Sheffield Children's NHS Foundation Trust Annual Report and Accounts

1 April 2007 to 31 March 2008

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

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NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance (the Code) issued by Monitor is issued as best practice advice and applies for the reporting years beginning on or after April 2006.

Statement of Compliance

The Board of Directors of Sheffield Children's NHS Foundation Trust recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance.

In September 2006, Monitor, the independent regulator of Foundation Trusts, published the NHS Foundation Trust Code of Governance (the Code). The purpose of the Code of Governance is to assist NHS Foundation Trust Boards to improve their governance practices by bringing together the best practice of the public and private sector corporate governance. The code has some disclosure requirements which NHS Foundation Trusts are required to observe in full in the reporting year 2007/8 (Application of the NHS Foundation Trust Code of Governance Section 3 para.2). The Trust's Annual Report for 2007/8 fulfills the disclosure requirements required by the Code.

1. Chairman's Statement

It is my pleasure to introduce this report which relates to the Trust's first full year of operation as a Foundation Trust, having achieved Foundation Trust Status from August 2006. The last year has been a very successful year for the Trust during which we have seen continued development of the important services we provide for children, young people and their families whose needs we serve.

I am able to confirm that during 2007/8 the Trust met all its key financial targets, and, subject to confirmation by the Healthcare Commission the Trust expects to have met all health care standards and all other key targets, with the exception of the diagnostic waiting time target, against which the Trust slightly underperformed.

The Trust, with the support of its Governors and key stakeholders, continues to drive forward, progressing in line with the organisation's ten high level strategic objectives which were set out in the Service Development Strategy in 2006. These objectives set the direction for the Trust and its endeavours for the five year period and they provided the framework for the Trust's activities in 2007/8 and remain constant in 2008/9. They are as follows:

- To provide top quality and accessible services for children and their families;
- To deliver care locally wherever possible;
- To expand and develop our specialist services;
- To work with others to improve the life chances of vulnerable children and young people;
- To help to keep children healthy;
- To actively involve children and families in the work we do;
- To recruit, develop and retain competent and committed employees;
- To be a leader in the field of training and research in children's health care;
- To provide care in a high quality environment;
- To ensure our organisation is effectively managed, well governed and uses resources effectively.

The performance of the Trust in 2007/8 continued to be very strong. This was reflected in the most recent assessment undertaken by the Healthcare Commission when the Trust was awarded the highest rating of 'Excellent' for both 'Quality', and 'Use of Resources', within the Annual Health-check for 2006/7. The Trust met all health care standards throughout the year and the Trust had no cases of MRSA in 2007/8. We expect our continued high performance to be reflected within the Healthcare Commission's assessment of the Trust in 2007/8.

As a Foundation Trust, we are enabled to deliver further improvements to the services we provide to the children and families we serve. Through the Board of Governors, we now have closer links with families, and our community stakeholders. We have benefited from the contribution that our Governors make to the work of the Trust, such as the recruitment of Non-executives and Auditors, and in assisting the Board of Directors in determining priorities for the organisation. We look forward to working increasingly closely with our Governors in the future in a number of key areas, including key strategic work and in relation to assessing the views of those who use our services. I am certain that the new arrangements and the involvement of Governors and members will help us to deliver real benefits for health and health care for children and families.

As Chairman of the Board of Directors and the Council of Governors, I am proud that Sheffield Children's NHS Foundation Trust remains at the forefront of health care for children and young people. The year ahead will be challenging; the Trust has an ambitious programme of work and a number of key initiatives underway. Of particular note is the work we are embarking on to review the strategic case for a substantial development of the Sheffield Children's Hospital. The Trust continues to see a rise in demand for its services, and it is vital we have a plan to ensure our estate is fit for purpose for the future, and meets the expectations of families.

Whilst we are extremely proud of the high quality of services provided by the Trust, we know that we can make further improvements. In 2008/9 we will drive forward on patient safety and quality, to ensure we do all that is possible to provide care of the very highest standard. We will also continue in our drive to make our services more accessible by reducing waiting times, and introducing a maximum 18 week wait for patients from the point of referral to the point of treatment.

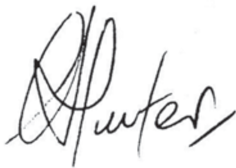
We are aware of the substantial changes underway in health care, and we understand the importance of working with commissioners and other key stakeholders to review the shape of services for the future. I believe the Trust is well placed to seize the opportunities that may arise for a specialist provider of health care for children within this changing context.

[1] 0-16 population statistics taken from Sheffield Council website

We take our responsibilities as a key organisation operating within the city of Sheffield very seriously, providing care for the local population of children and young people in Sheffield as well as children from the broader region and we forecast a turnover of over £95 million in the next 12 months.

I should like to conclude by thanking everyone who has contributed to our success over the last year including all our staff, our Governors, our members and the Board of Directors. I would also like to thank all of the volunteers, the Patient and Carer Advisory Group and the Sheffield Children's Hospital Charity who continue to provide so much support to the Trust which helps us in our drive to improve the care we provide to children and their families.

In particular I would like to pay tribute to Lynn Hagger, who was Chairperson of the Trust until January 2008. Lynn was Chairperson of the Trust for nearly 10 years and led the Trust during a period of substantial growth and considerable success.



Stephen Hunter Chairman
Date: 6 June 2008

2. Chief Executive's Statement

This report summarises the key achievements of the Foundation Trust over the last year. It shows the real progress we have made to develop our services and our organisation in line with our strategic aims as described in our Service Development Plan. As the designated Accounting Officer, it is my duty to review the performance of the Trust on behalf of the Board of Directors.

The Trust has a strong reputation for the high quality services provided for children, young people and families and we are extremely proud of the skilled teams of staff that provide the best care for our patients. This was recognised by the Healthcare Commission in their Annual Health Check 2006/7 where Sheffield Children's NHS Foundation Trust was considered to be excellent across all standards putting our performance in the top five percent of NHS organisations in England.

A number of important developments have taken place during the last year. We have commenced a major capital scheme for the expansion of our Critical Care Unit, which will see the development of a new High Dependency Unit. This will allow us to care for more children and young people needing this complex level of care. We have made progress with commissioners on the case for a new Tier 4 Child and Adolescent Mental Health Services (CAMHS) capital development, that will enable us to deliver care in the most modern facilities. We also opened the first paediatric Clinical Research Facility in the UK, which enables us to build on our strong portfolio of research projects. We are grateful to the Sheffield Children's Hospital Charity for their assistance with this important project. The Trust also established the 'Innovation and Development Board', which supports the development of specialist services and research in the Trust. These initiatives will assist the Trust in staying at the forefront of developments in children's health services.

We are committed to providing the highest standards of care. To this end the Board of Directors have made a commitment to ensure safety and quality are our top priorities. We are participating in the NHS Institutes, 'Leaders in Quality Academy' programme, and are seeing improvements in a number of important areas. This work supports the Trust's robust system of governance which is in place and performance is monitored monthly by the Board of Directors to ensure standards of performance are met. As we look forward in 2008/9 we are undertaking an assessment of our future capacity needs. We see year on year increases in demand for our services from our region and nationally, and are looking at the options for the hospital's development, and how we can increase capacity for more clinical services, improve the quality of facilities for patients, families and staff, with improved access and car parking. This is an ambitious plan and we will spend much of the year developing our options for the future.

I should like to thank all our staff for their commitment and dedication in providing high standards of care which have contributed to a very successful year for the Trust. Also, I would like to thank our governors and members for their support, and the tireless efforts of the volunteers and charities that support us in enhancing our services for the benefit of all.

Finally, I would like to record my appreciation to Lynn Hagger, who was the Chairperson of the Foundation Trust for most of the year. She has led the Board of Directors for almost 10 years and made an outstanding contribution to the development of the Trust.

Chris Sharratt Chief Executive
Date: 6 June 2008

3. Directors' Report

3.1 THE BOARD OF DIRECTORS IN 2007/8

The following individuals were members of the Trust's Board of Directors for all or part of the financial year:

Name	Job Title	Full year or part year
Lynn Hagger	Chairperson	Up to 31 Jan 2008
Stephen Hunter	Chairman	From 1 Feb 2008
Alan Bamford	Non-executive Director	Up to 31 July 2007
Professor Nick Bishop	Non-executive Director	Up to 31 July 2007
Lee Bond	Director of Finance	Up to 3 August 2007
Derek Burke	Medical Director	From 1 Feb 2007
Isabel Hemmings	Deputy Chief Executive	Full year
Peter Lamberton	Non-executive Director	Full year
Jeremy Loeb	Director of Finance (Deputy Chief Executive)	From 19 Nov 2007
Joseph McNally	Vice Chairman & Senior Independent Director	Full year
John Reid	Director of Clinical Operations & Nursing	Full year
Chris Sharratt	Chief Executive	Full year
John Turner	Non-executive Director	Full year
Gareth Watkins	Non-executive Director	From 1 Nov 2007
Louise Wembridge	Director of Human Resources	Full year
David Williams	Non-executive Director	From 1 Nov 2007

For the period 4 August 2007 to 16 November 2007 Mr Mark Smith (Deputy Director of Finance) was acting Director of Finance.

3.2 PRINCIPAL ACTIVITIES OF THE TRUST DURING THE COURSE OF 2007/8

The principal activity of the Trust during 2007/8 remained the provision of health care to children and young people and support to families. The Trust also continued to provide specialist genetics and pathology services.

As a provider of integrated health care, including community and mental health care as well as acute and specialist services, the Trust has already moved towards a broader, more comprehensive approach to supporting children and families. Our aim is to be at the forefront of best practice in delivering high quality care to children and young people.

The Trust provides its services in a large number of different locations. The majority of acute care is delivered at the Sheffield Children's Hospital which was first built in 1876. The hospital is situated on Western Bank, in a central location in the city. It is in close proximity to the Universities and to the Royal Hallamshire Hospital.

Our community and Child and Adolescent Mental Health Service (CAMHS) are provided from a number of locations, the main ones include the Ryegate Centre which is situated a mile away from the Children's Hospital in the South West of the city. It provides a focus for the delivery of services to children with disabilities, including those with complex neurodisability. Our mental health services are provided from a number of community sites across the city of Sheffield, including Shirle Hill Hospital, Centenary House and Oakwood Young People's Centre.

The Trust provides an exceptionally wide range of general and specialist services for children and young people across South Yorkshire and beyond on an outreach basis.

- Highly specialised health care, for example, medical and surgical specialties treatment for children and young people. These services include neurosurgery, oncology, endocrinology, specialist orthopaedics, neonatal surgery, ENT, plastic surgery including burns services, metabolic disease, respiratory diseases, gastroenterology, intensive care, cystic fibrosis and neurology. These services are provided to meet the needs of children and young people living across South Yorkshire, North Trent, Lincolnshire, and the Humber and in some cases from across the country.
- Secondary health care – providing a range of hospital services for the children and young people of Sheffield, including Accident and Emergency (A&E) services, orthopaedics, general surgery, general paediatrics, dermatology and diabetic care.
- Community based services – provided to the Sheffield population, including community paediatrics, child development, support for adoption and fostering, medical safeguarding advisory services and services for children with neurodisability.
- Mental health care – a full range of mental health care services for children and young people is provided, working closely with partner agencies in Sheffield. Services at tiers 2 and 3

and specialist services, such as forensic services and services for vulnerable children are provided. We also provide tier 4 services for the larger South Yorkshire/North Trent population.

- Specialist pathology and genetics – a number of highly specialised pathology services, including newborn screening and molecular genetics, cytogenetics and clinical genetics are provided.

3.3 BUSINESS REVIEW 2007/8

During 2007/8, the Trust treated more patients than in preceeding years, continued to expand the range of services provided and operated successfully during its first full year as a Foundation Trust.

As a Foundation Trust the Trust's performance is regulated by an external regulator, Monitor. Throughout the year the Trust maintained the highest rating (green) in Monitor's quarterly assessment of the Trust's performance against governance requirements which includes an assessment against key targets. The Trust was also assessed favourably by Monitor in its quarterly assessment of the Trust's financial position, receiving a financial rating of 4 for the first two quarters of the year, and achieving the top rating of 5 in the third and fourth quarter of the year.

Activity levels in contracts agreed with commissioners for 2007/8 were at higher levels than in 2006/7 and the Trust, in the main, met these activity targets. Whilst the Trust slightly underperformed against activity levels set for follow-up outpatient activity, it exceeded contract levels for first outpatient appointment activity and slightly exceeded target for elective activity. Details are shown in the table below:

The organisation met most of its key targets in 2007/8, achieving the milestones required for March 2008 for a reduction in waiting times for both admitted and non-admitted patients in advance of the maximum 18 week wait required from December 2008. Performance was also strong against other key targets, with good performance against the A&E four hour waiting time target, cancer waiting times, cancelled operations (low levels), maximum waiting times for outpatients and for elective admission and with slight under-performance against the diagnostic six week maximum waiting time target.

The Trust maintained its excellent record in relation to infection control, with no cases of hospital acquired MRSA reported for the full year 2007/8 and very low levels of *clostridium difficile*.

TABLE: ACTIVITY IN 2007/8 AND COMPARISON WITH 2006/7 AND 2005/6

	2005/6	2006/7	2007/8	Growth 2006/7 to 2007/8	% Growth 2006/7 to 2007/8
Elective inpatient spells	4,931	4,847	5,427	580	12.0%
Day-cases	6,210	6,852	6,903	51	0.7%
Non-elective spells	9,537	9,365	9,664	299	3.2%
1st outpatient attendances	19,798	24,797	26,533	1,736	7.0%
Follow-up outpatient attendances	57,075	58,866	61,878	3,012	5.1%
Total outpatient attendances	76,873	83,663	88,411	4,748	5.7%
Clinical Genetics – 1st and follow-up appointments	3,582	4,340	4,534	194	4.5%
A&E attendances	48,508	46,742	46,888	146	0.3%
Therapy assessments and attendances	28,874	28,858	31,601	2,743	9.5%
Mental Health community contacts[1]	12,670	14,982	10,278	-4,704	-31.4%
Mental Health inpatients (bed nights)	3,713	4,156	3836	-320	-7.70%
Mental Health day-cases	2,519	2,350	2,279	-71	-3.0%

[1] The Trust, following agreement with Sheffield Primary Care Trust has changed the information system which records Mental Health contact information to one which is patient centred and records only contacts directly with a service user. This change in the categories of data recorded from previous years is the explanation for the indicated reduction in mental health contacts.

The Trust declared full compliance against the Healthcare Commission's Health care Standards throughout 2007/8 and the evidence for this declaration was scrutinised and approved by the Trust's Council of Governors, the Patients' Forum, the Sheffield Local Authority Overview and Scrutiny Committee, Joint South Yorkshire Overview and Scrutiny Committee and internal audit.

The Trust also continued to develop the services it provides for children and families. Of considerable importance in 2007/8 was the setting up of an interim High Dependency Unit which was brought into operation in October 2007. This new unit was part of the plan for the development of Critical Care services for children which was supported by commissioners in 2007/8. This was the first step towards a new eight bed High Dependency Unit which will be built adjacent to the Paediatric Intensive Care Unit during 2008 to provide more comprehensive critical care facilities for children treated at the Children's Hospital.

The Trust was one of just 5% of trusts nationally to achieve a double 'excellent' rating for quality of services and use of resources in the Healthcare Commission's assessment of 2006/7, the results of which were published in October 2007, and the Trust would expect to achieve a similar rating of its performance in 2007/8.

