** - mandatory training has been introduced for all frontline staff including doctors, nurses, receptionists, allied health professionals, porters and anyone else that works directly with patients in ward or clinic based areas or out in the community.
- **Withholding treatment** - patients who are deliberately and persistently violent or aggressive face the risk of being given a verbal or written warning that their treatment could be withheld until their unacceptable behaviour stops. If the patient persists with this conduct they may, in extreme circumstances, be served with an exclusion order.

The Trust also completed preparations for the new national legislation came into force at the beginning of 2005 in the form of the Freedom of Information Act. This creates a general right of access to information held by public organisations such as the Trust.

We have already handled several complex requests for information, introduced an electronic request tracking database and set up an Information Governance website on the Trust's Intranet which contains policies, procedures and training covering all aspects of Information Governance. Information and codes of practice for staff on responding to requests for information have be written, approved and issued to all staff.

Dr Dipak Datta and his multi-professional team are part of the nationally recognised service at the centre

Mobility services gain credit

The Mobility and Specialised Rehabilitation Centre (M&SRC) at the NGH was named this year's Disablement Services Centre of Achievement by national advice and support group, the Limbless Association.

The centre - one of 43 around the country - was singled out for its multi-disciplinary team approach to ensuring the best possible quality of life for amputees, patients born without limbs (congenital limb deficiency) and other patients who need support to help them mobilise such as wheelchair or orthotics users.

The M&SRC is the fourth largest centre of its kind and a national centre of excellence for prosthetic, orthotic and wheelchair services. Each year around 1,900 patients use the prosthetics service, 12,500 come for orthotic appointments and over 4,000 wheelchairs are provided. In a recent patient survey, 98% of patients were satisfied with the service and 94% of patients felt their care was very good or excellent.

A multi-disciplinary team works closely with surgeons to ensure almost all planned amputations are carried out with the input of one or more amputee rehabilitation specialists. The centre has its own gait and motion analysis laboratory where patients can come to have their walking patterns assessed before undergoing hip/knee-joint replacement or amputation. The lab can also help patients with 'drop foot', suffered as a result of a stroke.

Strong links with university research centres has enabled the staff to undertake groundbreaking research into subjects such as the psychological effects of upper limb loss and publish more studies than any other centre in the UK.

"We're delighted to have been chosen as the Disablement Services Centre of the Year," says **John Adams**, Service Manager, "The reason we put ourselves forward for the award was to recognise the exceptional work of staff here and to let them know how much their hard work is appreciated,"

January

A month that began with record numbers of emergency patients at the hospitals also saw cranes and diggers move on to the Northern General to begin construction work and the publication of pioneering research from the hospitals.

2005 got off to an incredibly busy start for the hospitals. The number of emergency admissions - when patients require urgent admission to hospital - reached their highest ever recorded levels during the month.

In a typical week the Trust's hospitals would expect to see around 800 emergency admissions. Throughout January, that figure rose to 1,000 a week and peaked at 1,200 in mid January. Extra ward areas were opened to provide care for patients and staff worked above and beyond the call of duty to ensure the hospitals could meet the needs of the patients.

Thanks to improvements introduced to speed up access through Accident & Emergency, patients did not have long waits for admission to the wards. The pressure did have the knock on effect of leading to a number of postponed operations that were rescheduled as soon as possible.

"There was no particular virus or flu that had caused the rise in patient numbers," explains **Professor Chris Welsh**, Medical Director, "If we were to isolate a particular typical patient who was admitted during the pressures it would be elderly, frail patients with respiratory problems who needed assessment, monitoring and treatment. It was all about a sudden rise in illness and we had to change our priorities to adapt and deal with it."

Later in the month, work got underway on the site of the new £30 million medical wards at the Northern General Hospital. The Hadfield Wing will replace the Victorian 'Vickers Corridor' wards at the hospital and will be in full operation by Autumn 2006.

Kajima - the Trust's private sector partner who are building the Hadfield Wing - began work on the site. It quickly began the transformation from a former car park to a state-of-the-art NHS facility.

January also saw the Trust make international headlines with some pioneering research that could impact on millions of patients around the world. Results from a seven-year challenged the traditional view that controlling blood sugar is the only way that diabetics can combat the threat of serious nerve damage related to their condition.

The study led by **Dr Solomon Tesfaye** at the Royal Hallamshire found that people with Type 1 diabetes need to take extra steps to look after the health of their heart as well as the level of their blood sugars if they are to avoid serious long-term complications from nerve damage according to new medical research.

1,172 Type 1 diabetes patients were studied. Over a quarter of patients developed nerve damage during the time and the study found that the risk factors for heart disease were almost as important as blood-sugar levels in predicting which diabetics would develop nerve problems. For example, the study found that patients who had high blood pressure were twice as likely to develop nerve problems.

In light of the findings, experts believe cholesterol-lowering statin drugs and other heart disease treatments should be studied to see if they can help stave off or slow the progression of nerve damage in diabetics. It's an example of how the Trust's research is leading to changes in treatments for patients.

Who was Hadfield?

The names of the wards at the Northern General Hospital all relate to figures from Sheffield's steel industry and include Vickers, Osborne, Chesterman, Brearley, Huntsman and Sorby.

The new Hadfield Wing is no exception and is another famous Sheffield steel family. The most famous of the Hadfield family was Robert Hadfield.

He was born in Attercliffe in November 1858. He developed manganese steel, an exceptionally durable alloy that found vital uses in the construction of tram wheels, railroad rails and rock-crushing machinery amongst other items.

Redesigning our emergency services

Patients have seen major improvements in Accident and Emergency and other emergency services in 2004/05.

Emergency care has undergone a significant change over the last twelve months with a redesign of how the whole service is provided.

It has led to massive improvements in the patient experience in the Trust Accident and Emergency Department. Since January, 98% of patients coming to A&E were seen and treated, admitted to hospital or discharged within four hours of their arrival at the department. This figure was less than 90% in January 2004. This improvement has been due to many different initiatives including the Patient Tracking System, the Pit Stop scheme enabling senior staff to be at the front door of A&E and the Temporary Clinical Decisions Unit. Patient and staff satisfaction have also improved in the department and patients were seen quickly during even the busiest times of the year.

The changes have not just been about A&E. The whole emergency side of hospital care has been involved.

A&E have been working closely with the new specialist assessment areas meaning that patients are quickly assessed in A&E and then fast-tracked to the appropriate clinical specialty. Imaging, Labs, ward staff and the Hospital Discharge Lounge have also supported the A&E department reaching their targets. New Housekeeper posts have enabled us to improve the quality of our non clinical care immensely. Improvements have also been seen at the Emergency Admissions and Minor Injuries Units at the Royal Hallamshire Hospital. Emergency attendances continue to rise with over 192,000 patients seen in our emergency departments, which include A&E, MIU, Eye Casualty, Dental Emergency and the Walk In Centre.

"Staff have worked together to redesign the way we operate," says **Michael Harper**, manager of A&E, "We don't have patients waiting for a long time in the department any more so our staff can concentrate on emergency care. It's improved the experience for everyone involved - most importantly for our patients"

A rapid response - part of the newly strengthened A&E team that has helped improve the experience for our patients.

February

February saw the opening of a new facility for patients needing advice when in hospital, new work on making sure patients get the nutrition they need at mealtimes, and an anniversary for the Patient Forum

The National Director for Patients and the Public, **Mr Harry Cayton**, unveiled the new PALS 'Pod' situated at Huntsman Entrance at the Northern General Hospital.

The new 'pod' is an office area at the main entrance to the hospital where patients and their families can get advice and support regarding their hospital stay. PALS stands for Patient Advice and Liaison Service and is a free confidential service designed to:

- Provide confidential advice and support
- Give information on NHS Services
- Listen to concerns, suggestions and queries
- Help resolve problems quickly on the clients behalf
- Explain how the NHS complaints procedure works
- Provide information on how to get more involved in personal healthcare and the NHS locally

However, one of the main areas of work is in handling complaints that cannot be resolved at ward or departmental level. **Barry Williams**, one of the new PALS Officers, explains "Our job is to listen to patient concerns and complaints and try to resolve what is more often than not a breakdown in communication between staff and patients. It tends to work well as although we are employed by the hospital, we are independent of wards and departments and patients feel that they can talk to us without prejudice".

Good nutrition is a vital part of the patient experience and it's important that we ensure patients nutritional needs are properly catered for. In February we saw the start of the protected mealtimes project being piloted on a number of wards across the Trust.

The aim of protected mealtimes is to ensure patients are allowed to take their meals without disruption. Blood tests, ward rounds and other interventions are shown to dampen the appetite and prevent patients having the time to have their meal in peace. This in turn can seriously affect the nutrition of patients whilst they are in hospital.

The ward areas that are involved in piloting the initiative have made a number of changes to help ensure that lunchtime is geared around patient needs. Changes that contribute to protected mealtime include changing staff breaks so that staff are not at lunch when patients may need help and support with feeding. It has also led to changes in routine testing timetables so that lunch time is kept free for exactly what it should be there for - lunch.

Patient Forums in Sheffield were celebrating their first anniversary as an independent voice for the public to have their say on local health issues. The forum is made up of local volunteers across the Sheffield area, to help improve health services in the local hospitals and give the public a say in local health and health service decisions. This anniversary celebrates major steps in the involvement of Sheffield people in their health. The forums help the people of Sheffield campaign for improvements in health and healthcare.

Over the year, the members have worked closely with various departments throughout the Trust on issues that are close to everyone's hearts. Examples of areas in which the Patients Forum has worked with the Trust are Hospital Cleanliness and Hospital Acquired Infection, Communications and Patient Choice and Hospital Discharge. There is a real enthusiasm amongst members and the Trust to ensure that local people are heard and so have an even greater impact on shaping and improving health in Sheffield.

Supporting your patient forum

The Patient Forum is looking for more volunteers to join and help make a real difference to health in Sheffield.

If you would like to get involved or simply find out more about how your local forum can help you, please contact the Forum Support Office on 0114 292 2450/2451

Working with our patients

The Trust works in partnership with a wide-range of patient groups and actively encourages patients to work together with us to look at ways of improving services.

The Sheffield Epilepsy Services Users Group is one such example. Their work has led to the production of an innovative new Emergency Information Card for people with epilepsy that should help ensure that they receive fast and accurate treatment.

The card, which comes in an easily identifiable green plastic wallet, contains information that first-aiders, doctors, paramedics and hospital staff need to help ensure the patient is given the appropriate care for their condition. It gives details of the patient's epilepsy and medication, together will full contact information.

An epileptic seizure usually only lasts a matter of seconds or minutes after which brain cells return to normal, the individual recovers and is usually able to continue with everyday activities.

Different patients have different reactions and the cards will help guide a carer as to what the patient needs during or after a seizure.

The Epilepsy Services Users Group is made up of patients with epilepsy and their carers who use services at the Royal Hallamshire hospital. The group formed in 1995.

"We are very proud of the Epilepsy Service Users Group for seeing through the production of these cards," says **Carina Mack**, Clinical Manager for Neurology services at the Trust, " I really hope that the cards will help paramedics as well as doctors and nurses in places such as accident and emergency to quickly establish the severity of a patient's condition and give the best possible care for the individual's needs."

The information cards are available free of charge to patients with epilepsy who attend neurology clinics and at the Sheffield branch of Epilepsy Action.

Duncan Froggatt from the Epilepsy Group with the cards that are helping patients and professionals alike.

March

The end of the year saw a new post in place to support people who have lost loved ones, new dental services and success for our cardiothoracic services.

An important part of running a hospital service is looking after the needs of relatives who have lost a loved one and supporting them through what can be an incredibly difficult time.
A new post was created in response to recommendations following a detailed review of 'end of life and bereavement care' across the Trust.

Ian Eady is the Trust's new Bereavement Services Manager and leads on devising and implementing a strategy for the provision and delivery of bereavement care services in the hospitals, in line with national guidance and legal requirements.

Ian is responsible for managing the Bereavement Services offices with a view to ensuring a consistent and coordinated high quality service for bereaved people. He plans to work with key staff at a local level to promote good practice and develop processes for staff support. He will be providing training for staff on the psychological and practical aspects of care including multi faith issues.

A new service was launched at the Charles Clifford Dental Hospital to better deal with patients needing to access emergency dental treatment. Finding that their emergency service was becoming evermore overloaded, the hospital introduced a booking system for patients who do not require immediate treatment. The walk-in emergency service offered by the hospital is still available for patients having suffered a dental emergency.

Patients can phone a direct line to talk to a nurse who will offer advice and a booked appointment to see a dental clinician. A project team is continuing to evaluate the service, but already major improvements have been achieved. The team have found they are able to see more patients with the appointment system, patients no longer have to endure long, painful waits and staff can now get on with the jobs they enjoy without interruptions and having to deal with patients frustrated with waiting.

The increasing numbers of dental students that Charles Clifford Dental Hospital now trains can treat some of the booked patients in supervised clinics.

The Trust has become one of the first NHS hospitals in the country to openly publish individual surgical outcomes for its heart surgeons. It is part of the hospitals' commitment to provide open information to the public.

The information is available on the Internet and the statistics show the outcomes for each cardiac and cardiothoracic surgeon at the Trust.

The figures show that all of the surgeons based at the Chesterman Wing have excellent surgical records exceeding mortality rate expectations. This success was backed by the fact that by the end of the year, no patient was waiting more than three months for surgery or for angioplasty in our cardiothoracic services.

Mr Graham Cooper, Cardiothoracic Surgeon at the Trust, said:

"We have excellent surgical outcome results in Sheffield and we are proud of this. Although the published results are attributed to an individual surgeon, a team of people is responsible for caring for a patient before, during and after their heart operation and the skill and dedication of these people is important in the good results we achieve in Sheffield."

Heart statistics

Whilst patients can be assured by these statistics, this data is no substitute for a discussion with their consultant and ensuring that each patient has a clear understanding of their own surgery. There is no such thing as a standard heart operation.

Every patient is risk assessed and the risks of their personal surgery explained in a consultation so that they can take an informed decision on their own treatment.

Cutting waits for heart treatments

Senior Surgical Assistant Gary Chilton is one part of the theatre and medical teams who have helped cut waits for vital heart treatments.

Waiting times for life-saving heart treatments at Sheffield's Northern General Hospital came down to a new low of just three months by the end of March.

It means people in an area of the country with one of the highest rates of coronary heart disease are being seen faster than ever before.