Demand for the Trust's services continues to rise. During the last year, the Trust had an overall increase in referrals of 13%, with particular growth in referrals to orthopaedics, paediatric surgery, gastroenterolgy, plastic surgery and dermatology.

The increased demand for our services reflects the continued rise in referrals for specialist activity which the Trust has experienced over recent years. This is also in line with national trends with a greater proportion of care for children undertaken at specialist centres than previously. It is now well recognised that children's health care requires specialist expertise, with care and treatment provided by staff skilled in their needs and who care for children on a regular basis.

The Trust remains absolutely committed to working in partnership with staff in delivering patient services, ensuring that individuals have a supportive and safe environment and ensuring that individuals and teams are continually looking to improve themselves, the service delivered and the way that service is delivered. We are committed to the training and development of our entire workforce.

Key achievements during 2007/8 included:

- The retention of our Investors in People Standard following a comprehensive assessment process;
- The successful completion of the first year's Management Development Programme (accredited by the Institute of Leadership Management);
- The introduction of ward-based risk management training;
- The expansion of the Trust's volunteer network to approximately 65, the majority of whom are young people;
- The introduction of e-recruitment and the new integrated Human Resources and Payroll system, Electronic Staff Record (ESR);
- As Lead Employer for Paediatric Junior Doctors for South Yorkshire and South Humber, the successful implementation of Modernising Medical Careers (MMC).

Further detail on employment matters can be found in section 4 of the Annual Report.

Whilst the Trust continues to be one of the top performing trusts nationally, the organisation faces a number of challenges and these risks must be managed effectively going forward. Key risks identified are as follows:

- *Payment by Results (PbR) Income* – The Trust, together with other children's hospitals, was successful in influencing changes to the PbR tariff for 2008/9. This addressed problems in the system which inadequately reimbursed specialist children's services.

  However, the PbR system is reviewed on an annual basis and there is an intention to introduce a revised clinical coding system (HRG 4) for 2009/10. This determines the tariff the Trust will receive for its services. As a specialist hospital our income is very sensitive to these changes. The Trust is working with the Department of Health to understand the proposed changes and ensure they do not affect the Trust adversely.

  The Trust has also invested in detailed costing systems to understand, in more detail, the relationship between its income and costs in each of our clinical directorates.

- *The need for greater efficiency/ increased productivity* – given the financial climate within the public sector and within the health service, along with the potential deflation of the national tariff, it is important that the Trust keeps a clear focus on reducing costs and increasing efficiency. The Trust has a good track record of delivering year on year cost reductions and cost improvements were again delivered in 2007/8. In order to face the challenges of the future, the Trust will adopt a new approach in 2008/9 with the introduction of an organisation-wide service improvement initiative with a significant focus on service redesign. This initiative is included in the Trust's Annual Plan for 2008/9.
- *The Trust estate* – given the increase in activity undertaken at the Children's Hospital and the shortcomings of the accommodation provided by this hospital in terms of the adequacy of ward space, parental facilities, numbers of single rooms and car parking, the Trust Board of Directors has identified a key priority for the future as being the redevelopment or the replacement of the Children's Hospital. The Trust is embarking upon an assessment of the Strategic Outline Case for such a development which will be undertaken during 2008/9. It is clear that the risks to the organisation of not developing the hospital are significant in terms of the future business of the Trust. However, any such development will need to be affordable and the business case robust before any such development could proceed.
- *Investment in other capital schemes* – the Trust has a number of important

capital schemes for which investment is likely to be required, including the provision of a new single site for Tier 4 CAMHS services. However, given the investment which is likely to be required for the redevelopment of the Children's Hospital, the availability of capital funding for larger capital schemes will require careful evaluation. The Trust will be assessing the Full Business Case for the Tier 4 scheme during the first months of 2008/9.

- *Delivering the 18 week wait for all patients from December 2008* – whilst the Trust was successful in meeting the milestone targets required for March 2008, delivering the maximum 18 week wait for all patients by the end of 2008 is challenging for the organisation. The absence of a national patient tracking system will require a local solution within the Trust to collect data from a number of different systems. Another uncertainty relates to referral rates which increased in a number of specialities in 2007/8 which led to some in-year risk in delivering milestones. Effective systems for monitoring referral patterns as well as activity and progress against trajectories will form part of the Trust's management plan for delivery of 18 weeks in 2008/9.
- *Information Systems* – in recognition of the importance of robust information systems, and of the importance of maximising the benefits of technology to support excellent health care, the Trust will be undertaking a full review of the suitability of its systems together with a review of its Information Management and Technology Strategy.

3.4 FINANCIAL PERFORMANCE 2007/8

The Trust achieved a surplus on the income and expenditure account of £5.5m for the 12 months ending 31 March 2008. This was significantly in excess of the planned surplus of £0.4m. This strong performance reflected a number of factors.

Non-elective income is historically very variable and in 2007/8 non-elective surgical income exceeded budget. In medicine the good income performance reflected increased specialist referrals during the year.

Expenditure was less than plan because of unavoidable delays in recruitment to both medical and nursing posts.

Interest on cash was significantly higher than last year because a number of capital developments were not scheduled until 2008/9 and this resulted in significant cash holdings during the year.

The Trust implemented year two of a three year efficiency programme which was set to achieve a saving of 5% of expenditure. Of this, 3% was a national requirement and an additional 2% was required to meet internal cost pressures. The programme target was £3.8m and £3.7m was achieved within the year with the remainder deliverable in 2008/9. The programme included both income generation schemes as well as service re-organisation.

The strong financial performance during the year was reflected in the financial compliance ratings issued by Monitor for each quarter. The end of year rating was 5 on a score of 1 to 5 with 5 the highest.

3.5 KEY TRENDS AND FACTORS LIKELY TO AFFECT THE FUTURE DEVELOPMENT OF THE TRUST

Sheffield Children's NHS Foundation Trust has been increasingly successful over recent years and its high performance has been reflected in external assessments undertaken by the Healthcare Commission, Monitor and other organisations involved in assessing performance. However, it is critical to the continued success of the organisation that assessment is made of the potential impact of future trends and changes in the external environment on the Trust's future business. Key changes and trends which may impact on the Trust have been identified as follows:

The Operating Framework for the NHS in England 2008/9 describes the main policy agenda for health care and health services for 2008/9 and the future. This document confirms the existing main policy agenda and outlines the future direction of travel. This document has informed the Trust's priorities for 2008/9. Of particular importance for the Trust are the following:

a) Cleanliness and Health Care Acquired Infections (HCAIs)

The Trust will continue to place infection control at the top of its agenda, maintaining high standards and continuously seeking improvement in line with national policy.

b) Access – the delivery of the following is specified:

- 18 week maximum wait from December 2008 (90% for admitted, 95% for non-admitted patients)

The Trust met key milestone targets towards 18 weeks in 2007/8 and has plans in place to achieve the maximum 18 week waiting times for all patients from December 2008.

c) Health inequalities

- Cancer – progressing the reform strategy, and a focus on prevention and early diagnosis
- Children – more partnership working and reducing childhood obesity by 2020 to 2000 levels

As a Principal Treatment Centre for children's cancer care, the Trust will implement improvements to its services for children with cancer in line with plans agreed with commissioners in order to achieve Improving Outcomes Group standards for care of children and young people with cancer.

The Trust will continue to work in close partnership with other key partners to support the reduction in health inequalities for children and to seek to reduce obesity in children.

d) Experience, satisfaction and engagement –

The Trust will continue to learn from the experience of users and their carers and through our Governors and members, from the broader population of stakeholders. We will seek to actively engage with our staff

in both improving working lives and in considering the strategic direction of the Trust.

e) Emergency preparedness – NHS organisations are expected to have emergency plans in place to include a response to pandemic flu by December 2008, and to include response to dangerous incidents including chemical, biological, radiological, nuclear or terrorist attack.

The Trust will have the necessary arrangements in place to support an emergency response to any dangerous incident including a pandemic flu plan.

f) Other priorities – other national priorities which will require local solutions and are of particular note are:

- No 16-17 year olds to be on adult psychiatric wards by 2010
- Improvements to be made to access to psychological therapies
- Local plans to be drawn up to improve end of life care
- Improved services for disabled children, including short breaks, palliative care and access to therapies.

The Trust is currently working with commissioners and other partners in relation to the provision of mental health care for 16-17 year olds and the Trust is engaged in multi-agency planning for children with disabilities.

Our NHS, Our Future – Professor Lord Darzi's work, nationally, on defining clinical issues which should impact on the future delivery of patient services. Two main themes of this work are:

- the importance of providing care locally wherever possible
- the importance of providing specialist care in appropriate centres of expertise with high quality outcomes for patients.

The Trust already provides a number of outpatient and day case based services on an outreach basis within local hospitals across South Yorkshire and North Humber. The Trust will consider how best to configure services for the future within the assessment undertaken within the Strategic Outline Case for the development of the Children's Hospital, working with commissioners and other key stakeholders to review options.

Sheffield PCT commissioning intentions 2008/9 – The Sheffield PCT published its Commissioning Intentions for 2008/9 in early January. The Trust will ensure that its activities are undertaken in accordance with the requirements specified by Sheffield PCT.

Rising demand – Over recent years the Trust has experienced a continued rise in demand for services with increased referrals of patients. To date the Trust has managed to meet the rise in demand and also achieve key targets including reductions in waiting times. Capacity is in place to meet expected demand in 2008/9 and an assessment has been made of the likely demand for services over the next three years. However, there is a level of uncertainty in this matter and it is important that the Trust remains able to flex its capacity up and down to meet varying levels of demand. This will be increasingly important in the future when waiting times are reduced to a maximum 18 weeks to treatment. The Trust will have variation in referrals by month but with a requirement to ensure treatment within 18 weeks for all patients. A close analysis and monitoring of referral patterns will be required and services will need to respond and flex appropriately to variable demand.

Payment by Results (PbR) – Further changes to PbR nationally could affect the Trust's income position. Recent changes improved the position for specialist children's services which were initially disadvantaged following the introduction of this system. Trust representatives continue to work with the Department of Health on the further development of PbR. Direct involvement in this process will help to reduce the risk of further developments having an adverse impact on specialist children's services.

Environmental responsibilities

The Trust continues to seek to reduce its energy consumption. A fully automated computerised building management system is in place to control heating and lighting plant for optimal efficiency. The Trust has forty-eight Local Energy Representatives to champion best practice in local areas, and over the last year we have invested in new high efficiency light fittings.

Working with key partners

The Trust is actively involved in the 0-19 Partnership for children and young people, a multi-agency local strategic partnership led by Sheffield City Council, and works closely with Sheffield PCT on initiatives to improve the health of children in Sheffield. The Trust also works closely with specialist commissioners in relation to plans to improve specialist services for children.

The Trust has contracts with 19 Primary Care Trusts, the majority of which are negotiated through a collaborative commissioning arrangement led by the Sheffield PCT.

The Trust actively engages with its staff with joint staff consultative arrangements in place.

The Trust works closely with the Sheffield Teaching Hospitals NHS Foundation Trust from which the Trust purchases a number of services, including the provision of some specialist surgical services.

The Trust provides outpatient services on an outreach basis in local District General Hospitals. The Trust also provides surgical time to other hospitals to support the localised delivery of day case surgery in towns outside Sheffield.

3.6 KEY FINANCIAL PERFORMANCE INDICATORS

Monitor's compliance framework uses five key financial performance indicators. Performance against these indicators for 2007/8 and for 2006/7 are shown in the table on page 14.

The table shows that the Trust achieved the highest rating for four of the five indicators in both years. The compliance framework sets a maximum rating of 4 in the first year of Foundation Trust status and this applied in 2006/7.

Metric	Weighting	2007/2008 Actual		2006/2007 Actual	
		% Ratio	Rating	% Ratio	Rating
EBITDA Margin	25%	10.7	4	9.3	4
EBITDA % achieved	10%	217.5	5	363.8	5
Return on Assets	20%	14.1	5	7.6	5
I&E surplus margin	20%	6.9	5	4.6	5
Liquidity ratio (days)	25%	84.5 days	5	84.7 days	5
Weighted average rating			5		4

3.7 KEY PERFORMANCE INDICATORS (NON-FINANCIAL)

Key non-financial performance indicators for 2007/8 were:

- To submit complete and timely data on the numbers of C. difficile infections and by year end to have agreed a local target for the number of C. difficile infections with the appropriate PCT commissioners;
- Data Quality on Ethnic Groups: to ensure that ethnicity data is recorded on Trust systems in order to monitor the reduction in health inequalities related to ethnic diversity;
- Drug Misusers: information, screening and referral: to ensure that information is available and clear screening and referral processes are in place for any patients presenting to A&E with alcohol or drug problems;
- Emergency Bed Days: to improve health outcomes for people with long term conditions indicated through a reduction in the number of emergency bed days by 5% from the 2003/4 baseline;
- To demonstrate a reduction in the number of MRSA bacteraemia infections;
- Obesity: compliance with National Institute for Health and Clinical Excellence (NICE) guidance 43. To tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole;
- Referral to Treatment times milestones: to ensure that 85% of admitted and 90% of non-admitted patients receive treatment within 18 weeks of referral;
- Waiting times for diagnostic tests: linked to the Referral to Treatment times milestones. To ensure that patients do not wait more than six weeks for a diagnostic test;
- Self Harm: compliance with NICE guidance. To ensure that processes are in place to ensure compliance with NICE guidelines on the treatment and management of self harm in emergency departments;
- Outpatient waiting times: patients referred from a General Practitioner wait no longer than 13 weeks to be seen in a consultant led service;
- Inpatient waiting times: patients do not wait longer than 26 weeks for elective surgery;
- To ensure that patients are offered a choice of appointment dates and that services can be booked using the Choose and Book facility via General Practitioners;
- To ensure that more than 98% of patients who attend the A&E department are discharged or admitted within four hours;
- Where a GP makes an urgent referral for suspected cancer, no patient waits more than 2 weeks from referral to first outpatient appointment;
- To ensure that no patient waits more than 31 days from diagnosis of cancer to treatment.

Performance against these indicators is reported on pages 25/26.

3.8 AUDIT INFORMATION

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware and they have taken all of the steps that they should have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of the information.

3.9 RESEARCH AND DEVELOPMENT

The Trust continues to strengthen its role in research, and attracted external funding of £1.3 million in 2007/8 which was a significant increase compared to the previous year. The Trust opened a new Clinical Research Facility (CRF) in January 2008 which was opened by the Rt Hon Mr Alan Johnson, Secretary of State for Health. This facility is the first dedicated children's CRF in the UK and provides research space for staff to help investigators to undertake high quality research. During the year, the Trust continued its involvement in networked research. In total, 54 clinical trials and 84 research projects were undertaken at the Trust during 2007/8.

4. Background Information

4.1 FOUNDATION TRUST STATUS

Sheffield Children's NHS Trust was established in 1992 and is a major provider of health care for children and young people in Sheffield, South Yorkshire and beyond. Under the Health and Social Care (Community Health and Standards) Act 2003, the Trust became an NHS Foundation Trust in August 2006 and has an excellent reputation for the services it provides.

Foundation Trusts are autonomous organisations, free from central Government control. As a Foundation Trust we can decide how to improve our services and we are able to retain any surpluses we generate or can borrow money to support these investments.

As a Foundation Trust we have been able to build on our already strong links with the local community and have representatives from the community as our members and governors. These new found freedoms mean that we can better shape our health care services around the needs and priorities of our patients and the public.

The independent regulator, Monitor, rigorously assesses our performance to make sure that we honour our obligations and remain true to the NHS principles of free care based on need rather than ability to pay.