The Trust has made reducing waits for routine heart operations one of the key priorities over the last few years. Only five years ago, patients could often wait up to 18 months for coronary artery bypass grafts (known as a CABG). Now all patients are being seen within a maximum of three months after the decision is made that treatment is needed.

Patients are given bypass operations when an artery in the heart is narrowed or blocked due to coronary heart disease. Waiting times for angioplasty services are also now below three months. Angioplasty is a procedure where a catheter is passed through an artery in the groin up to the heart.

Waiting times for angioplasty were over 12 months five years ago and have now dropped to a maximum of three months.

The procedures mean that treatments for coronary heart disease are now amongst the fastest in the country and more patients are benefiting from services that will reduce their risk of heart attacks. "The reason that we can treat patients so quickly is down to the team we have working here at the Chesterman Wing and in the cardiac service at the Royal Hallamshire," says **Dr Stephen Campbell**, Clinical Director of Cardiothoracic Services, "The surgeons, doctors, nurses, perfusionists, theatre teams, clerical staff and managers have all played a key role in helping us deliver these results. We're incredibly proud of the team we have here in Sheffield. As well as reducing waits for surgery, we also have some of the country's best clinical outcomes and that's down to the quality of the care that the team provides."

Financial Review

Neil Priestley, Director of Finance

The 2004-2005 financial year was another extremely challenging one.

In addition to the normal pressures and issues faced by a provider of NHS services, the Trust encountered the additional major financial challenges of moving to the new NHS Foundation Trust regime from 1st July 2004 and, perhaps even more fundamentally, moving to full implementation of the Payment by Results system at the start of the year. The combined effect of all of these issues at times stretched the organisation to its financial limits. It is a reflection of the skill and commitment of the financial and general management within the Trust that such an excellent set of financial results was achieved in such circumstances.

A further challenge was to produce separate sets of Accounts, with different financial targets and accounting policies, for the three months to 30th June 2004 for which the organisation was an NHS Trust, and for the nine months to 31st March 2005 for which the organisation was an NHS Foundation Trust. It was extremely pleasing that a small Income and Expenditure Account Surplus was achieved in each period and that all financial targets were achieved. An underspend of just £141.5 thousand on a turnover of nearly £563 million reflects good financial management whilst maximising use of available resources.

The NHS Foundation Trust application and assessment processes were very challenging and time consuming. However, they were also stimulating and have undoubtedly added value to the Trust's financial management and governance processes. In some areas of the Foundation Trust financial regime 2004-2005 was no more than a transition year but in other areas, such as the greater focus on cash and working capital management, the change was significant. Whilst promised freedoms are clearly limited, the even greater accountability for success and failure is readily apparent.

The Payment by Results system is one of the more major financial reforms faced by the NHS for many a year. The Trust is, in principle, very supportive of it for the clarity it will ultimately bring to NHS financing and because it puts incentives in the right places. The complexity and data handling consequences are great and, as a northern teaching centre, the Trust is hoping for significantly greater reflection of case-mix differences in tariffs in due course and a fundamental revision to the Market Forces Factor. The question of how quality improvements are funded in a tariff based funding system remains to be answered which may prove to be a major issue in coming years.

In practical terms, Payment by Results adds considerable instability to income positions. The Trust faced a major loss in one specialty in 2004-2005 but overall gained significantly from being paid at full tariff for activity undertaken in excess of contract targets. This was particularly true in respect of emergency activity where the propensity to under-commission was no longer rewarded. The additional income received enabled the Trust to provide some additional capacity but also compensated for elective activity cancelled as a consequence of the high levels of emergency admissions.

The Foundation Trust and Payment by Results changes would have been challenging at any time. However, the Trust embarked on these initiatives in a very difficult NHS financial environment. The combined effect of funding shortfalls for major pay reform initiatives and increased employers superannuation costs, a funding reduction on the Postgraduate Medical Education contract, reduced funding and a revised accounting policy for fixed asset impairments, the unfunded cost of delivering the 98% A&E four hour clearance time target, critical care capacity pressures, massive increases in energy costs and the usual NHS efficiency targets provided a backdrop against which a breakeven position represents a major achievement.

The Trust had a major capital programme in 2004-2005 and invested just under £30 million in new and replacement assets. Planning delays on large Department of Health funded schemes caused some slippage but the Public Dividend Capital resources not utilised in 2004-2005 will be carried forward to undertake the relevant schemes in 2005-2006. The Trust had no requirement to utilise its new borrowing powers as an Foundation Trust in 2004-2005 but will undoubtedly do so in the coming years. The Trust did however achieve financial close on its £30 million medical ward block PFI scheme in December 2004 which was the conclusion of another major piece of work.

As previously stated, Foundation Trust status brings a much greater focus on cash and working capital balances. The balance sheet of an NHS Trust, which operates in a system which minimises cash balances at each year-end, provides a poor working capital position to operate in the self-reliant Foundation Trust regime.

Statement on Internal Control 2004-2005.

The failure to address this issue in the establishment of Foundation Trusts remains a concern. The Trust was able to slightly improve its working capital position during 2004-2005 but remains in a position of having net current liabilities.

The outlook for the future reflects many of the issues faced in 2004-2005 with Foundation Trust status, Payment by Results development, pay reform initiatives, access target delivery and major productivity and efficiency requirements being at the forefront. The 2004-2005 financial year is over but the financial challenges remain.

Neil Priestley
Director of Finance

1. Scope of responsibility

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

I am also personally accountable for all Governance related issues. These responsibilities are reflected in the Trusts Governance Framework including its Financial Strategy and Risk Management Strategy.

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

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

To allow me to discharge my personal accountabilities I have established a governance and management framework across the whole organisation, which includes the development of a Governance Committee to operate as a sub group to the Trust Board. I have also taken steps to ensure that roles, functions and objectives of Directors and Directorate Management Teams are unambiguous, clearly detailed and understood. These objectives are regularly monitored and reviewed by my Executive Director colleagues and myself.

The Governors Council, established in compliance with the Health Service Act, is now well established and contributing effectively to the governance of the Trust.

Progress against my own objectives is measured, monitored and assessed by the Independent Regulator of NHS Foundation Trusts, the Chairman and the Trust Board, the Audit Commission and Internal Audit Services who monitor progress against the development and integration of an assurance framework as well as ensuring that the organisation operates within the six principles of Good Governance in Public Services which are set out below:

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

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

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

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

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risks to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Sheffield Teaching Hospitals NHS Foundation Trust since inception to the period to 31 March 2005, and up to the date of approval of the annual report and accounts. This system has been subjected to independent audit and verification by the Internal Audit Service.

3. Capacity to handle risk

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

- Management Audit Committee
- Governance Committee

The above are both formal sub committees of the Trust Board with Executive and Non-Executive Director membership.

The Governance Committee has a defined role to oversee the actions taken to manage significant risk issues, its focus being provided by the assurance framework.

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

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

Very detailed, specialised and externally accredited training is provided for the managers and staff within the organisation who have specific responsibility for the management of risk. The overall Risk Management Strategy is widely supported by policies, procedures and guidelines which are subject to scrutiny and dissemination by the Corporate Policy Unit within the Directorate of Legal Services and Corporate Governance.

The Trust recognises the importance and benefits of initiatives such as Improving Working Lives and the role of personal development planning in promoting and achieving a competence based workforce. In particular the Trust has recently reviewed its corporate induction in line with the NHSU requirements and commenced a comprehensive programme of conflict resolution and personal safety training. At the same time an audit of mandatory training is being undertaken to check progress against the Mandatory Training Strategy that spells out in detail the annual update programme for existing staff.