4.2 PENSIONS AND RETIREMENT BENEFITS

The accounting policy for pensions is set out in section 19. Pension and retirement benefits of senior managers are shown in section 15.

4.3 EXTERNAL AUDITOR

The Trust's External Audit programme is provided by KPMG who became the Trust's Auditors with effect from 1 April 2007. Prior to this, the Auditors to the Trust were the Audit Commission. At their meeting of 1 August 2006, the Council of Governors decided to extend the appointment of the Audit Commission for the remainder of the 2006/7 financial year. The Council of Governors subsequently declared an intention to market test for this appointment in 2007/8 which led to the appointment of KPMG.

Work in the period to 31 March 2008 has predominantly focused on the annual accounts related work. This work, which includes reviews of material systems, internal audit liaison, audit of accounts and examination of the annual report and publication of the audit certificate has been supplemented by additional work reviewing the statement of internal control and continued performance review of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources.

The total fee needed to deliver the audit programme in the period was £48,750. Of this, £32,050 related to Accounts work, £6,300 related to the statement of internal control, £5,100 to performance reviews and £5,300 for additional work in the form of follow up to previous reviews and the production of the management letter.

The Trust expects its external audit provider to act independently. Under the terms of engagement they are required to have control processes in place to ensure that this status is preserved and to notify the Audit Committee of any matter that could compromise the independence or objectivity of the audit team. This position is monitored by the audit committee and the auditor is required under International Standard on Auditing 260 to confirm this position in the annual governance report.

More detailed information relating to the role and function of the Audit Committee is available in section 11 of this report.

4.4 FUTURE DEVELOPMENTS

The Trust is committed to the further development of the services it provides for children and young people. The Trust's plans for 2008/9 are set within the context of national policy determined by the Department of Health and local priorities determined by local commissioners and other key partners. The Trust's plans for 2008/9 are also determined by the longer term strategic objectives which have previously been identified and which provide the broad goals of the organisation. The Trust's priorities for 2008/9 will take account of the following:

4.4.1 NATIONAL POLICY – THE OPERATING FRAMEWORK FOR THE NHS IN ENGLAND 2008/9

The Operating Framework for the NHS in England 2008/9 determines the main priorities of the NHS in England in the year ahead and specifies the key priories for health care organisations. This document is produced annually and sets the planning framework for all NHS organisations. The Operating Framework identifies five key priorities for the NHS in 2008/9:

- improving cleanliness and reducing health care associated infections
- improving access through achievement of the 18-week referral to treatment pledge, and improving access to GP and primary care services
- keeping adults and children well, improving overall health and reducing health inequalities
- improving patient experience, staff satisfaction and engagement
- preparing to respond in a state of emergency, such as an outbreak of pandemic flu.

These priorities and all the targets specified by the Department of Health are reflected in the Trust's plans for 2008/9. This plan also reflects the overall context of national policy for the health service including the broader reform agenda and the financial framework in operation.

4.4.2 NATIONAL POLICY – NHS NEXT STAGE REVIEW

In the interim report of the NHS Next Stage Review (Our NHS, Our Future), Professor Lord Darzi, sets out a vision for an NHS that focuses on improving the quality of care and identifies a number of key principles to support personalised care so that the NHS is:

- **fair**: equally available to all, taking full account of personal circumstances and diversity;
- **personalised**: tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice;
- **effective**: focused on delivering outcomes for patients that are among the best in the world;
- **safe**: as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive;
- **locally accountable**: so that staff are empowered to lead change and innovate locally, ensuring that this is based on the best clinical evidence, meets local needs, and is the product of engagement with patients and the public.

Locally, in Yorkshire and the Humber, a review of clinical pathways for children has been undertaken and the Trust will work with commissioners and other key partners in 2008/9 to implement changes in line with agreed plans.

4.4.3 LOCAL PRIORITIES – SHEFFIELD PRIMARY CARE TRUST PCT

The Sheffield PCT published its Commissioning Intentions for 2008/9 in early January. The priorities identified by the Sheffield PCT are in line with the strategic priorities determined by the PCT strategy 'Achieving Balanced Health'. The Sheffield PCT five year strategy identified nine key priority areas, one of which related to children and young people. Priorities identified for 2008/9 in relation to children and young people include obesity and mental health care. The Commissioning Intentions document also places a high degree of emphasis on public health measures to improve health and the Trust will seek to reflect these intentions within its own plans for 2008/9.

4.4.4 LOCAL PRIORITIES – COLLABORATIVE COMMISSIONING GROUP

The Trust holds contracts with a number of local PCTs which collaborate in the process of negotiation with the Trust. The activity levels for 2008/9 have been reviewed with commissioners and revised to ensure the delivery of reductions in waiting times to support the implementation of the 18 week maximum wait from referral to treatment required from December 2008. Contracts for 2008/9 therefore include activity levels which will support the delivery and ensure that the Trust achieves the national target of a maximum wait of 18 weeks from referral to treatment.

4.4.5 LOCAL PRIORITIES – SPECIALIST COMMISSIONING GROUP

The Yorkshire and Humber Specialised Commissioning Group – South, has identified priorities for the development of specialised services in 2008/9, and the Trust has worked with commissioners on plans in relation to the development of services in the year ahead.

4.4.6 TRUST STRATEGIC PRIORITIES

The Trust has identified ten key strategic objectives, which were set out in the Trust's Service Development Strategy in 2006, which set the direction for the Trust and its endeavours. These overarching strategic objectives provided the framework for the Trust's activities in 2007/8 and these strategic goals are retained by the Trust in 2008/9. They can be summarised as follows:

- To provide top quality and accessible services for children and their families;
- To deliver care locally wherever possible;
- To expand and develop our specialist services;
- To work with others to improve the life chances of vulnerable children and young people;
- To help to keep children healthy;
- To actively involve children and families in the work we do;
- To recruit, develop and retain competent and committed employees;
- To be a leader in the field of training and research in children's health care;
- To provide care in a high quality environment;
- To ensure our organisation is effectively managed, well governed and uses resources effectively.

The Trust's priorities and plans for 2008/9 have been drawn up in line with the 10 strategic objectives outlined above. The Trust's Council of Governors have been involved in the development of the Trust's objectives for 2008/9.

4.4.7 TRUST PRIORITIES IN 2008/2009

a) DEVELOPMENT OF THE CHILDREN'S HOSPITAL

Within the Trust's Service Delivery Strategy the Trust stated its aim to expand specialist services, and this plan remains of considerable importance to the Trust. However, the Children's Hospital site in which acute services are delivered does not allow much scope for development. The hospital itself is over 130 years old, is situated on a very restricted site and is increasingly difficult and costly to maintain. The Board of Directors is therefore now progressing with assessing scope for developing the hospital, either through an expansion of the existing footprint, or the replacement of the hospital on a greenfield site. Such a development would enable the further expansion of clinical services, provide improved access and car parking, and accommodation fit for the future,

including good quality patient and family amenities and a high proportion of single room accommodation. Whilst these plans are at an early stage of development, the Trust will commence a formal process to examine the feasibility of a significant development. The Trust is working with key stakeholders to examine the feasibility of all options, and will progress with the Strategic Outline Case (SOC) during 2008/9.

b) PROVIDING TOP QUALITY AND ACCESSIBLE SERVICE FOR CHILDREN AND YOUNG PEOPLE

Achieving 18 weeks and access times

Achieving the 18 week referral to treatment time target is a significant and challenging priority for the Trust in 2008/9. The requirement is that this target is achieved from December 2008. The Trust will need to ensure that 90% of admitted and 95% of non-admitted patients are treated within 18 weeks. Whilst activity levels agreed with commissioners are sufficient to reduce the stages of treatment in line with this requirement, the Trust will ensure robust systems are in place to ensure the case management of patients along an 18 week pathway. Infrastructure such as a new Referral Booking and Management Service, and a patient tracking system, will be in place to support delivery of this target.

The Trust will also ensure that existing standards are maintained for the individual stages of treatment times (26 weeks for inpatient care, 13 weeks for outpatient care); cancer waiting times and the A&E maximum four hour wait. The Trust will also ensure that outpatient capacity is available to support electronic booking by GPs.

Patient safety and quality

Whilst the Trust has an excellent reputation for the quality and safety of its services, in 2008/9 we intend to give an even greater priority to driving forward the quality and safety of our services. The Trust has joined the Centre for Innovation and Improvement's national programme 'Leading Improvement inpatient Safety', which brings international best practice to the NHS in relation to safety.

A new Trust–wide patient safety initiative will be taken forward aimed at minimising risk and increasing safety of patients. Evidence based, systematic approaches will be used to identify risk and strengthen measures in place to prevent harm to patients. This initiative, led and funded by the Board of Directors, will focus on a number of important Trust-wide projects, such as the introduction of the 'Global Trigger Tool' and the extension of the 'Paediatric Early Warning system'.

Within this context the Trust will further develop effective infection prevention and control measures. As part of the patient safety initiative the Trust will continue with the Review of Antibiotics project and will introduce and audit a standard of care on hand-washing.

The Trust will comply with the Code of Practice for the Prevention and Control of Health care Associated Infections and implement best practice from Saving Lives.

During 2008/9, the Trust will implement MRSA screening for all elective admissions and will implement the HCAI and Cleanliness Strategy and will take action to comply with Level 2 of the NHSLA standards.

Health Care Standards

The Trust will ensure that all core Health Care Standards continue to be met throughout the year and that good progress is made towards achieving compliance with Developmental Standards in 2008/9.

c) PROVIDING LOCALLY DELIVERED SERVICES

The Trust works in partnership with other providers to deliver a range of outreach services in locations across South Yorkshire. These arrangements offer greater convenience for families in accessing health care, and support the continued delivery of paediatric services in District General Hospitals. These services have been in place for a number of years, but the range and scope of services provided in other locations has increased. In 2008/9 we plan to strengthen both the governance and financial arrangements in place to support outreach services through the implementation of new contractual arrangements. We will also further develop the partnerships we have in place through for example the development of orthopaedic partnerships with two local Trusts and by the development of shared care in relation to paediatric cancer services.

The Trust is also committed to working with the Sheffield PCT and other partners within the city on strengthening joint delivery of services in community settings. During 2008/9 CAMHS will continue to strengthen links with the city's Service Districts to co-ordinate services for vulnerable children.

d) EXPANDING AND DEVELOPING OUR SPECIALIST SERVICES

The Trust has a national reputation for the highly specialised services it provides for children and young people and over recent years the Trust has seen a growth in demand for these services. The importance of children receiving care and treatment from professionals trained in their care is now well recognised. This has been reinforced by the work undertaken by Professor Lord Darzi which stresses the importance for clinical outcomes of having centres of expertise for specialised services. During the coming year the Trust will take forward a number of important developments in its specialist services thereby enhancing the range and quality of care and treatment the Trust is able to provide. These initiatives include the following:

Additional activity to achieve 18 weeks

The organisation will deliver a substantial increase in the level of patient activity undertaken in 2008/9 in order to deliver the reduction in waiting times required to meet the 18 week maximum wait from December 2008. The level of growth required for 2008/9 will be 6.6% above 2007/8 plan for both elective and outpatient activity. To support delivery of the activity, additional capacity will be established,

including the use of the seventh operating theatre and thirteen additional weekly outpatient clinics. The Trust will also increase capacity within the Day Case Unit and increase inpatient capacity through the continuation of 24 hour opening of the eight bed Acute Assessment Unit. Additional capacity in a number of diagnostic areas is also required to ensure that patients are treated promptly.

Development of Critical Care Services

The Trust has worked with commissioners on a plan to increase the provision of Critical Care facilities at the Children's Hospital. A £3 million capital scheme will provide the facilities for the creation of a new eight bed High Dependency Unit, which will be situated adjacent to the Paediatric Care Unit and the Neonatal Surgical Unit to form a new contiguous Critical Care facility. The capital scheme will commence in April 2008 and will open in October 2008. This important scheme will support the growth in specialist activity at the Trust and provide appropriate post-operative care for children undergoing complex surgery or other treatment. It will also reduce the risk associated with caring for children with complex needs on general inpatient wards.

Specialist Obesity Services

In line with national and local priorities, the Trust expects to establish a new specialist Obesity Service for young people aimed at treatment for those who might otherwise require surgery. The aim is to establish a small service for a maximum 40 patients to provide lifestyle and drug interventions for significantly overweight individuals. The service would be multi-disciplinary and provide intensive support to patients for up to a year. The service would be evaluated to inform future service provision for both adults and children.

Paediatric Cancer Services

Following recognition by the Trust as a Principal Treatment Centre for paediatric and young people's cancer, over the next two years the Trust will work with commissioners to implement an action plan to meet the Improving Outcomes Guidance standards for this service.

Strengthening specialist medical services

During 2008/9 the Trust will work with commissioners and other partners to strengthen two particular services. Paediatric Cardiology requires the development of the Leeds Cardiology service and clinical network across Yorkshire and Humber. It is expected that the Trust will be recognised formally as part of the network, offering shared care and with the Leeds service outreaching to Sheffield. A new partnership with Leeds for the provision of Rheumatology services on an outreach basis will also be established in the year ahead, following the retirement of the rheumatologist providing the service currently.

Development of Genetic and Specialist Pathology services

The Specialist Genetic and Pathology Services have developed substantially over recent years and the Trust is well placed to take forward opportunities for further development in this area in 2008/9.

e) IMPROVING THE LIFE CHANCES OF VULNERABLE CHILDREN AND YOUNG PEOPLE

The Trust provides a number of services for vulnerable children and will continue to work in partnership with partners including the Local Authority and the Sheffield PCT to develop these services to make improvements to health and life chances.

Sheffield children and young people's mental health services (CAMHS)

During 2008/9 CAMHS will develop further links to professionals working within Service Districts to support the development of capacity at Tiers 1 and 2, including mental health promotion and programmes to support emotional well-being.

The Trust will work with the Sheffield City Council on a national pilot providing multi-systemic therapy to young people with behavioural problems. Working with multi-agency partners, the Trust will develop CAMHS services in line with the agreed city-wide CAMHS strategy.

Tier 4 Mental Health services

The Trust will develop a Full Business Case for the development of a single site Tier 4 CAMHS which will replace services currently provided at Oakwood Young People's Centre and Shirle Hill. Plans for this development have been considered by commissioners who have notified the Trust of their wish to purchase services for those aged 16-18 in addition to the services up to age 16 currently provided by the Trust. This is in line with the national commitment to provide age appropriate mental health services for those aged 16-18 by 2010. It is expected that the Trust will commence work on a capital scheme for the single site Tier 4 service later in 2008/9.

Safeguarding and Child Death Review service

The Trust is committed to providing effective safeguarding and child protection services for children and young people and provides expert medical support in child protection within the city. Commissioners have requested that the Trust develops a new service to support a new Child Death Review service, an extension of the Sudden Infant Death service. The Trust will work with commissioners to establish this new service in 2008/9.

Review of Neurodisability Services

The Trust provides a number of inter-related and integrated services to support children with a range of neurodisabilities, provided on multi-professional basis at the Ryegate Centre, in community settings and also by CAMHS. The range of services provided to assess children is good as are links with other agencies. However, access arrangements are complex and there is a need to review clinical pathways through these services to ensure effective and timely treatment and to support the delivery of the 18 week wait. In view of this the Trust will work with partners to undertake a review of services in 2008/9.

f) HELPING TO KEEP CHILDREN HEALTHY

The Trust will take measures to support children and young people to stay healthy through working with partners involved in the 0-19 Partnership in the development of health promoting strategies. The Trust will take an active involvement in the Safeguarding Board, the CAMHS Strategy Group, and other multi-agency groups. The Trust will also develop strategies internally to promote healthy eating and support active lifestyles. The Emergency Department will provide accident prevention and other health promoting advice to children and families, and the new Obesity Service will also support this goal.

4.5 RESEARCH AND DEVELOPMENT

During 2007/08 the Sheffield Children's NHS Foundation Trust:

- Hosted 54 clinical trials and 84 research projects
- Mounted successful bids for external research funding amounting to £1.3m and has attracted potential trial income of over £100k
- Published 71 research articles in peer review journals
- Supported 10 new projects through Sheffield Children's Hospital Charity funding with the ongoing support of a further 26 projects

Networking Research

The introduction of the new R&D Strategy 'Best Research for Best Health' in 2006 has helped the Trust focus its attention on the role of research within a children's service. The aim of the strategy is to ensure that research is targeted towards areas of important health need and is used to promote better outcomes for children. The National UK Clinical Research Network (UKCRN) was formed as part of this strategy and facilitates a networked approach to the conduct of high quality research.

Sheffield Children's NHS Foundation Trust is affiliated to a number of research networks around the UK and this optimises the output of our research findings. In total the Trust has 48 research projects which are considered part of the national UKCRN research portfolio.

The Medicines for Children Research Network (MCRN) has six local networks (LRNs) across England. We are an integral part of the Trent LRN and work closely within it to promote the conduct of research which ensures that medicines are optimised for use in children. We are currently actively involved in nine MCRN studies and are undergoing feasibility exercises for four more.

The Trust also plays an active role in the Dementias & Neurodegenerative Diseases Research Network (DeNDRoN) in which, because of our extensive work in Genetics and in particular Juvenile Huntington's Disease (JHD), we have two current DeNDRoN projects led by clinicians within the Trust.

The Comprehensive Research Network (CRN) covers the whole of England and is divided into Comprehensive Local Research Networks (CLRNs). We are an active member and work closely with South Yorkshire CLRN (SYCLRN). SYCLRN is still in development and will support the safety and organisation of research as well as providing valuable support to enable the conduct of research.

The Devices for Dignity (D4D) Health care Technology Co-operative has been established to bring together patients, doctors, scientists and manufacturers to boost the development of new technology and products which will help patients with long term disorders maintain and improve their quality of life. The Trust is pursuing a number of areas where this may benefit children.

Research Directorate

In 2007 the Trust took the bold step of making research a directorate in line with other core activities. This is intended to raise the profile of paediatric research locally and nationally and to ensure that new and helpful research findings are quickly integrated into clinical practice. This is a forward looking development that should provide a framework to develop research activity in the Trust.

Clinical Research Facility (CRF)

The CRF was officially opened in January 2008 by the Rt Hon Mr Alan Johnson, Secretary of State for Health. The facility, which is the first dedicated children's CRF in the UK, provides research space and staff to help investigators to undertake high quality research. Its provision consists of three bedrooms and two consulting rooms as well as a lab and sample preparation area. A Research Nurse supervises the work which is conducted in the unit and also works on a number of ongoing research trials. In addition, the staff in the CRF can provide expert advice and support in the formulation and preparation of research grant applications and assistance through the governance process. There are currently nine ongoing studies being conducted in the clinical area and this is anticipated to increase to around 15 by the end of the summer.

4.6 EMPLOYMENT POLICIES

The Trust has a programme for reviewing all policies which is jointly agreed with staff side and significant progress has been made over the last year in updating existing policies as well as developing new policies in line with new legislative requirements and best practice. These are approved by TEG (Trust Executive Group), JNCC (Joint Negotiation and Consultation Committee) and by the Human Resources Committee (a sub Committee of the Trust Board). Final ratification occurs at Trust Board. Policies are communicated to all staff through the intranet and managers are briefed and/or trained to ensure successful implementation.

4.7 POLICIES SUPPORTING EMPLOYMENT OF DISABLED STAFF

The Trust continues to discharge its duties in relation to the employment of

disabled people. It has the Positively Disabled Two Ticks award and discharges its duties under the Disability Discrimination act.

Policies applied to promote equality in relation to disability are based on the five commitments made by the Trust as part of the national Positive About Disabled People 'Two Ticks' initiative.

The award of the symbol means that the Trust meets the following commitments:

- To interview all disabled applicants who meet the minimum criteria for a job vacancy and consider them on their abilities.
- To ensure there is a mechanism in place to discuss at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities.
- To make every effort when employees become disabled to make sure they stay in employment.
- To take action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.
- Each year to review the five commitments and what has been achieved, to plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans.

Displaying the Disability symbol on our advertisements helps make it clear to job applicants that we welcome applications from them, are positive about their disability and value their contribution. The Recruitment and Selection training course for managers emphasises the need to focus on what disabled candidates can do, the importance of working jointly with the disabled candidate to identify reasonable adjustments to minimise or overcome any barriers, and the need to become a 'disability confident' organisation.

Staff who disclose a disability are typically referred to our Occupational Health Service in the first instance, who provide advice on the condition and any adjustments, redeployment where appropriate, and/or training which may be beneficial. The Trust has established links with the Government's Access to Work service, which has provided part-funding for several employees who have become disabled over the last year. The Support Staff Development Worker has developed links with the disability charity the Shaw Trust, particularly with regard to training for dyslexic staff.

The annual Personal Development Review process paperwork includes a question for managers to discuss with staff what can be done to ensure they can develop and use their abilities (including training or reasonable adjustments to enable development). The review process ensures all employees have a Personal Development Plan and explicitly discuss career development.

4.8 COMMUNICATION AND CONSULTATION WITH STAFF

Information is communicated to staff within the Trust in a number of ways, many of which also provide the opportunity for staff to be consulted on key issues:

Trust and Members' Newsletters – produced on a quarterly basis to keep staff and members up to date with key initiatives/developments within the Trust along with information on the strategy and financial performance of the Trust.

Governors' Bulletin – circulated monthly to governors bringing to their attention key issues and events from both within the Trust and other health care organisations. The bulletin also informs governors of up and coming events, presentations and training sessions.

Governors' Forum – electronic forum accessible to all of our governors which is password secured. The forum allows governors to raise and discuss issues with their peers.

Open staff meetings – meetings are held **during the year**, hosted by the Chief Executive and Executive Director team. All members of staff are invited to the briefings which provide an opportunity for all staff to discuss the overall performance of the Trust during the year. Both service and financial outline plans for the following year are also presented to staff. The meetings are an opportunity for any member of staff to raise any questions or concerns on any other matter relating to the Trust and its services.

Departmental Meetings – information is cascaded from Trust Board, Trust Executive Group and Directorate Board meetings through departmental meetings.

Team Brief – key messages from the Trust Executive Group meeting are summarised in the Team Brief which is circulated to all staff within the Trust.

'All Employees' messages – e-mail is used to communicate key messages to all staff on a regular basis.

Staff Suggestion scheme –provides staff with a further forum for submitting ideas and providing the Trust with feedback on day to day issues.

Away Days – held by a number of directorates/departments within the Trust.

Raising the awareness of employees of the financial and economic factors affecting the Trust's performance is ongoing and is a standing agenda item at the JNCC (Joint Negotiation and Consultation Committee) which brings together Executive Directors, Senior Managers and Staff side representatives on a monthly basis. In addition, away days are held twice each year and where topics such as 'Partnership Working', 'Improving Working Lives' and 'Strategy and Performance' are discussed.

Staff Side have representation on a number of the key committees including the Human Resources Committee, the Diversity and Public Involvement Group and the Health and Safety Committee.

The National Annual Staff Survey also provides a mechanism for staff to communicate their feelings about the organisation, the outcome of which is communicated to all staff and an action plan is developed to address issues of concern.

5. Operating and Financial Review – Operational Reporting

"Our aim is to provide care and treatment of the highest standard to the children and young people of Sheffield, South Yorkshire and beyond, working closely with children and their families, other partners, and our staff to improve the health, well-being and life chances of the younger population"

5.1 BRIEF HISTORY AND PRINCIPAL ACTIVITIES

As a provider of integrated health care, including community and mental health care as well as acute and specialist services, the Trust has already moved towards a broader, more comprehensive approach to supporting children and families. Our aim is to be at the forefront of best practice in delivering high quality care to children and young people.

The Trust provides its services in a large number of different locations. The majority of acute care is delivered at the Sheffield Children's Hospital which was first built in 1876. The hospital is situated on Western Bank, in a central location in the city. It is in close proximity to the Universities and to the Royal Hallamshire Hospital.

Our community and mental health services are provided from a number of locations. The main ones include the Ryegate Centre which is situated a mile away from the Children's Hospital in the South West of the city. It provides a focus for the delivery of services to children with disabilities, including those with complex neurodisability. Our mental health services are provided from a number of community sites across the city of Sheffield, including Shirle Hill, Centenary House and Oakwood Young People's Centre.

The Trust provides an exceptionally wide range of general and specialist services for children and young people across South Yorkshire and beyond on an outreach basis.

- Highly specialised health care, for example, medical and surgical specialties treatment for children and young people. These services include neurosurgery, oncology, endocrinology, specialist orthopaedics, neonatal surgery, ENT, plastics including burns services, metabolic disease, respiratory diseases, gastroenterology, intensive care, cystic fibrosis and neurology. These services are provided to meet the needs of children and young people living across South Yorkshire, North Trent, Lincolnshire, and the Humber and in some cases from across the country.
- Secondary health care – providing a range of hospital services for the children and young people of Sheffield, including Accident and Emergency (A&E) services, orthopaedics, general surgery, general paediatrics, dermatology and diabetic care.
- Community based services – provided to the Sheffield population, including community paediatrics, child development, support for adoption and fostering, medical safeguarding advisory services and services for children with neurodisability.
- Mental health care – A full range of mental health care services for children and young people is provided, working closely with partner agencies in Sheffield. Services at tiers 2 and 3 and specialist services, such as forensic services and services for vulnerable children are provided. We also provide tier 4 services for the larger South Yorkshire/North Trent population.
- Specialist pathology and genetics – A number of highly specialised pathology services, including newborn screening and genetics are provided.

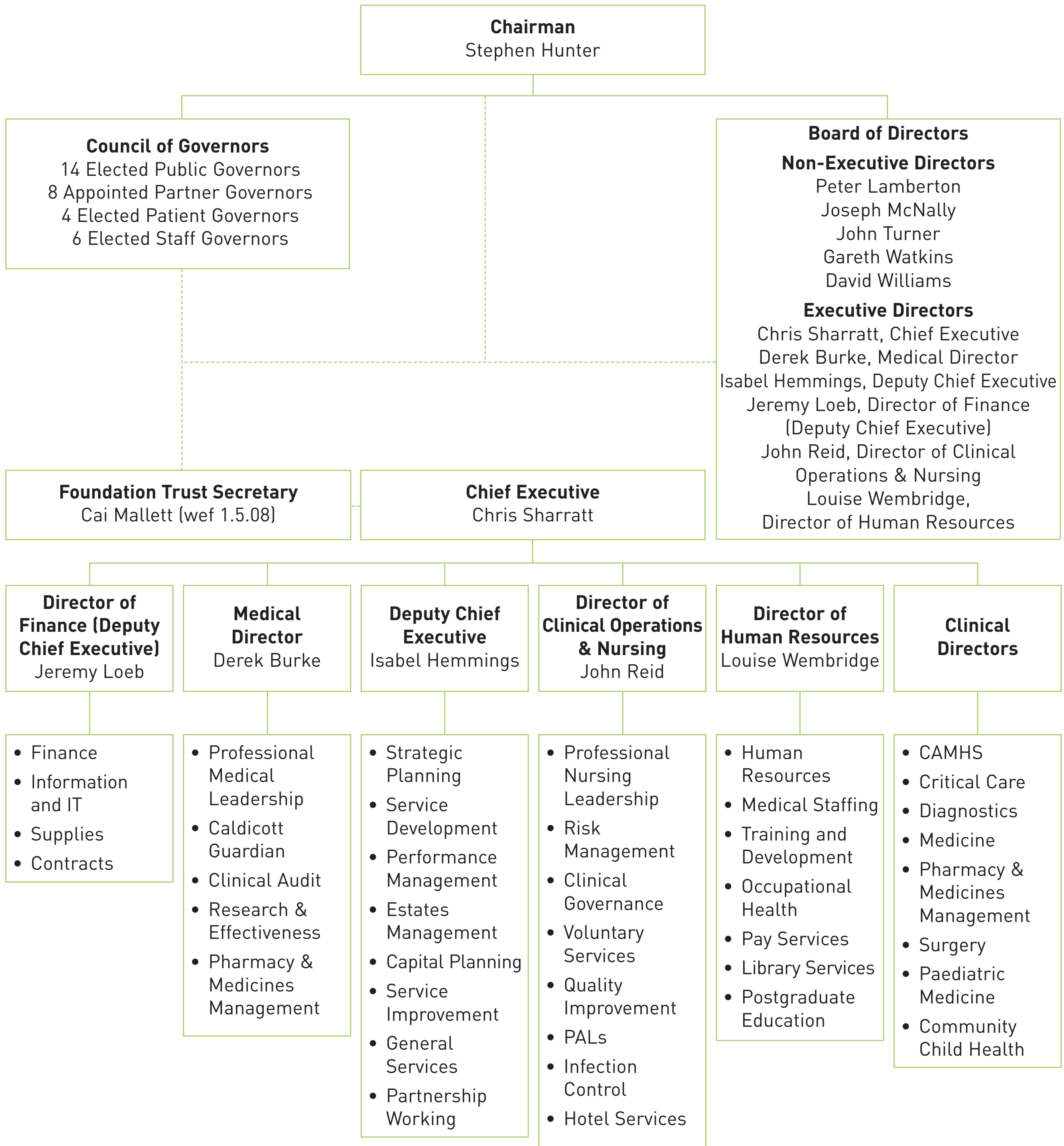
The Trust employs over 1,500 staff and had a turnover of £97.6 million in its first full year operating as a Foundation Trust. There are 165 inpatient beds, including 145 acute beds in the Sheffield Children's Hospital, eight respite care beds for children with specialised health needs at Ryegate Centre and 12 inpatient beds based at Oakwood Centre (specialist mental health provision). We also have a 20 place acute Day Case Unit, as well as day care provision for mental health patients and specific day care for oncology patients and for patients with Cystic Fibrosis.

As a teaching hospital the Trust works closely with our major academic partner, Sheffield University, playing a significant role in the education and training of doctors, nurses and other health professionals.

The Trust became an NHS Foundation Trust on 1 August 2006. Foundation Trusts were created under the Health and Social Care (Community Health and Standards) Act 2003 and are a key part of the reform programme in the NHS.