4. The risk and control framework

The integration of the assurance framework into the business planning of the Trust is ongoing. However, the principal objectives, based upon the key themes identified in the Trust's Strategic Direction document and the Patient Services Plan have been reviewed and amended as necessary to embrace the principles contained in the Good Governance Standard for Public Services and the Standards for Better Health. A review of the identification and assessment of principal risks is currently underway.

Our framework initially identified a number of gaps in assurance and controls, particularly in the areas of changes associated with Foundation Trust status, strategies for dealing comprehensively with a demographically dynamic and changing population and case mix structure and the development of a whole health and social care community approach to improving the patient experience.

The Trust continues to play a leading role in the development of foundation trusts nationally and is working closely with other health and social care providers to effectively manage improvements to the patient experience. These processes are evolutionary and ongoing. As would be anticipated in a large, complex organisations operating in a changing environment there remain gaps in assurance and control. The Trust reviews its framework regularly to ensure that the necessary actions are taken.

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

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

5. Review of effectiveness

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

My review is also informed by:

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

My review of the effectiveness of the system of internal control is assisted by the deliberation of the Management Audit Committee and the Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place. As part of this process the Executive Directors have been actively engaged in considering and reviewing the system of internal control. The Management Audit Committee has been receiving and monitoring relevant audit reports and the Internal Audit Service continues to work against a risk-based audit plan. At the same time the Assurance Framework exercise described earlier has been progressively developed.

Signed

Chief Executive Officer
(On behalf of the board)

24 June 2005

Public Interest Disclosure

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

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

Chairman

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

Non-Executive Directors

Mr J Stoddart	National Extension College Bolton Institute Guardian, Sheffield Assay Office
Ms O Bright	
Mr J Donnelly	
Ms V Ferres	Chief Executive, Age Concern Doncaster Director and Chair, Disability Doncaster Director and Chair, South Yorkshire Centre for Integrated Living Director, Doncaster Energy Services Director and Chair, John William Chapman Trust Independent Assessor for CHAI
Mr V Powell	Governor, Sheffield College Member of FTFF Credit Committee
Professor A Weetman	University Representative Medical Advisor and Trustee, British Thyroid Foundation Private Medical Practice at Thornbury Hospital

Executive Directors

Mr A Cash	Chief Executive Visiting Professor University of York Health Services Development Unit Non Executive Director of Medilink (Yorkshire and Humber) Ltd Chair of Foundation Trust Network
Mrs H Tierney-Moore	Chief Nurse Trustee, Cavendish Centre for Cancer Care, Sheffield
Mr C C Linacre	Director of Service Development Non Executive Director, Medipex Ltd
Professor C Welsh	Medical Director Private Medical Practice at Claremont Hospital Tutor, Medical Leadership Programme - Keele University Part Owner and Director of CL Welsh and Company Ltd
Mr N Priestley	Director of Finance
Mr J Watts	Director of Human Resources

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

I have audited the financial statements on pages 37-62 which have been prepared in accordance with the accounting policies relevant to NHS Foundation Trusts as set out on pages 39 to 44.

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

Respective responsibilities of directors and auditor

As described on page 36 the Directors are responsible for the preparation of the financial statements in accordance with directions issued by the Independent Regulator. My responsibilities, as independent auditor, are established by statute, the Audit Code for NHS Foundation Trusts issued by the Independent Regulator and my profession's ethical guidance.

I report to you my opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the period, in accordance with the accounting policies directed by the Independent Regulator as being relevant to NHS Foundation Trusts.

I review the directors' statement on internal control. I report if it does not meet requirements of the NHS Foundation Trust Manual for Accounts 2004/05 or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' statement on internal control covers all risks and controls. I am also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. My review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

Basis of audit opinion

I conducted my audit in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and the Audit Code for NHS Foundation Trusts issued by the Independent Regulator, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In my opinion the financial statements give a true and fair view of the state of affairs of Sheffield Teaching Hospitals NHS Foundation Trust as at 31 March 2005 and of its income and expenditure for the nine months then ended in accordance with the accounting policies directed by the Independent Regulator as being relevant to NHS Foundation Trusts.

Certificate

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

29 June 2005

J G Prentice FCCA
District Auditor
Audit Commission
Littlemoor House
Littlemoor
Eckington
Sheffield S21 4EF

Statements of Responsibilites

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

Monitor has directed that the Chief Executive should be the Accounting Officer to the Trust. The relevant responsibilities of Accounting Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the 'NHS Foundation Trust Accounting Officer Memorandum', dated 12 April 2005, issued by Monitor.

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

24 June 2005
Chief Executive

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required in accordance with schedule 1 sections 24 and 25 of the Health and Social Care (Community Health and Standards) Act 2003 to prepare accounts in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of the Treasury, directed. Monitor, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing those accounts, the directors are required to:

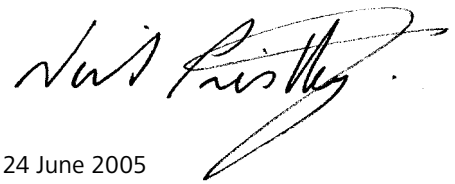
- apply on a consistent basis accounting policies laid down by Monitor with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the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

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

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

By order of the Board

24 June 2005
Chief Executive



24 June 2005
Director of Finance

Foreword to the Accounts

Sheffield Teaching Hospitals NHS Foundation Trust

These accounts for the nine month period ended 31 March 2005 have been prepared by the Sheffield Teaching Hospitals NHS Foundation Trust in accordance with schedule 1 sections 24 and 25 of the Health and Social Care (Community Health and Standards) Act 2003 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Income and Expenditure Account for the 9 months Ended 31 March 2005

	NOTE	£000
Income from activities	3	**351,398**
Other operating income	4	**75,358**
Operating expenses	5-7	**(418,546)**
OPERATING SURPLUS		**8,210**
Profit on disposal of fixed assets	8	**23**
SURPLUS BEFORE INTEREST		**8,233**
Interest receivable		**627**
Interest payable	9	**(45)**
Other finance costs - unwinding of discount		**(69)**
SURPLUS FOR THE PERIOD		**8,746**
Public Dividend Capital dividends payable		**(8,645)**
RETAINED SURPLUS FOR THE PERIOD		**101**

The notes on pages 39-62 form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance Sheet as at 31 March 2005

	NOTE	£000	30 June 2004 £000
FIXED ASSETS			
Intangible assets	10	**900**	543
Tangible assets	11	**416,019**	390,844
Investments	12	**0**	0
		416,919	391,387
CURRENT ASSETS			
Stocks and work in progress	13	**8,931**	9,448
Debtors	14	**25,345**	30,995
Investments	15	**0**	0
Cash at bank and in hand	19.3	**8,957**	7,327
		43,233	47,770
CREDITORS: Amounts falling due within one year	16	**(48,524)**	(52,603)
NET CURRENT LIABILITIES		**(5,291)**	(4,833)
TOTAL ASSETS LESS CURRENT LIABILITIES		**411,628**	386,554
CREDITORS: Amounts falling due after more than one year		**0**	(358)
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(6,829)**	(10,540)
TOTAL ASSETS EMPLOYED		**404,799**	375,656
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital	18.2	**280,275**	271,275
Revaluation reserve	18.3	**80,634**	63,769
Donated asset reserve	18.3	**38,213**	37,135
Government grant reserve	18.3	**169**	0
Income and expenditure reserve	18.3	**5,508**	3,477
TOTAL TAXPAYERS' EQUITY		**404,799**	375,656