5.2 ORGANISATIONAL STRUCTURE

The Directorate structure which was established in 2005 is now firmly embedded within the Trust. The Trust has well developed clinical leadership with significant operational responsibility devolved to Clinical Directors and Directorate General Managers. These important roles are supported and guided by the Executive Directors. The structure of the organisation is illustrated in the diagram on page 22:


Chairman
Stephen Hunter
Council of Governors
14 Elected Public Governors
8 Appointed Partner Governors
4 Elected Patient Governors
6 Elected Staff Governors
Board of Directors
Non-Executive Directors
Peter Lamberton
Joseph McNally
John Turner
Gareth Watkins
David Williams
Executive Directors
Chris Sharratt, Chief Executive
Derek Burke, Medical Director
Isabel Hemmings, Deputy Chief Executive
Jeremy Loeb, Director of Finance (Deputy Chief Executive)
John Reid, Director of Clinical Operations & Nursing
Louise Wembridge, Director of Human Resources
Foundation Trust Secretary
Cai Mallett (wef 1.5.08)
Chief Executive
Chris Sharratt
Director of Finance (Deputy Chief Executive)
Jeremy Loeb
Medical Director
Derek Burke
Deputy Chief Executive
Isabel Hemmings
Director of Clinical Operations & Nursing
John Reid
Director of Human Resources
Louise Wembridge
Clinical Directors
Finance
Information and IT
Supplies
Contracts
Professional Medical Leadership
Caldicott Guardian
Clinical Audit
Research & Effectiveness
Pharmacy & Medicines Management
Strategic Planning
Service Development
Performance Management
Estates Management
Capital Planning
Service Improvement
General Services
Partnership Working
Professional Nursing Leadership
Risk Management
Clinical Governance
Voluntary Services
Quality Improvement
PALs
Infection Control
Hotel Services
Human Resources
Medical Staffing
Training and Development
Occupational Health
Pay Services
Library Services
Postgraduate Education
CAMHS
Critical Care
Diagnostics
Medicine
Pharmacy & Medicines Management
Surgery
Paediatric Medicine
Community Child Health

5.3 KEY AIMS AND OBJECTIVES

The Trust has identified 10 Strategic Objectives which are key to meeting the aspirations described in the Trust's Mission Statement. Over the next five years our services will be developed in line with these objectives. We have identified a number of Key Performance Indicators (KPIs) to ensure that we have a method for measuring our success in developing our organisation in line with our overall strategic aims.

The Strategic Objectives and the KPIs which will be used to measure our success are given below:

These broad objectives were translated into specific actions for 2008/9. Each action has been assigned to an Executive Director, with a regular review of progress against the Corporate Plan. Quarterly progress updates are provided to the Board of Directors. A traffic light rating is used to determine the level of progress made.

There were 35 objectives in our 2007/8 Corporate Plan, resulting in 78 specific actions which were given a traffic light at the year end to determine the level of progress. At 31 March 2008, 77 (98.7%) of the actions had been rated as achieved or on target to be achieved in the near future.

There was only one action that the Trust had failed to deliver as planned which was the development of a model contract governing outreach clinics. This contract for use with other providers is currently in the final stages of being completed but is not currently in place.

STRATEGIC OBJECTIVE		WHAT WE WILL DO	KEY PERFORMANCE INDICATORS
1	**We will provide top quality and accessible services for children and young people**	We will provide care and treatment of the highest quality, which is accessible, evidence-based, effective, and safe and provided in holistic manner exclusively for children and young people.	Performance against Standards for Better Health. Access targets. Patient satisfaction surveys.
2	**We will provide locally delivered care wherever possible**	We will provide care as close to home as possible, expanding our services in local hospitals and setting up more community based services.	Number of services held off site. Number of patients seen in other settings.
3	**We will expand and develop our specialist services**	We will develop our range of specialist services, strengthening our role as a national leader in the care of children and young people with complex health problems.	Referral rates to specialist services. Activity levels.
4	**We will work with others to improve the life chances of children and young people, particularly those who are most vulnerable**	We will work in close partnership with other organisations to support children and young people who are particularly vulnerable, such as those who have mental health difficulties, disability, are looked after or at risk in other ways.	Involvement in partnership measured by attendance at partnership events. 0-19+ Partnership agreed performance indicators. CAMHS access waits. Child Protection standards compliance. Number of health assessments of Looked After Children.
5	**We will keep children healthy**	We will work in close partnership with other organisations to contribute to the broader agenda of keeping children healthy.	Involvement in 0-19+ Partnership. 0-19+ Partnership performance targets.
6	**We will involve children and their families**	We will ensure families and carers are enabled to fully participate in the care and treatment of their child and that children and young people themselves are, where possible, empowered to make decisions about their own care.	Patient satisfaction surveys. Number of members under age 18. Number of Associate members.

STRATEGIC OBJECTIVE		WHAT WE WILL DO	KEY PERFORMANCE INDICATORS
7	**We will recruit, develop and retain competent and committed employees**	We will ensure that care and treatment is provided by staff suitably trained and experienced in the needs of children and their families. We will support all of our staff in developing the skills and behaviours necessary to deliver organisational success, in an environment that encourages them to achieve their full potential.	HR indicators including - sickness absence rates - staff turnover - agency staff usage. Improving Working Lives practice plus. Staff satisfaction surveys.
8	**We will lead training and research in children's health care**	We will promote best practice in the care of children as a provider of education and training and in actively supporting research and service evaluation.	Staff training activity. Research activity and income.
9	**We will provide care in a high quality environment**	We will ensure that care is provided within an environment suited to the needs of the child or young person and with appropriate facilities and equipment and with high standards of cleanliness.	Estate efficiency standards. PEAT ratings. MRSA ratings. Patient satisfaction surveys.
10	**We will ensure our organisation is effectively managed, well governed and uses resources effectively and efficiently**	We will ensure that the organisation is effectively governed and managed. We will ensure that our systems, process protocols and care pathways support the efficient delivery of all our services.	Key financial indicators including - income and expenditure - cash flow - balance sheet. Performance against 10 High Impact Changes. Performance from external assessment i.e. Audit Commission studies.

5.4 KEY OPERATIONAL PERFORMANCE

5.4.1 ANNUAL HEALTH CHECK

The Healthcare Commission assesses all Trusts in England each year through the Annual Health Check process that was introduced from April 2005. There are two main parts of the Annual Health check and organisations receive two separate performance scores for the 'Use of Resources' and 'Delivering Quality Services'. The "Use of Resources" rating will be determined by the financial risk score allocated by the independent regulator, Monitor.

The 'Delivering Quality Services' rating is derived from a number of components and these are illustrated in the diagram below:

Getting the Basics Right	THE ANNUAL HEALTH CHECK	Making and Sustaining Progress
Performance against Core Standards Performance against Existing Targets		Performance against new National Targets

All Trusts will be given a rating of excellent, good, fair or weak based on their performance against the aggregated components of the Annual Health Check.

In 2006/7, our Trust received a rating of Excellent against the Quality of Services element of the Health Check and Excellent against the Use of Resources.

The Healthcare Commission will publish the 2007/8 ratings in October 2008, however, we anticipate the ratings for the Quality of Services element to be good or excellent and the Use of Resources element to be rated excellent.

A self-assessment of our performance is listed below:

USE OF RESOURCES

Performance Measure	Self-Assessment
Compliance with Monitor Financial Risk Rating	A compliance rating of 5 (on a score of 1 to 5 with 5 being the highest)

CORE STANDARDS

Performance Measure	Self-Assessment
Compliance against Core Standards	Fully Met

EXISTING TARGETS

Performance Indicator	Target	Trust Performance	Self-Assessment
Cancelled operations – To maintain the standard that all patients who have operations cancelled for non-clinical reasons will be offered another binding date within 28 days.	< 0.8% cancellations < =5% breaches of 28 day standard	0.78% cancelled 1.04% breached 28 day standard	G
Convenience and choice – To ensure that every hospital appointment will be booked for the convenience of the patient.	100%	98.2%	G
Inpatient waiting times – To maintain the national maximum wait of 26 weeks for inpatients.	100%	100%	G
Outpatient waiting times – To maintain the national maximum wait of 13 weeks for an outpatient wait.	100%	100%	G
A&E waiting times – To maintain the maximum four hour wait in A&E from arrival to admission, transfer or discharge.	=> 98%	98.6%	G
Cancer 2 week wait – To maintain a two-week maximum wait from urgent GP referral to first outpatient appointment. The target measures the percentage of patients seen within this time-frame.	=> 98%	100%	G
Cancer 31 day wait – To ensure a maximum waiting time of one month (31 days) from diagnosis to treatment for all cancers. The target measures the percentage of patients seen within this time-frame.	=> 98%	100%	G

NEW TARGETS

Performance Indicator	Target	Trust Performance	Self-Assessment
Obesity – Compliance with NICE Guidance indicator – as an employer, to have plans in place for the development of public health policies to prevent and manage obesity.	Plans in place	Met	**G***
C Difficile – To submit complete and timely data on the numbers of C Difficile to the Health Protection Agency mandatory surveillance system for the four quarters of 2007/8.	Submission of data	achieved 2 of 3 data quality indicators	**A**
Emergency bed days – Improve health outcomes for people with long term conditions and to reduce emergency bed days by 5% by 2008 (from 2003/4 baseline).		14% increase in bed days	**R**
Data quality on ethnic group – To ensure that ethnicity data is recorded on Trust systems in order to monitor the reduction in health inequalities related to ethnic diversity.	High levels of reporting	87.6%	**G***
MRSA – Number of hospital acquired infections per 1,000 bed days.	< 2	0	**G**
Self-harm – To ensure that processes are in place to ensure compliance with NICE guidelines on the treatment and management of self harm in emergency departments.		Yes	**G***
Waiting times for diagnostic tests – To meet the national access targets for diagnostic tests. The target measures the % of people waiting longer than 6 weeks on 31 March 2008.	Expected measure: < 0.5% achieve between 0.5% and 1.5% underachieve	1.1%	**R**
18 week milestones – 85% of admitted patients and 90% of non-admitted patients should receive treatment within 18 weeks of referral by 31 March 2008.	85% admitted 90% non-admitted	85% admitted 94.5% non-admitted	**G**
Drug misusers – This indicator measures the Trust responses to questions relating to information, screening and referrer processes for this client group.		Yes	**G***

Key:

G	**Used to flag indicators that the Trust has definitely achieved as at 31.3.08**
G*	**Used to flag indicators that the Trust expects to achieve based on self-assessment**
R	**Used to flag indicators the Trust has not achieved as at 31.3.08 (see commentary below)**
A	**Used to flag an indicator where clarification is being sought from the Healthcare Commission**

The Trust achieved the 18 week milestone targets of 85% of admitted patients and 90% of non-admitted patients receiving treatment within 18 weeks of referral. This was a great success in part because the Trust managed to achieve this despite only receiving the necessary upgrade to the existing patient information system in February 2008. The achievement of the diagnostic target of no patient waiting over six weeks presented a significant challenge for the Trust as the Trust's single MRI scanner was out of service for a large part of March. The Trust achieved a score of 0.73% of reported patients not receiving their diagnostic test within six weeks, based on the tolerances from 2006/7 the Trust anticipates this will be viewed by the Healthcare Commission as underachieved against the target. The Trust was required to reduce the number of emergency bed days against a baseline set in 2003/4. The target is primarily aimed at long stay patients with chronic health issues and as such the Trust believes it is not helpful in assessing a paediatric trust's performance. The Trust has written to the Healthcare Commission to present a case for being excluded from being measured against this target.

5.4.2 ACTIVITY

The Trust had another successful year with respect to driving down waiting times, seeing more patients in its outpatient departments and delivering more day-case activity.

[1] The Trust, following agreement with Sheffield Primary Care Trust has changed the information system which records Mental Health contact information to one which is patient centred and records only contacts directly with a service user. This change in the categories of data recorded from previous years is the explanation for the indicated reduction in mental health contacts.

Whilst year-on-year activity comparisons must be treated with some caution due to changes in contracting and reporting currency, overall outpatient and elective clinical activity has increased.

Increasing day care activity is a key productivity measure for the Trust and during 2007/8 the Day Care Strategy Group has taken action which has resulted in a number of operational changes being implemented to maximise the use of the Day Care Unit within the Trust. The day case rate has decreased from 57.7% in 2006/7 to 54.8% in 2007/8. This was in part due to a change in the way medical oncology cases were recorded.

A&E attendances and emergency admissions were 56,552 in 2007/8 compared to 56,107 in 2006/7, an increase of 0.8%.

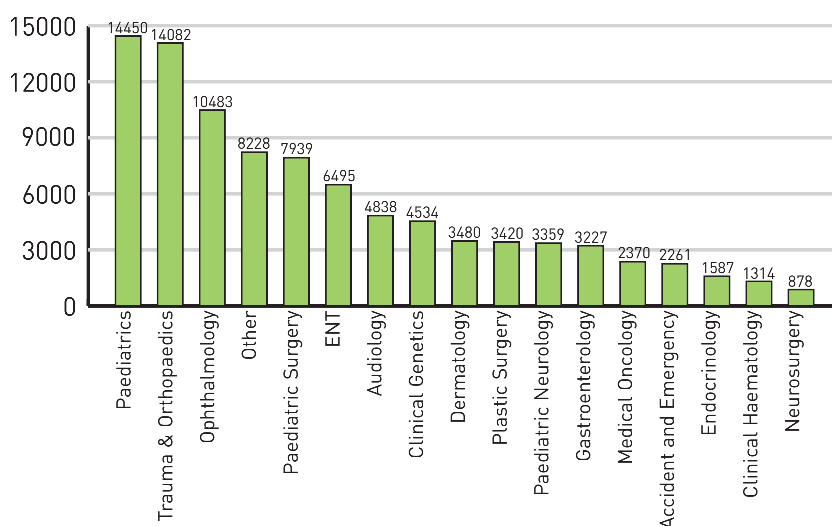
ACTIVITY IN 2007/8 AND COMPARISON WITH 2006/7 AND 2005/6

	2005/6	2006/7	2007/8	Growth 2006/7 to 2007/8	% Growth 2006/7 to 2007/8
Elective inpatient spells	4,931	4,847	5,427	580	12.0%
Day-cases	6,210	6,852	6,903	51	0.7%
Non-elective spells	9,537	9,365	9,664	299	3.2%
1st outpatient attendances	19,798	24,797	26,533	1,736	7.0%
Follow-up outpatient attendances	57,075	58,866	61,878	3,012	5.1%
Total outpatient attendances	76,873	83,663	88,411	4,748	5.7%
Clinical Genetics – 1st and follow-up appointments	3,582	4,340	4,534	194	4.5%
A&E attendances	48,508	46,742	46,888	146	0.3%
Therapy assessments and attendances	28,874	28,858	31,601	2,743	9.5%
Mental Health community contacts[1]	12,670	14,982	10,278	-4,704	-31.4%
Mental Health in-patients (bed nights)	3,713	4,156	3836	-320	-7.70%
Mental Health day-cases	2,519	2,350	2,279	-71	-3.0%

OUTPATIENT ACTIVITY

As can be seen from the chart our highest volume specialties are Paediatrics (including Diabetic clinics) 15½%, Trauma and Orthopaedics 15% and Ophthalmology 11%.

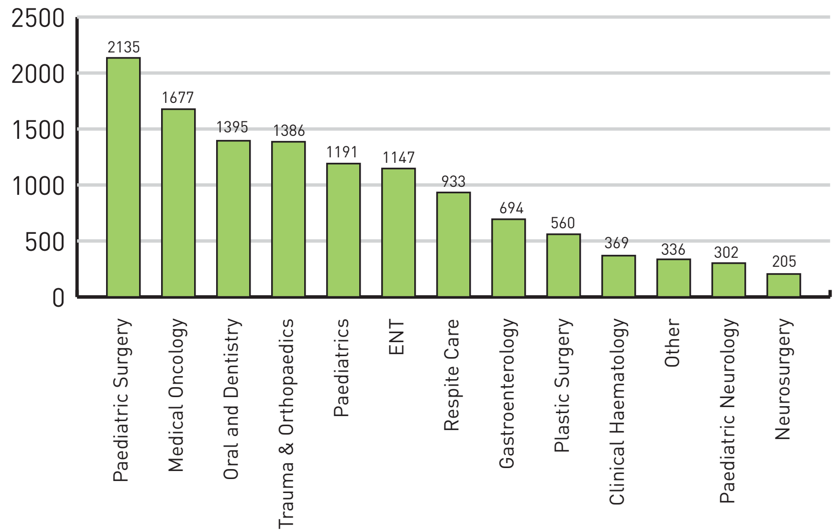
Outpatient Attendances by Specialty 2007-08



A summary of our activity by specialty is illustrated in the charts that follow:

ELECTIVE ACTIVITY
As can be seen from the chart our highest volume specialties are Paediatric Surgery 17%, Medical Oncology 14%, and Oral and Dentistry 11%.

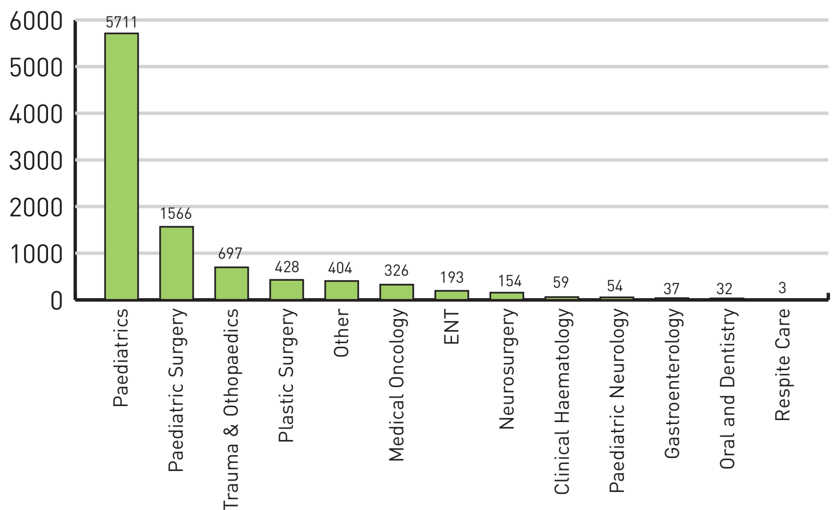
Elective (admitted from a waiting list)
inpatient spells by specialty 2007-08



NON-ELECTIVE ACTIVITY
As can be seen from the chart our highest admissions are from Paediatric Medicine 59%.

Detailed analysis of our financial performance against plan is included within section 8.2 of the financial review.

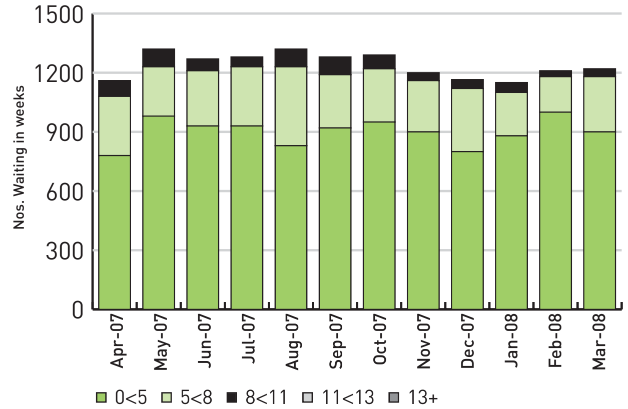
Non-Elective (admitted as an emergency)
inpatient spells by specialty 2007-08



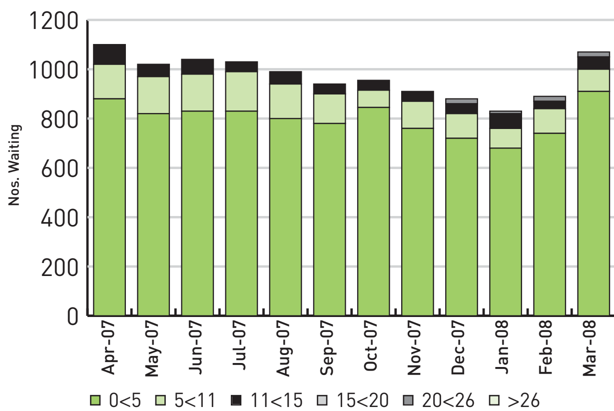
5.4.3 WAITING TIMES

The Trust also continued to reduce waiting times for patients as part of the on-going work to ensure that no patient will wait more than 18 Weeks RTT (from referral-to-treatment) by December 2008. The milestones for March 2008 were to ensure that 85% of patients admitted to hospital were treated within 18 weeks and that over 90% of non-admitted patients were treated within 18 weeks. The Trust achieved these targets. Graphs illustrating our performance are illustrated below:

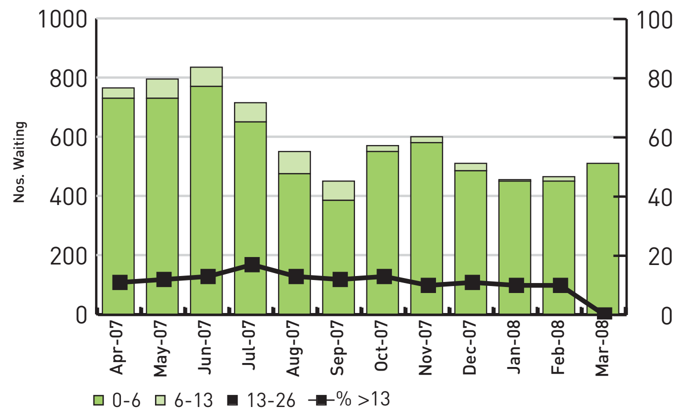
Number of patients on the outpatient waiting list (GP referred)



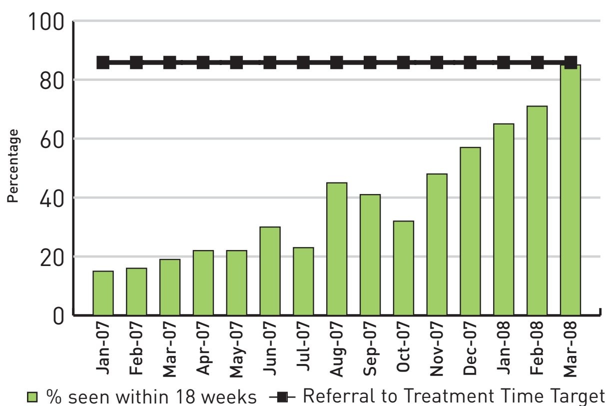
Number of patients on the inpatient waiting list illustrated by length of wait (in weeks)



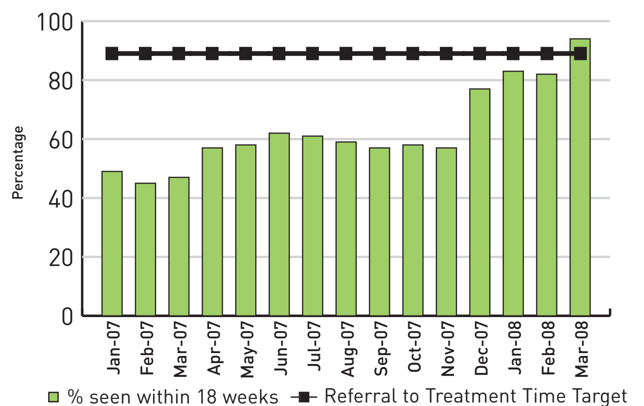
Patients waiting for a diagnostic test illustrated by length of wait (in weeks)



18 week wait pathway monitoring
% of admitted patients treated in 18 weeks



18 week wait pathway monitoring
% of non-admitted patients treated in 18 weeks



5.5 YEAR END POSITION

The Trust successfully managed its finances for its first full year as an NHS Foundation Trust, with a risk rating of 5 received from Monitor.

Please see section 8 for more detail relating to the Trust's performance against the criteria set out in its Terms of Authorisation, as reported in the annual accounts, the year-end financial position, and the prospects for 2008/9.

5.6 FUTURE TRENDS

The Trust has seen a year on year rise in referrals and activity levels, in each of the last five years. We would expect these trends to continue in 2008/9. Referrals to the Trust rose from 20,990 in 2006/7 to 23,987 in 2007/8 demonstrating an increase of 14.2% The Trust is well placed to continue to develop its specialist services. Nationally, recognition has been given to the importance of meeting appropriate standards of care when treating children in hospital. The review of services led by Professor Lord Darzi has highlighted the importance of high quality services for children. This echoes the growing realisation that these standards can only be achieved by a smaller number of regional centres forming the hub of a wider specialist network. The Trust is well placed for further expansion of services to meet growing demand. The recent and continuing expansion of High Dependency Beds provides capacity to treat more patients, and the Trust has also used the larger Day Case Unit and Acute Assessment Unit to provide for the increased need for short term care.

The Department of Health set out the policy for shifting care closer to home in *Our Health, Our care, Our Say*. The principle of only managing patients as inpatients if no alternatives exist has long been an approach adopted by the Trust, and the Trust has also identified a specific strategic objective in relation to its intention to provide more localised delivery of care. The Trust will continue to work with local hospitals to provide more care on an outreach basis within local hospitals. The Trust is also committed to working in partnership with the Sheffield PCT and the Sheffield City Council on developing more community based multi-agency services.

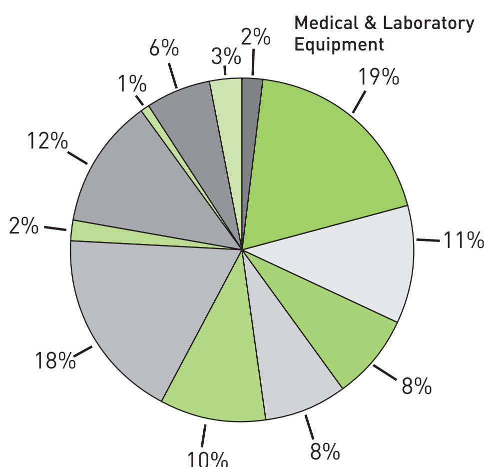
The Trust has now registered on the 'Extended Choice' network which means that as a Foundation Trust, Sheffield Children's Hospital will appear as an option on every primary care choice menu in England. If patients in other areas of the country would prefer to be treated at our Trust they will now have the option to be so. As part of the arrangements, the Trust will adhere to national guidance on the appropriate use of advertising and other marketing tools.

5.7 CAPITAL INVESTMENT

The pie chart below provides detailed information of investment for each individual element of the capital expenditure program. In total £3.6 million (excluding donated assets) was spent on capital investment projects during 2007/8.

Key areas of investment are shown in the pie chart below. Accommodation investment related to a number of minor schemes and also the expansion of outpatients. Professional services includes architect fees and estates staff costs. Flockton House was purchased for use by the CAMHS Directorate. The HDU investment was the first phase of investment in the expansion of the High Dependency Unit.

Capital Investment



Key - clockwise from:

- Medical & Laboratory Equipment £690,000
- Accommodation £393,000
- IT £287,000
- Plant Improvement £296,000
- Flockton House £357,000
- HDU/S1 Expansion £666,000
- Access Control £91,000
- 8/10 Northumberland Road £452,000
- Health and Safety £23,000
- Professional Services £221,000
- Genetics Expansion £124,000
- PACS £55,000

5.8 ENVIRONMENTAL RESPONSIBILITIES

The second year of the 'Earthcare and Health Care Energy Efficiency Campaign' we are running has continued to raise awareness of the environmental impact of energy use. Regular information bulletins are sent out to identify how everyone can contribute to saving energy both at work and in the home environment by making small alterations to how we operate and eradicating wasteful practices. The local energy representatives continue to police energy usage in their respective work environments and encourage colleagues to be as energy conscious as possible to help reduce the Trust's overall carbon footprint.

Useful energy saving and recycling opportunities which are provided via an email subscription service by the Friends of The Earth organisation are sent out to staff via the Trust's own email system to further encourage staff to be more environmentally aware and friendly.

In conjunction with our waste management contractor, a pilot scheme is underway in some areas of the Trust to collect and recycle paper and cardboard. It is anticipated that in time this project will be rolled out to other areas to increase our recycling performance.

In compliance with the Waste Electrical and Electronic Equipment (WEEE) Regulations, two fenced compounds have been built in which to store electrical and electronic equipment waste safely and securely prior to it being collected by our registered waste management contractor and taken to a suitable facility to be treated and recycled and residue disposed of in an environmentally sound and authorised way.

6. Operating and Financial Review – Patient Care

6.1 IMPROVING PATIENT CARE

One of the key roles of the Council of Governors is to provide a steer on how the Foundation Trust can carry out its business to meet the needs of its members and the wider community.

In the period Governors have formed a new sub-committee to look specifically at patient views. The Patient Feedback Committee has taken an overview of the work of the Trust to gauge patients and their carers' views. The Council of Governors as a whole looked at the results of the Picker survey in November 2007 and further work has been planned for the future to follow up on this.

As a Foundation Trust the organisation has the opportunity to work with members on the changes and developments of the Trust. During the period a number of members' events encouraged members to share their views with specific service areas. In addition, smaller projects were piloted including one involving members and CAMHS services where a poster was designed to feedback to patients the outcomes of their completed satisfaction surveys.

Further detail relating to the Council of Governors and their role in helping to shape patient care is available in Section 9 of this report.

6.2 PATIENT TARGETS

The Trust is anticipating meeting all of the national key patient targets. Detailed information is contained within section 4.4 of this report.

6.3 STANDARDS FOR BETTER HEALTH

Each year the Trust is assessed against the Standards for Better Health. This comprises 24 core standards. The Trust declaration and its performance against national performance targets are used to produce a scoring on the Annual Health Check of all NHS trusts. The score is widely reported by the Healthcare Commission.

The Trust was able to declare itself as compliant against all standards for the whole of 2007/8. The declaration has been published on the Trust Internet site.

The Trust was able to make a declaration of compliance against the new Code of Practice on Prevention and Control of Health care Associated Infection, as part of this process.

The evidence for the declaration has been scrutinised and approved by the Council of Governors, Patients Forum, Local Authority Children's Overview and Scrutiny Committee, Sheffield Safeguarding Children Board and Internal Audit.

6.4. EXTERNAL IMPROVEMENT REVIEWS

The Trust participated in several external reviews of quality in the past year.

6.4.1 URGENT AND EMERGENCY CARE REVIEW

The objectives of the review are to support improvement in the performance and value for money of urgent and emergency care services and to highlight key national issues in urgent and emergency care.

The main output from the review will be the assessment of the quality and value for money of local urgent and emergency care services across each area in England, which will include a summary score for these services.

This score is intended to provide assurance to patients and the public about the quality of services and act as a basis for identifying areas for local improvement. It will be backed up by a range of detailed indicators, including information about each of the main services providing urgent and emergency care.

The Trust has supplied data for this review and awaits publication of the report.

6.4.2 NHS LITIGATION AUTHORITY

The NHSLA is a Special Health Authority, established to administer the Clinical Negligence Scheme for Trusts (CNST), expanded to cover Liability to Third Parties Scheme and the Property Expenses Scheme which cover the cost of legal liabilities to third parties and property losses. An integral component of these schemes is the promotion of good risk management, governance and assurance. Membership is voluntary with funding on a non profit basis with organisations receiving a discount on their contributions where compliance with the relevant NHSLA risk management standards can be demonstrated.

In 2007, the Trust cooperated in piloting the new standards and was successful in achieving Level 1 of the new NHSLA Risk Management Standards for Acute Trusts. This accredits the Trust with having policies and procedures which meet the NHSLA requirements for safety.

6.5. ORGANISATION WIDE QUALITY – PATIENT SURVEY

The Trust commissioned Picker International to carry out a children's and young people's survey based upon the question set used in the 2004 national survey. The survey involved a random sample of 850 young people who had previously been inpatients at the trust. The questionnaire was mailed out with two reminders between April and May 2007 with a 47.2% response rate.