Signed: Andrew Cash. (Chief Executive)

Date: 24 June 2005

Statement of Total Recognised Gains and Losses for the 9 Months Ended 31 March 2005

	£000
Surplus for the period before dividend payments	**8,746**
Fixed asset impairment losses	**(2,916)**
Unrealised surplus on fixed asset revaluations/indexation	**22,394**
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**2,897**
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	**(2,333)**
Total recognised gains and losses for the period	**28,788**

Cash Flow Statement for the 9 Months Ended 31 March 2005

	NOTE	£000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	19	**24,696**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received		**630**
Interest paid		**(45)**
Net cash inflow from returns on investments and servicing of finance		**585**
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets		**(23,056)**
Receipts from sale of tangible fixed assets		**23**
(Payments) to acquire intangible assets		**(530)**
Net cash (outflow) from capital expenditure		**(23,563)**
DIVIDENDS PAID		**(11,526)**
Net cash (outflow) before management of liquid resources and financing		**(9,808)**
MANAGEMENT OF LIQUID RESOURCES		
(Purchase) of current asset investments		**(75,000)**
Sale of current asset investments		**75,000**
Net cash inflow/(outflow) from management of liquid resources		**0**
Net cash (outflow) before financing		**(9,808)**
FINANCING		
Public dividend capital received		**9,000**
Other capital receipts		**2,438**
Net cash inflow from financing		**11,438**
Increase in cash		**1,630**

Notes to the Accounts

1 ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts' Manual for Accounts which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2004/05 NHS Foundation Trusts Manual for Accounts issued by the 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 Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Period.

The Trust achieved Foundation Status on 1st July 2004. Accordingly, these accounts are prepared for the 9 months ending 31st March 2005.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.3 Acquisitions and discontinued operations

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

1.4 Income Recognition

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

1.5 Pooled Budgets

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

1.6 Intangible fixed assets

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

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

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

1.7 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 2004-05 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 and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on 31 March 2005.

Negative balances have been brought forward from previous accounting periods under the NHS Trust accounting regime.

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

Additional alternative Open Market Value figures have only been supplied for operational assets once they have been taken out of operational use and subsequently disposed of.

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

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

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets as 'assets under construction and payments on account' where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the

specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

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 of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

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

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

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

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

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

1.8 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.

1.9 Government Grants

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

1.10 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) 'How to Account for PFI transactions' which provides definitive guidance for the application of the FRS 5 Amendment and the guidance 'Land and Buildings in PFI schemes Version 2.

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 a 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.

1.11 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.12 Research and development

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

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

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

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

1.13 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 3.5% 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 2004/05 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as a defined contribution scheme and the cost of the Scheme is equal to the contributions payable to the Scheme for the accounting period. The total employer contribution payable in the nine months to 31 March 05 was £24,849,198.

The Scheme is subject to a full valuation every four years. The last valuation took place as at 31 March 2003. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions remain at 7% of pensionable pay until 31 March 2003 and then be increased to 14% of pensionable pay with effect from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

NHS bodies are directed by the Secretary of State to charge employers' pension costs contributions to operating expenses as and when they become due. Until 2002-03 HM Treasury paid the Retail Price Indexation costs of the NHS Pension scheme direct but as part of the Spending Review Settlement, these costs have been devolved in full. For 2003-04 the additional funding was retained as a Central Budget by the Department of Health and was paid direct to the NHS Pensions Agency and the employers' contribution remained at 7%. From 2004-05 this funding was devolved in full to NHS Pension Scheme employers and the employers' contribution rate rose to 14%.

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

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health.

For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement account at the time the Authority commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice final years' pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years' pensionable pay less their retirement lump sum for those who die after retirement is payable.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

1.15 Liquid resources

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

1.16 Value Added Tax

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

1.17 Foreign Exchange

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

1.18 Third Party Assets

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

1.19 Leases

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

1.20 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

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 calulated as a simple average of opening and closing relevant net assets.

For 2004-05 the average carrying amount of assets is calculated before the national revaluation figures are applied on 31 March 2005. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.21 Losses and Special Payments

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

2 Segmental Analysis

	Total	Healthcare
	£'000	£'000
Income		
Income from activites	**351,398**	**351,398**
Other operating Income	**75,358**	**75,358**
TOTAL INCOME	**426,756**	**426,756**
Surplus/(deficit)		
Surplus/(deficit) before interest and common costs	**8,233**	8,233
Common Costs	**0**	0
SURPLUS BEFORE INTEREST	**8,233**	8,233
TOTAL ASSETS EMPLOYED	**404,799**	404,799

3. Income

3.1 Income from Activities

	Total
	£000
Elective income	**85,287**
Non Elective income	**104,481**
Outpatient income	**56,722**
Other types of activity income	**82,184**
Accident and Emergency Income	**6,682**
Payment by Results transitional gain	**13,677**
Private Patient Income	**2,365**
TOTAL	**351,398**

3.2 Private Patient Income

		Base year(2002-03)
	£000	£000
Private Patient Income	**2,365**	2,774
Total patient related income	**351,398**	367,782
Proportion (as percentage)	**0.67%**	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
	£'000
Primary Care Trusts	**344,461**
Local Authorities	**387**
Department of Health	**2,225**
NHS Other	**597**
Non NHS: Private patients	**2,230**
Non NHS: Overseas patients (non reciprocal)	**135**
Road Traffic Act	**1,321**
Non NHS: Other	**42**
TOTAL	**351,398**

4. Other Operating Income

	Total
	£'000
Research and Development	**5,633**
Education and Training	**36,178**
Transfers from the donated asset reserve in respect of depreciation, impairments, and disposal of donated assets	**1,502**
Transfers from the government grant reserve in respect of depreciation, impairments, and disposal of government grant financed assets	**831**
Non patient care services to other bodies	**22,608**
Other	**8,606**
TOTAL	**75,358**

5. Operating Expenses

5.1 Operating expenses comprise:

	Total
	£000
Services from other NHS Foundation Trusts	556
Services from other NHS Trusts	5,655
Services from other NHS bodies	4,728
Purchase of healthcare from non NHS bodies	4,988
Directors' costs	717
Staff costs	274,979
Drugs costs	34,440
Supplies and services - clinical	42,760
Supplies and services - general	5,176
Establishment	4,837
Transport	454
Premises	12,201
Bad debts	180
Depreciation and amortisation	16,178
Fixed asset impairments and reversals	2,096
Audit fees	137
Clinical negligence	3,836
Other	4,628
	418,546

5.2 Operating leases

5.2/1 Operating expenses include:

	£000
Other operating lease rentals	1,218
	1,218

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

	Land and buildings	Other leases
	£000	£000
Operating leases which expire:		
Within 1 year	2	318
Between 1 and 5 years	0	651
After 5 years	264	312
	266	1,281

5.3 Salary and Pension entitlements of senior managers

A) Remuneration (nine months to 31 March 2005)