6.5.1 KEY AREAS WHERE WE REMAINED ABOVE AVERAGE IN COMPARISON TO THE 2004 NATIONAL BENCHMARK

- Doctors and nurses knowledge of the child's condition/treatment
- Overall rating of care
- Environment
    - Cleanliness
    - Visiting

- Communication
  - Staff
  - Involvement of parents and children in decisions
  - Explanation of surgery
- Discharge
- Dignity and Respect
- Overnight stay for parents

6.5.2 AREAS WHERE THERE HAD BEEN SOME DETERIORATION IN THE TRUST'S PERFORMANCE

- Emergency – >1hr to admit to ward
- Emergency – care not organised
- Hospital – ward did not look nicely decorated
- Hospital – toys or entertainment fair/poor
- Hospital – child bored most or all of time
- Hospital – food poor or fair
- Staff – contradict each other
- Medicines – side effects of new medicines not explained
- Discharge – not told who to contact if worried

6.5.3 ACTION PLAN

The ward staff, Patient and Carer's Council and Council of Governors have all been involved in drawing up a comprehensive action plan to improve on these areas. Actions include:

- Refurbishment of kitchen and restaurant facilities;
- Installation of free bed end computers/telephone/tv facilities to all areas by end of 2008-09;
- Appointment of ward based pharmacists;
- Nurse led discharge project;
- Expansion of acute admissions ward.

6.6 INFECTION CONTROL

Over the course of the year, the Trust has consistently been amongst the lowest in the country in its infection rates in relation to MRSA and Clostridium Difficile.

There were no new cases of MRSA Septicaemia identified in 2007/8.

Infection control continues to be a high priority for the Trust, with a number of initiatives designed to reduce infection transmission:

- Clean your Hands campaign, augmented by "naked below the elbows campaign";
- Opening of a new two bedded infectious isolation facility in summer 2007;
- Ward cleaning initiative – the daily cleaning on each ward is now supplemented by a team of domestics who clear and deep clean each clinical area weekly. This has been funded recurrently, extended to equipment cleaning and now incorporates outpatient/diagnostic areas;
- Increased Infection Control Nursing hours.

The Trust infection control team, led by Dr P Fenton, Consultant Microbiologist leads on the above preventative initiatives. They are supported by link nurses in each department. Individual cases of infection are regularly reviewed and consultants advised on containment and treatment.

6.7. DIVERSITY

The Trust is committed to diversity and equality. Over the last year we have improved access to facilities and services by reviewing compliance with new equalities legislation. The Trust impact assesses all new policies for their effect on minority groups.

Regular and improved reporting from the HR department has been based upon the Electronic Staff Record. This has resulted in improved analysis of staff turnover, promotion, disciplinary and other interventions on minority groups. Information from this has contributed to the formulation of new policies.

The Trust Equality Scheme has been updated this year and published on the internet site. A pilot post has been established to ensure disabilities compliance in all new planning applications and schemes. This post is currently under review and may be made recurrent.

6.8 PATIENT CARER INFORMATION AND INVOLVEMENT

6.8.1 INTERNET SITE

The Trust web site has information about many aspects of the services patients can access. It is designed to provide patient members access to more details about the Trust, minutes of meetings and service development. Updates are regularly provided and links are maintained to other important local sites such as the Sheffield Children's Hospital Charity, HR vacancies site and other local NHS Trusts. Access is provided to hundreds of patient information leaflets including, for example, how to prepare for a visit to the Trust.

The Trust has a number of ways of involving patients and parents.

6.8.2 COUNCIL OF GOVERNORS

The Council of Governors forms the core of the patient and carer involvement in the business of the Trust. Governors are encouraged to work both formally and informally with the Trust on various developments. In their capacity as representatives of their communities Governors also encourage their members to feedback to the Trust views and suggestions.

6.8.3 PATIENT AND CARER ADVISORY GROUP

This comprises a group of young people and their carers who meet quarterly to discuss developments in service, comment on patient access and give a users' viewpoint to senior Trust staff. The Council is chaired by the Trust Chairman and is attended by senior Executives and Patient Advice and Liaison Service (PALS) officers.

Topics discussed during the last year include review of:

- Trust Financial Position;
- Child and Adolescent Mental Health Services (CAMHS);
- Patient Information;
- Catering;
- Patient Survey;
- Clinical Research Facility.

6.8.4 PUBLIC & PATIENT INVOLVEMENT FORUM (PPIF)

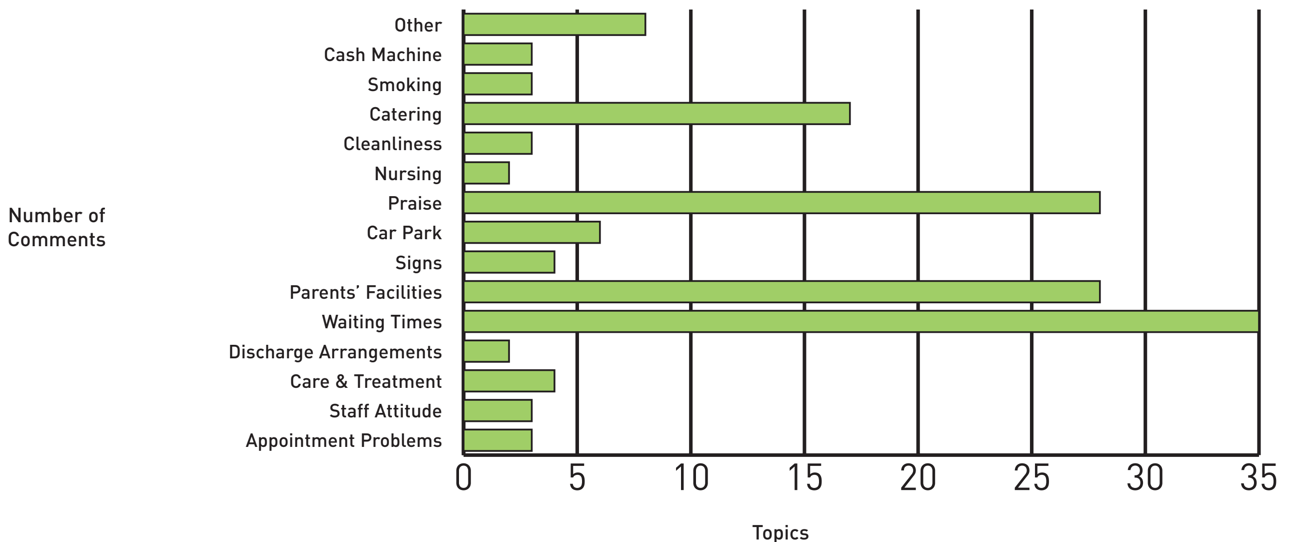
The PPIF has continued to provide an independent scrutiny of Trust operations and community public health. The Forum has been dissolved as part of a national review of patient involvement. Many of the members are likely to join the emerging Local Involvement Networks (LINks). Other areas of activity include:

- Reviews of cleanliness standards;
- Review of Sheffield dental services;
- Participation on the local authority Child Oversight and Scrutiny Committee.

6.9 COMMENTS AND COMPLAINTS

6.9.1 COMMENTS AND SUGGESTIONS

All the Trust's clinical departments have comments and suggestions cards which are gathered by our Patient Advice and Liaison Service (PALS) on a regular basis. In the last year we have received 148 completed cards (see attached table). Comments range from dissatisfaction with outpatient waits to complaints about parent facilities, including sitting rooms and catering. Each comment is fed back to the department concerned and if a name and address has been supplied, a response is made directly to the individual with a description of the action taken. These comments have been very helpful in fine tuning our services and in many cases provide a greater resolution of issues than the patient surveys.



6.9.2. PATIENT COMPLAINTS

There has been an increase in the numbers of formal complaints received by the Trust from 47 during April 2006-March 2007 to 58 during April 2007-March 2008.

The National Health Service (Complaints) Regulations 2004 were amended on 1 September 2006. One effect of the amendments has been the change in the length of time for the Trust to respond to complaints. This changed on 1 September 2006 and is reflected in the table below.

The time scale for responses was 20 working days until 31 August 2006, after that time it extended to 25 working days – or longer – with the agreement of the Complainant. This means that the Trust is able to produce full and detailed responses in complex clinical cases within an agreed time scale.

All complaints are acknowledged by letter within two working days. The acknowledgement letter includes the issues that the investigation will cover, the process of handling the complaint and several contact details of Trust staff and the independent support agency.

Formal Complaints Performance	**2005/6**	**2006/7**	**2007/8**
Number of Formal Complaints received	70	47	58
Acknowledged within two days	69	47	58
Final response sent within 20 days (before 1/9/06) 25+ days (after 1/9/06)	48	14 19	32
Concluded after time scale (20 or 25 days)	14	9	8
Still being pursued	8	5	18

The principal reasons for patients' and parents' complaints can be seen in the following table. These are categories set out by the Department of Health. There is only one category that reflects all complaints about clinical treatment. The highest numbers of complaints are found in this category. The Trust is setting up a more detailed coding system for this topic to allow further analysis to take place.

Subject of Complaint	**2006/7**	**2007/8**
Admission, discharge, transfer	4	1
Aids, appliances equipment or premises	1	3
Appointments delay/cancellation (outpatient)	3	1
Appointments delay/cancellation (inpatient)	3	4
Attitude of staff	5	6
All aspects of clinical treatment	19	29
Communication to patient	4	3
Patient's privacy and dignity	1	1
Patient's property & expenses	0	0
Personal records	0	3
Failure to follow agreed procedure	4	3
Patient's status, discrimination (race, gender, age)	0	0
Transport (ambulances and other)	0	1
Policy/commercial decisions by Trust	1	0
Hotel services (include food)	0	0
Others	2	3
Total	**47**	**58**

In the event a complainant is not satisfied with the final response to their complaint, the complainant can refer their complaint to the Healthcare Commission who will review the internal complaint process and investigation as part of the second stage of the complaint procedure.

During the period 1 April 2007-31 March 2008, the Healthcare Commission (HCC) reviewed four complaints in comparison to six the previous year.

	Trust received complaint	Notified by HCC	Closed by HCC	Outcome
1	20 February 2007	2 July 2007	24 October 2007	Complaint upheld with recommendations
2	21 February 2007	17 July 2007	13 November 2007	Complaint upheld with recommendations
3	11 July 2007	7 November 2007	Remains open	Complaint upheld with recommendations to carry out further investigations
4	3 December 2007	19 March 2008		Awaiting decision

In all cases the main justification for upholding the complaint was that the Trust had not answered all the points in the original complaint. The Trust has reviewed its response writing process to ensure that all points are referenced and answered individually.

Learning from Complaints

The following improvements or reviews have been carried out as a result of Patient Complaints:

- Outpatient sister ensures any outcome forms are returned once the receptionist has left and they are placed in her office until the next day;
- There has been a review of the process for dealing with faxed test results to ensure they are acted upon by medical staff;
- Improved arrangements for notification of renal impairment to the Radiology department;
- Improved information for breast feeding parents receiving antibiotics.

7. Operating and Financial Review – Stakeholder Relations

We have maintained our strong working relationships with our local commissioners and key stakeholders. An effective commissioning and contracting process with Sheffield as the lead commissioner has led to the Trust agreeing the Legally Binding Contract and activity schedules in a timely manner to support the delivery of access targets. Regular meetings have been held with the collaborative commissioning group with no recourse to dispute resolution. The Collaborative Commissioning arrangement includes commissioning representatives from: Sheffield PCT, Rotherham PCT, Doncaster PCT, Barnsley PCT, Derbyshire County PCT and Bassetlaw PCT.

Our relationship with Yorkshire and Humber Specialist Commissioning Group (the consortium of North Trent Primary Care Trusts that commissions specialist services) is also strong and this can be demonstrated by joint planning work undertaken throughout the year in relation to specialist services, for example, critical care services and CAMHS Tier Four.

The Trust has a long tradition of working in partnership with local hospitals to deliver specialist services in local settings. The Trust provides a number of outreach services. These are summarised in the table below:-

Outpatient Services									
	Paediatric Surgery	**Neurology**	**Cystic Fibrosis**	**Renal**	**Gastro Enterology**	**Metabolic**	**Endocrine**	**Genetics**	**Ortho-peadics**
Barnsley	✓	✓		✓	✓	✓	✓	✓	✓
Doncaster	✓	✓	✓				✓	✓	
Bassetlaw	✓	✓	✓				✓	✓	
Rotherham	✓	✓	✓			✓	✓	✓	
Chesterfield	✓	✓					✓	✓	✓
Grimsby	✓	✓	✓		✓			✓	
Scunthorpe	✓		✓		✓				
Boston		✓							
Oakes Park	✓	✓							
Worksop		✓						✓	
Kings Mill									✓
Retford								✓	
Buxton									✓
Outreach Surgical Services The Trust employs surgeons who visit other hospitals on a regular basis to undertake day-case surgery, as shown below									
Barnsley	✓								✓
Chesterfield									✓

The Trust remains an active partner within the 0-19+ Strategic Partnership for Children and Young People within Sheffield. The Trust is involved in both planning and delivery of multi-agency services which support vulnerable children.

8. Operating and Financial Review – Finance

The accounts for the period 1 April 2007 to 31 March 2008 are included in full within section 19 of the report.

8.1 OVERVIEW OF FINANCIAL POSITION

In its first full 12 months as a Foundation Trust, Sheffield Children's Hospital has achieved a net financial surplus of £5.5m. This reflects patient income exceeding our start of year plans and lower than expected expenditure due to delays in recruitment and interest earned on cash held pending investment in the capital programme. This healthy position results in a short-term high return on capital and a strong liquidity position. Plans to invest surplus cash in the extensive capital programme will reduce the level of cash holdings over the next two years.

In the period, the Trust had no requirement to borrow against its prudential borrowing limit of £16.7 million set in its terms of authorisation.

Performance against the national 'better payment practice code' which requires the Trust to pay all valid non-NHS invoices within 30 days of receipt (or the due date, whichever is the later) has also remained at a high level with 96% of invoices paid complying with this measure (see Note 7.1 in the accounts).

8.2 INCOME AND EXPENDITURE

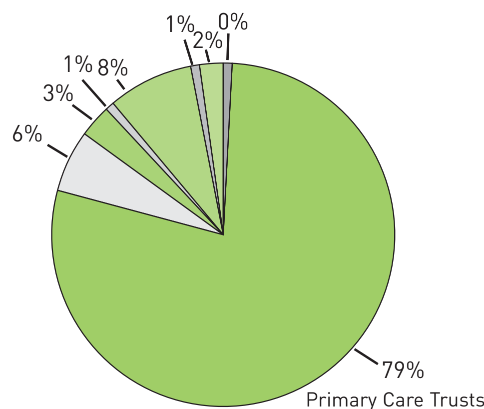
The net surplus generated was in excess of the net surplus planned for the year and mainly arose due to the following:

1. Total income was £3.2 million above plan. Patient related income accounted for £2.1m of this and the balance to grant funded project income. Non-elective surgical directorate income and elective medical directorate income exceeded plans. The medical directorate saw strong growth in bone marrow transplant and gastro enterological income. In surgery, a small over-performance on elective activity was achieved but this was not translated into over-performance on income for a number of reasons including case complexity and clinical coding issues.
2. Expenditure was £1.7 million below plan. This reflected delays in recruiting staff to reduce waiting times as well as recruitment difficulties in theatres and High Dependency Unit.
3. Interest received was £0.6 million above plan due to significant cash balances held pending commitment to capital schemes. These include the Higher Dependency Unit and the new decontamination service both of which open in 2008.