Name and Title	To 31 March 2005		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to nearest £100
Mr A J Cash, Chief Executive	115 - 120	-	-
Mr J Watts, Director of Human Resources	75 - 80	-	-
Mr N Priestley, Director of Finance	75 - 80	-	-
Mrs H Tierney-Moore, Chief Nurse	75 - 80	-	-
Professor C Welsh, Medical Director	95 - 100	-	-
Mr C C Linacre, Director of Service Development	80- 85	-	-
Mr J P Donnelly, Non-Executive Director	0 - 5	-	-
Ms V R Ferres, Non-Executive Director	0 - 5	-	-
Mr V G W Powell, Non-Executive Director	0 - 5	-	-
Mr J M Stoddart, Non-Executive Director	0 - 5	-	-
Professor A P Weetman, Non-Executive Director	0 - 5	-	-
Ms O V Bright, Non-Executive Director	0 - 5	-	-
Mr D Stone, Chairman	15 - 20	-	-

5.3 Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2005	Cash Equivalent Transfer Value at 31 March 2005	Cash Equivalent Transfer Value at 31 March 2004	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Mr A J Cash, Chief Executive	7.5 - 10	210 - 215	789	714	55	21,400
Mr J Watts, Director of Human Resources	5 - 7.5	175 - 180	718	666	33	14,700
Mr N Priestley, Director of Finance	5 - 7.5	105 - 110	340	304	27	14,700
Mrs H Tierney-Moore, Chief Nurse	5 - 7.5	125 - 130	403	362	31	14,700
Professor C Welsh, Medical Director	5 - 7.5	200 - 205	917	843	51	18,000
Mr C C Linacre, Director of Service Development	5 - 7.5	180 - 185	809	744	44	15,300

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

6. Staff costs and numbers

6.1 Staff costs

	Total	Permanently Employed	Other
	£000	£000	£000
Salaries and wages	**227,534**	223,166	4,368
Social Security Costs	**17,442**	17,442	0
Employer contributions to NHSPA	**24,849**	24,849	0
Other pension costs	**(130)**	(130)	0
Agency/contract staff	**5,952**		5,952
	275,647	**265,327**	**10,320**

Included in the above figure of £275,647k is the figure of £574k in respect of capitalised salary costs.

6.2 Average number of persons employed

	Total	Permanently Employed	Other
	Number	Number	Number
Medical and dental	**1,263**	1,215	48
Administration and estates	**2,301**	2,198	103
Healthcare assistants and other support staff	**1,209**	1,209	0
Nursing, midwifery and health visiting staff	**4,615**	4,274	341
Scientific, therapeutic and technical staff	**1,825**	1,800	25
Total	**11,213**	**10,696**	**517**

6.3 Employee benefits

	£000
None	**0**
	0

6.4 Early Retirements Due to Ill Health

	£'000	Number
Number of early retirements agreed on the grounds of ill health		31
The estimated additional liabilities (in £'000s)	**675**	

7 The Late Payment of Commercial Debts (Interest) Act

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

8 Profit on Disposal of Fixed Assets

Profit on the disposal of fixed assets is made up as follows:

	Total	Protected	Unprotected
	£000	£000	£000
Profit on disposal of land and buildings	**23**	0	23
	23	0	23

9 Interest Payable and similar charges

	£000
Interest on early retirements	**45**
	45

10.1 Intangible Fixed Assets

	Software Licences	Total
	£000	£000
Gross cost at start of period	988	988
Reclassifications	409	409
Additions purchased	89	89
Disposals	(9)	(9)
Gross cost at 31 March 2005	**1,477**	**1,477**
Amortisation at start of period	445	445
Impairments	5	5
Provided during the year	136	136
Disposals	(9)	(9)
Amortisation at 31 March 2005	**577**	**577**
Net book value		
- Purchased at start of period	519	519
- Donated at start of period	24	24
- Total at start of period	**543**	**543**
- Purchased at 31 March 2005	885	885
- Donated at 31 March 2005	15	15
- Total at 31 March 2005	**900**	**900**

10.2 Analysis of intangible fixed assets

Net book value		
- protected assets at 31 March 2005	0	0
- unprotected assets at 31 March 2005	900	900
Total at 31 March 2005	900	900

11. Tangible Fixed Assets

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at start of period	26,800	316,201	2,922	22,968	90,485	846	13,594	15,008	488,824
Additions purchased	0	2,058	4	16,771	1,713	28	218	550	21,342
Additions donated	0	(8)	0	1,454	429	0	22	0	1,897
Additions government granted	0	0	0	922	78	0	0	0	1,000
Impairments	0	(877)	(112)	(825)	0	0	0	0	(1,814)
Reclassifications	0	18,008	0	(22,264)	1,954	0	686	1,207	(409)
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(4,203)	(89)	(282)	(372)	(4,946)
National Revaluation Exercise	(356)	(12,289)	(228)	0	0	0	0	0	(12,873)
At 31 March 2005	**26,444**	**323,093**	**2,586**	**19,026**	**90,456**	**785**	**14,238**	**16,393**	**493,021**
Depreciation at start of period	0	22,863	224	0	55,043	663	9,973	9,214	97,980
Provided during the year	0	9,185	79	0	4,968	46	793	971	16,042
Impairments	0	0	0	0	247	0	25	5	277
Reclassifications	0	0	0	0	(739)	0	(40)	779	0
Other in year revaluation	0	(32,048)	(303)	0	0	0	0	0	(32,351)
Disposals	0	0	0	0	(4,203)	(89)	(282)	(372)	(4,946)
Depreciation at 31 March 2005	**0**	**0**	**0**	**0**	**55,316**	**620**	**10,469**	**10,597**	**77,002**
Net book value									
- Purchased at start of period	25,430	275,411	2,479	12,012	29,313	156	3,595	5,336	353,732
- Donated at start of period	1,370	17,927	219	10,956	6,129	27	26	458	37,112
- Government Granted at start of period	0	0	0	0	0	0	0	0	0
Total at start of period	**26,800**	**293,338**	**2,698**	**22,968**	**35,442**	**183**	**3,621**	**5,794**	**390,844**
- Purchased at 31 March 2005	25,098	294,610	2,397	17,507	28,857	142	3,652	5,389	377,652
- Donated at 31 March 2005	1,346	28,483	189	1,519	6,205	23	26	407	38,198
- Government Granted at 31 March 2005	0	0	0	0	78	0	91	0	169
Total at 31 March 2005	**26,444**	**323,093**	**2,586**	**19,026**	**35,140**	**165**	**3,769**	**5,796**	**416,019**

11. Tangible Fixed Assets (contd)

11.2 Analysis of tangible fixed assets

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
- protected assets at 31 March 2005	26,444	323,093	2,586	14,166					366,289
- unprotected assets at 31 March 2005	0	0	0	0					0
Total at 31 March 2005	**26,444**	**323,093**	**2,586**	**14,166**	**0**	**0**	**0**	**0**	**366,289**

11.3 Assets held at open market value

	Land	Buildings excluding dwellings	Dwellings	Total
	£000	£000	£000	£000
Open market value at 31 March 2005	0	0	0	0

11.4 The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date are as follows

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 31 March 2005	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

11.4/1 The total amount of depreciation charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Depreciation 31 March 2005	0	0	0	0	0	0	0	0	0

11.5 The net book value of land, buildings and dwellings at 31 March 2005 comprises:

	Total	Protected	Unprotected
	£000	£000	£000
Freehold	352,123	352,123	0
Long leasehold	0	0	0
Short leasehold	0	0	0
TOTAL	**352,123**	**352,123**	**0**

12. Fixed asset investments

	Investment	Other	Total
	£000	£000	£000
Cost or valuation at start of period	0	0	**0**
Additions	0	0	**0**
Disposals	0	0	**0**
Revaluations	0	0	**0**
At 31 March 2005	0	0	**0**
Provisions at start of period	0	0	**0**
Provided during the year	0	0	**0**
Disposals	0	0	**0**
Other	0	0	**0**
At 31 March 2005	0	0	**0**
Net book value			
Total at start of period	**0**	**0**	**0**
Net book value			
Total at 31 March 2005	**0**	**0**	**0**

13 Stocks and Work in Progress

		30 June 2004
	£000	£000
Raw materials and consumables	**8,931**	9,448
TOTAL	**8,931**	9,448

14 Debtors

		30 June 2004
	£000	£000
Amounts falling due within one year:		
NHS debtors	**13,376**	18,182
Provision for irrecoverable debts	**(712)**	(562)
Other prepayments and accrued income	**1,060**	2,510
Other debtors	**9,577**	9,058
Sub Total	**23,301**	29,188
Amounts falling due after more than one year:		
NHS debtors	**240**	275
Other debtors	**1,804**	1,532
Sub Total	**2,044**	1,807
TOTAL	**25,345**	30,995

NHS Debtors include £53k prepaid pension contributions at 31 March 2005 (£Nil at 30 June 2004)

15 Current Asset Investments

		Total
	£000	**£000**
Balance at start of period	0	**0**
Additions	75,000	**75,000**
Disposals	(75,000)	**(75,000)**
Balance at 31 March 2005	**0**	**0**

16 Creditors

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

		30 June 2004
	£000	£000
Amounts falling due within one year:		
Interest Payable	**0**	2,882
NHS creditors	**7,588**	7,612
Non - NHS trade creditors - revenue - other	**11,420**	9,551
Non - NHS trade creditors - capital	**7,639**	7,626
Tax and social security costs	**7,779**	7,209
Other creditors	**3,576**	5,605
Accruals and deferred income	**10,522**	12,118
	48,524	52,603
Amounts falling due after more than one year:		
NHS creditors	**0**	358
	0	358
	48,524	52,961

NHS creditors include £358k (30th June 2004, £657k) for payments due in future years under arrangements to buy out the liability for 3 early retirements over 5 years; and £4,082k (30th June 2004, £3,868k) outstanding pensions contributions at 31 March 2005.

16.2 Loans [and other long-term financial liabilities]

	Total
	£000
Amounts falling due:	
In one year or less	0
Between one and two years	0
Between two and five years	0
Over 5 years	0
TOTAL	0

	Total
Of Which:-	£000
Wholly repayable within five years	0
Wholly repayable after five years, not by instalments	0
Wholly or partially repayable after five years, by instalments	0
TOTAL	0

Loans [and long-term financial liabilities] wholly or partially repayable after five years:

	Interest rate	Value outstanding	30 June 2004
	%	£000	£000
Terms of payment	not applicable	0	0

16.3 Prudential Borrowing Limit

16.3 Prudential Borrowing Limit	Target	Actual	Planned
Prudential Borrowing Limit set by Monitor	10,000	-	-
Working Capital Facility	15,000		
Actual borrowing in year	0	-	-
Minimum Dividend Cover	-	3.15	2.75
Minimim Interest Cover	-	0.00	0.00
Minimum Debt Service Cover	-	0.00	0.00
Minimum Debt Capital Cover	-	0.00	0.00
Minimum Debt Service to Revenue	-	0.00	0.00

16.4 Finance lease obligations

	£000
Payable:	
Within one year	0
Between one and five years	0
After five years	0
	0
Less finance charges allocated to future periods	0
	0

16.5 Finance Lease Commitments

The Trust had no finance lease obligations at 31st March 2005.

17 Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
At start of period	1,863	715	7,962	**10,540**
Arising during the year	146	527	6,005	**6,678**
Utilised during the year	(99)	(186)	(9,763)	**(10,048)**
Reversed unused	(153)	(257)	0	**(410)**
Unwinding of discount	50	19	0	**69**
At 31 March 2005	**1,807**	**818**	**4,204**	**6,829**
Expected timing of cashflows:				
Within one year	120	818	4,204	**5,142**
Between one and five years	439	0	0	**439**
After five years	1,248	0	0	**1,248**

Pensions relating to other staff represent liabilities relating to staff retiring before April 1995 (£652k) and Injury Benefit Liabilities (£1,155k).

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

Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA and not included above. There is, in addition, a provision of £250,000 included in legal claims for a case brought under the Health and Safety Executive's remit.

'Other' costs relate to costs likley to be incurred under the new Consultant Contracts and amounts provided under the 'Agenda for Change' pay deal. These amounts are subject to agreement with individual members of staff.

Consultation with staff on this matter is continuing.

Of the above total provision and related payments , some £698,862 has been covered by "back-to-back" income arrangements with the Trust's major Purchasers.

£19,933,755 is included in the provisions of the NHS Litigation Authority at 31/03/2005 in respect of clinical negligence liabilities of the Trust (31/3/2004 £18,928,288).

18.1 Movement in taxpayers' equity

	31 March 2005
	£000
Taxpayers' equity at start of period	375,656
Surplus for the financial year	8,746
Public dividend capital dividend	(8,645)
Gains from revaluation of purchased fixed assets	18,795
New public dividend capital received	9,000
Transfers from donated asset reserve	1,078
Additions to the government grant reserve	169
Taxpayers' equity at 31 March 2005	404,799

18.2 Movements in public dividend capital

Public Dividend Capital at start of period	271,275
New Public Dividend Capital received	9,000
Public Dividend Capital at 31 March 2005	280,275

18.3 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Government Grant Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	**£000**
At start of period	63,769	37,135	0	3,477	**104,381**
Transfer from the income and expenditure account				101	**101**
Fixed asset impairments	(2,739)	(177)	0		**(2,916)**
Surplus on other revaluations/indexation of fixed assets	21,534	860	0		**22,394**
Transfer of realised profits (losses) to the Income and Expenditure reserve	(28)	0	0	28	**0**
Receipt of donated/government granted assets		1,897	1,000		**2,897**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/ government granted assets		(1,502)	(831)		**(2,333)**
Other transfers between reserves	(1,902)	0	0	1,902	**0**
At 31 March 2005	**80,634**	**38,213**	**169**	**5,508**	**124,524**

19 Notes to the cash flow Statement

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

	£000
Total operating surplus	**8,210**
Depreciation and amortisation charge	**16,178**
Fixed asset impairments and reversals	**2,096**
Transfer from donated asset reserve	**(1,502)**
Transfer from the government grant reserve	**(831)**
Decrease in stocks	**517**
Decrease in debtors	**6,162**
(Decrease) in creditors	**(2,972)**
(Decrease) in provisions	**(3,162)**
Net cash inflow from operating activities	**24,696**

19.2 Reconciliation of net cash flow to movement in net debt

	£000
Increase in cash in the period	**1,630**
Change in net debt resulting from cashflows	**1,630**
Net debt at start of period	**7,327**
Net debt at 31 March 2005	**8,957**

19.3 Analysis of changes in net debt

	At 1st July 2004	Cash changes in year	**At 31 March 2005**
	£000	£000	**£000**
OPG cash at bank	7,027	(6,631)	**396**
Commercial cash at bank and in hand	300	8,261	**8,561**
	7,327	**1,630**	**8,957**
Third party assets held by the NHS Foundation Trust	8		

20 Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £26.3 million (30 June 2004 £8.5 million)

21 Post Balance Sheet Events

From 1 April 2005 HM Treasury changed the discount rate used in calculating provisions from 3.5% to 2.2%. This change will result in an increase in provisions of £252,671 which will be charged to the Income and Expenditure account in 2005-06. National funding of NHS commissioners will be increased by the total estimated effect to offset this charge.

22 Contingencies

	£000
Gross value	(339)
Amounts recoverable (if any)	0
Net contingent liability	**(339)**

Contingencies represent the consequences of losing all current third party legal claims. In accordance with FRS 12, these accounts only provide for the weighted average probability of losing a case.

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	Expenditure
	£ million	£ million
North Sheffield PCT	73.5	
Sheffield West PCT	44.0	
Sheffield South West PCT	45.9	
South East Sheffield PCT	68.6	
North Eastern Derbyshire PCT	11.2	
Chesterfield PCT	7.9	
High Peak and Dales PCT	6.4	
Barnsley PCT	25.3	
Rotherham PCT	21.1	
Doncaster Central PCT	6.5	
Doncaster East PCT	5.6	
Doncaster West PCT	7.1	
Bassetlaw PCT	7.3	
South Yorkshire Ambulance Service		2.6
NHS Litigation Authority		3.8
National Blood Authority		3.9
National Heath Service Logistics Authority		6.8

Also received from the Department of Health and from the Trent and South Yorkshire Workforce Confederations in the period is £41.8m in respect of Education ,Training and Research Funding

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

Of the Trust's total debtors of £25,345k at 31 March 2005, (note 14) £13.6m 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. £3.1m was receivable from the University of Sheffield at 31 March 2005 in respect of clinical and estates support services provided.

Professor C Welsh and Professor A P Weetman have clinical commitments at Thornbury and Claremont private hospitals, both of which are sited in Sheffield. In the period the Trust purchased healthcare from these two hospitals in the sum of £0.5m and £1.96m respectively.

The Trust also purchased orthopaedic healthcare from Sheffield Orthopaedics Ltd, a limited company who manage healthcare provided at the above hospitals. This amounted to £1.3m during the period.

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

Creditors falling due within one year of £48,524k (note 16) include £7,588k owing to NHS bodies. This sum includes monies owing to the Department of Health in respect of pension contributions, and to other NHS Trusts for clinical support services received.

The Trust is a significant recipient of funds from Sheffield Hospitals Charitable Trust. Grants received in the nine month period from this Charity amounted to £1.8m.

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

24. Private Finance Transactions

24.1 PFI schemes deemed to be off-balance sheet

	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	0
Amortisation of PFI deferred asset	0
Net charge to operating expenses	**0**
The Trust is committed to make the following payments during the next year.	
PFI scheme which expires;	
Within one year	0
2nd to 5th years (inclusive)	0
6th to 10th years (inclusive)	0
11th to 15th years (inclusive)	0
16th to 20th years (inclusive)	0
21st to 25th years (inclusive)	0
26th to 30th years (inclusive)	0
31st to 35th years (inclusive)	0
36th Year and beyond	0

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year. The likely financial effect of this is £2,683k.

	£000
Estimated capital value of the PFI scheme	25,700
Contract Start date:	Sept 2006
Length of project (years)	30
Number of years to end of project	31.50
Contract end date	Nov 2036

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

Key dates

Financial Close - 20.12.04

Projected Practical completion - September 2006
(date of commencement of unitary charge)

End of concession period - November 2036

The unitary payment is £2,483,000 per annum at 2004/05 prices (subject to indexation based on RPI at 1 April each year).

Residual interest projected value at November 2036 is based on average percentage for similar schemes.

This is to be replaced by projection from professional valuer on practical completion of the scheme.

There are no deferred assets associated with this scheme.

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

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

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

25 Sheffield Teaching Hospitals NHSFT Pooled Budget

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

The Trust's share of this pooled budget in the nine months to 31 March 2005 amounted to £139k. £87k was used to fund the Rapid Assessment Clinics and £52k was used within the Rehabilitation and Resource Centre.

26 Financial Instruments

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

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions should be shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

Liquidity risk

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

Interest-Rate Risk

9.81% of the Trust's financial assets and 100% of its financial liabilities disclosed under this note carry nil or fixed rates of interest. Sheffield Teaching Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

26.1 Financial Assets

					Fixed rate	Non-interest bearing
Currency	**Total**	**Floating rate**	**Fixed rate**	**Non-interest bearing**	**Weighted average interest rate**	**Weighted average period for which fixed**	**Weighted average term**
	£000	**£000**	**£000**	**£000**	**%**	**Years**	**Years**
At 31 March 2005							
Sterling	9,197	8,295	240	662	3.5%	n/a	n/a
Gross financial assets	**9,197**	**8,295**	**240**	**662**			

Note: The public dividend capital is of unlimited term.

26.2 Financial Liabilities

					Fixed rate	Non-interest bearing
Currency	**Total**	**Floating rate**	**Fixed rate**	**Non-interest bearing**	**Weighted average interest rate**	**Weighted average period for which fixed**	**Weighted average term**
	£000	**£000**	**£000**	**£000**	**%**	**Years**	**Years**
At 31 March 2005							
Sterling	(287,654)	0	(7,379)	(280,275)	3.5%	n/a	n/a
Gross financial liabilities	**(287,654)**	**0**	**(7,379)**	**(280,275)**			

Note: The public dividend capital is of unlimited term.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

26.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2005.

	Book Value	Fair Value	Basis of fair valuation
	£000	£000	
Financial assets			
Cash	8,957	8,957	
Debtors over 1 year:			
Agreements with commissioners to cover creditors and provisions	240	240	Note a
Total	9,197	9,197	
Financial liabilities			
Provisions under contract	(6,829)	(6,829)	Note b
Public dividend capital	(280,275)	(280,275)	Note c
Total	(287,104)	(287,104)	

Notes

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

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

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

27 Third Party Assets

The Trust held £7,654.49 cash at bank and in hand at 31/03/05 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.

28 Losses and Special Payments

There were 131 cases of losses and special payments totalling £125,125 approved during the nine months to 31st March 2005.

There were no cases of losses exceeding £100,000.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

29. Public Dividend Capital Dividend

The Trust is required to absorb the cost of capital at a rate of 3.5% of average net relevant assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £11,526k bears to the average net relevant assets during the nine month period of £339,939k, that is 3.4%

This is calculated as follows:

	31 March 2005	30 June 2004
	£000	£000
Total Capital and Reserves	404,799	375,656
Less - Donated Asset Reserve	(37,529)	(37,135)
Less - Cash held at Paymaster General's Office	(396)	(7,027)
Ner Relevant Assets before revaluation	366,874	331,494
National Revaluation Exercise	(18,489)	0
Total Net Relevant Asssets	348,385	331,494
Average Net Relevant Assets	339,939	
Dividend paid per Cash Flow statement	11,526	
Percentage	3.4%	

The Trust's actual rate of return of 3.4% is not materially different from its forecast rate of 3.5%.

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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