Total income from patient care activities for the 12 month period was £87.1 million. This represents 89% of total income. Income from non patient care income totalled £10.5 million or 11% of total income for the year.

Of the £87.1 million of patient related income, the Trust received £41 million of other income outside of the payment by results system (PbR). This is made up of a number of items, notably community services, mental health services, critical care services, tests, blood and drug recharges and other block contract income.

Analysis of Total Income for 2007-08

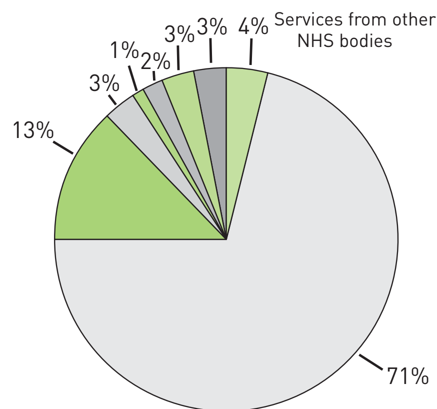


Key - clockwise from

- Primary Care Trusts £46,665,000
- NHS Foundation Trusts £5,815,000
- Department of Health £2,921,000
- Non NHS £1,328,000
- Education, training and research £7,674,000
- Charitable, and other contributions to expenditure £709,000
- Other income £686,000
- NHS Trusts £465,000

Total expenditure for the period totalled £91.4 million. The largest component of the Trust's expenditure is on salaries and wages. It employed an average of 1,530 whole time equivalent staff during the year at an overall cost of £64.6 million. A further £12.3 million was spent on clinical supplies and services used in providing health care to patients.

Analysis of Total Expenditure



Key - clockwise from:

- Services from other NHS bodies £3,519,000
- Staff & Directors' costs £64,650,000
- Supplies & services £12,293,000
- Depreciation and amortisation £2,755,000
- Clinical negligence £713,000
- Establishment £1,958,000
- Premises £3,028,000
- Other £2,451,000

8.3 KEY FINANCIAL RISKS

The Trust has exceeded its plan for its first full 12 months as a Foundation Trust. However a significant proportion of the financial surplus for the year is due to one-off factors which cannot be relied upon in future years. To maintain a strong financial base it is essential that the organisation continually assesses future financial risks and seeks sustained productivity and efficiency gains.

Key financial risks include:

Payment by Results (PbR) Income

The Trust, together with other children's hospitals, was successful in influencing changes to the PbR tariff for 2008/9. This addressed problems in the system which inadequately reimbursed specialist children's services.

However, the PbR system is reviewed on an annual basis and there is an intention to introduce a revised clinical coding system (HRG 4) for 2009/10. This determines the tariff the Trust will receive for its services. As a specialist hospital our income is very sensitive to these changes. The Trust is working with the Department of Health to understand the proposed changes and ensure they do not affect the Trust unfairly.

The Trust has also invested in costing systems to understand, in more detail, the relationship between its income and costs in each of its clinical directorates.

Clinical Activity Projections

Under PbR, our income is very sensitive to the number of patients which are seen by our doctors. The Trust's future income will be affected by a number of factors:

- The achievement of the 18 week waiting target in December 2008 will (all other factors remaining equal) reduce the level of activity undertaken by the Trust post 2008/09 and this will reduce income;
- The Trust has seen a growth in referrals to its specialist services. This is expected to continue and will go some way to offset the income reduction noted above;
- The Trust has also attracted growing numbers of non-local referrals and this is expected to continue;
- Plans to provide more primary care based services may act as a break on rising levels of referrals;
- The new standard contract, which all commissioners are seeking to introduce across the NHS, is not expected to have a significant affect on the volume of clinical activity which will be provided by this Trust. However the Trust expects to build on the good existing contractual relationship with commissioners by joint working on an incentive scheme. Under this arrangement the Trust will be financially rewarded for offering proposals which meet commissioning objectives. This may result in shifting some activity from hospital to the community to free up capacity to provide more specialist work;
- Revised arrangements for specialised commissioning are being introduced from 2008/9. The Trust is working with commissioners to understand the impact of these changes on our services.

Cost Management: The inability of the organisation to manage its cost base in the light of changes to the activity base as discussed above or the inability to achieve the required cost improvement programmes could have a significant financial impact on the Trust.

The national tariff includes an efficiency deduction of 3%. The internal efficiency requirement for 2009/10 and beyond will be determined in the autumn.

Directorates will face the dual pressure of budget reductions for both efficiency and for the likely reduction in required capacity following achievement of the 18 week waiting time target.

Directorate planning to resolve these pressures will start in mid 2008/9. Directorate financial positions are tightly monitored and recovery plans put in place where necessary.

Education and research income

National changes in the funding of research has resulted in a loss of £100K income in 2007/8 to support the Trust's research infrastructure and a further loss of £350K in 2008/9 will be incurred.

These reductions have been anticipated in the Trust's plans. As outlined in last year's report, the Trust and its associated charity have invested in a new clinical research facility (CRF). The Trust has attracted c£580K in new research income. In overall terms the negative impact to the Trust of losing funding through the national changes is hoped to be offset in the medium term by continued generation of new research income through the CRF.

As a teaching hospital, the Trust receives over £5.7m to cover its costs of supporting clinical education. A national review of the funding of education contracts for medical education may affect the trust from 2009/10 onwards.

This list of risks is by no means exhaustive. The Trust undertakes regular risk assessments and puts controls in place to pre-empt the impact of risks as far as is practicable.

8.4 INDEPENDENT ASSESSMENT

The Independent Regulator of NHS Foundation Trusts (Monitor) also assesses the Trusts financial performance using specific financial risk ratings. The Trusts performance against Monitor's 2007/8 financial risk ratings are shown right:

When assessing financial risk, Monitor looks at four criteria: achievement of plan; underlying performance; financial efficiency; and liquidity.

Achievement against each of these criteria is scored from 5 to 1. A weighted average of these scores is then used to determine the overall financial risk rating.

The risk rating is forward-looking and is intended to reflect the likelihood of a financial breach of the Terms of Authorisation. The ratings indicate:

Metric	Weighting	2007/2008 Actual		2006/2007 Actual	
		% Ratio	Rating	% Ratio	Rating
EBITDA margin	25%	10.7	4	9.3	4
EBITDA % achieved	10%	217.5	5	363.8	5
Return on Assets	20%	14.1	5	7.6	5
I&E surplus margin	20%	6.9	5	4.6	5
Liquidity ratio (days)	25%	84.5 days	5	84.7 days	5
Weighted average rating			5		4

- 5 = lowest risk, no regulatory concerns
- 4 = no regulatory concerns
- 3 = regulatory concerns in one or more components. Significant breach of Terms of Authorisation is unlikely
- 2 = risk of significant breach in Terms of Authorisation in the medium term
- 1 = highest risk, high probability of significant breach of Terms of Authorisation in the short-term

8.5 CAPITAL INVESTMENT

The Trust invested £4.76m in capital expenditure for the period, of which £1.11m was funded through donations.

Buildings used in the provision of health care are classed as 'protected' assets, whereas other buildings and equipment are 'unprotected'. The table right shows the expenditure for each of these categories.

Capital Investment Analysis for 2007/08	Total (£m)
Protected Asset Investment	2.0
Unprotected Asset Investment (Including equipment and IT)	1.6
Donated capital investment	1.1
Total capital Investment	4.7

More detailed information on the capital investment programme is included within section 5.7 of this report.

8.6 ACCOUNTING POLICIES

There were no changes to accounting policies during the year.

8.7 PRIVATE PATIENT INCOME

Under the Trust's terms of authorisation, the proportion of private patient income to the total patient related income should not exceed its 2002/3 proportion. The allowable percentage of the Trust was 0.2%. Private patient income from 1 April 2007 to 31 March 2008 was £84k compared to total patient related income of £87.1 million. This represents a proportion of 0.1%. The Trust is therefore compliant with its obligation under its terms of authorisation.

8.8 GOING CONCERN

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

8.9 THE SHEFFIELD CHILDREN'S HOSPITAL CHARITY

Sheffield Children's Hospital Charity was created in 1975, and over the past thirty-three years has been helping the Trust to enhance the quality of its services to children, young people and families. Resources are also made available to support the Trust's role as a world class centre for the research, prevention, care and cure of childhood illnesses.

During 2007/8, £1.74 million was donated by our generous supporters from across the region. The Trust is very grateful to everyone who has contributed to the Charity or been involved in the fundraising. The money will be used to make a huge difference to everyday life around our hospital, highlights include:

Medical Research

This year the charity has raised £250,000 to further child-centred research here at Sheffield Children's NHS Foundation Trust. The Clinical Research Facility, funded by the charity last year, was opened by the Secretary of State for Health, Rt Hon Alan Johnson and has been instrumental in recent bidding successes for over £1 million in national research funding.

Mobile Intensive Care Vehicle

The Charity has raised £173,000 to fund a new mobile intensive care unit – 'Bear 2'. This is a state of the art fully equipped vehicle designed by intensive care and ambulance staff to ensure that critically ill children can be stabilised and safely transported from district general hospitals to intensive care.

Patient Interactive Entertainment System

This year over £140,000 was raised to fund this project – the pilot of an integrated system to provide entertainment and educational facilities at every child's bed, free of charge. No other children's hospital in the country will have such a system funded in this way.

It will offer TV, radio, internet access, facilities for our hospital clinicians and teachers and will of course enable children to communicate more easily with their families and friends. The system has already been installed in one of our inpatient wards and is being rolled out to all areas by the end of the year.

Operating Microscope – Eye Surgery

Over £121,000 has been raised towards an enhanced operating microscope. This unit will enable microsurgery to be carried out on smaller children than previously and enhances our ability to carry out an extended range of specialist surgery.

For more information about our Charity and the projects undertaken, please visit:
www.sheffieldchildrenshospital.org.uk

9. Council of Governors

9.1 ROLE OF THE COUNCIL OF GOVERNORS

The Council of Governors has three key roles:

Strategic

Providing advice on the longer term direction for the Trust so that the Board of Directors can effectively determine its policies.

Guardianship

Ensuring that the Board of Directors conforms to the terms of the Trust's authorisation, acting in a trustee role for the welfare of the organisation.

Advisory

Providing a steer on how the Foundation Trust can carry on its business in ways consistent with needs of the members and the wider community.

The Council of Governors is responsible for:

- Working with the Board of Directors to discuss, advise and support the future development of the Trust;
- Acting as a source of ideas about how the Trust can provide its services in a way that meets the needs of the communities it serves;
- Representing the interests of the members;
- Being an essential link between the Trust and various partner organisations;
- Appointing and removing the non-executive directors, including the Chairman of the Trust;
- Setting the pay levels of the Chairman and non-executive directors;
- Approving the appointment of the Chief Executive;
- Appointing the Trust's financial auditors;
- Receiving copies of the Trust annual accounts, auditors' report and annual report.

In discharging its responsibilities, the Council of Governors has met formally four times during the year. As well as participating in other relevant sub-groups and other fora, Governors are involved in activities to communicate and seek the views of the Foundation Trust's members.

Throughout the year, Governors have worked jointly with the Board of Directors, on a review of their role and the interactions of the Directors with Governors. This has resulted in improvements in the way the Governors develop their knowledge of the Trust, and how their views are collected and shared within the Trust.

9.2 COMPOSITION OF THE COUNCIL OF GOVERNORS

The Council of Governors is chaired by the Chairman of the Board of Directors. Ms Lynn Hagger held this post until 31 January 2008 when Rev. Stephen Hunter succeeded her.

The Sheffield Children's NHS Foundation Trust, is governed by a Council of Governors, made up of 32 governors. Our Governors have an important role to play. It is through the Governors that the population served by the Foundation Trust will be directly involved in the management of the Trust.

The Council of Governors is composed of (14) Public Governors, (4) Patient and Carer Governors, (6) Staff Governors (8) Appointed Partner Governors. Public, patient/carer and staff governors are elected by members of the constituency they intend to represent. The elected Governors are split into 18 constituencies.

Elections to the Council of Governors

The patient, carer, public and staff members of the Council of Governors are elected from the membership by the members to serve for three years (half of elected Governors served two years in the first term to allow a rolling Council, thereafter all terms are three years). Elections took place in March 2006 and were held in accordance with the election rules as set out within the Trust's Constitution using an independent electoral service. Partner Governors are nominated and appointed by their respective organisations.

Following the resignation of two governors during the period, previous candidates were approached following approval from the Council of Governors. The candidates who had previously stood for election in their respective constituencies, and who had been the second highest polling candidates in each case, were approached to complete the terms of office of the previous governors. Abdirahman Mohamoud for Shiregreen/Burngreave and Donna Adams for Patients living in Sheffield both agreed to take up post.

In the case of two other resignations in January 2008 the Council of Governors agreed to hold vacancies until the next round of elections. Nominations for these positions have been received and they are expected to be filled with effect from October 2008.

Elected Governors

Patient and Carer Governors

Four Governors represent, and are elected by the patient and carer members of Sheffield Children's NHS Foundation Trust. They represent those patients who live outside the Sheffield electoral ward boundaries and those within Sheffield who opt to be a patient rather than a public member.

Name	Representing	Term of Office and Expiry
Helen Cumper	All carers	3 years (Sept 09)
Elizabeth Harper [1]	Patients from outside of Sheffield	Resigned w.e.f. 23rd Jan 08
Charlotte Hadfield [2]	Sheffield Patients	Resigned w.e.f. 26th July 07
Harry Potter		3 years (Sept 09)
Donna Adams [3]		14 months (Sept 09)

[1] Stepped down Jan 08 post vacant until Oct 08

[2] Stepped down July 07

[3] Concluding the term of office of Charlotte Hadfield from July 07

Public Governors (Sheffield)

The Public Constituency is defined by electoral ward boundaries within Sheffield. The Governors within this group represent and are elected by the public members of Sheffield Children's NHS Foundation Trust.

Name	Representing	Term of Office
Richard Newton	Hillsborough and Upper Don	2 years (Sept 08)
Michelle Brown		3 years (Sept 09)
Stephanie Swain [1]	Parson Cross/Ecclesfield	Resigned w.e.f. 23 Jan 08
Jan Bagge	Shiregreen/Burngreave	Resigned w.e.f. 15 Nov 07
Abdirahman Mohamoud [2]		3 years (Sept 09)
Sam Ramos-Pears	Manor/Darnall	3 years (Sept 09)
Ian Thompson	Mosborough/Handsworth	2 years (Sept 08)
Patricia Baker		3 years (Sept 09)
James Symonds	Greenhill/Gleadless	2 years (Sept 08)
Sabine Vanacker	Rivelin to Sheaf	3 years (Sept 09)
Jane Evans		3 years (Sept 09)

[1] Stepped down Jan 08 (no longer eligible). Position vacant until Oct 08

[2] Concluding the term of office of Jan Bagge from Nov 07

Public Governors (outside Sheffield)

Representing and elected by the public members of Sheffield Children's NHS Foundation Trust (constituencies outside Sheffield):

Name	Representing	Term of Office
Chris Leatherland	Barnsley	2 years (Sept 08)
Martha McFetridge	Doncaster	2 years (Sept 08)
John Barrie Otter	North Derbyshire & North Nottinghamshire	2 years (Sept 08)
Paul Jarvis	Rotherham	3 years (Sept 09)

Staff Governors

Representing and elected by the staff members of Sheffield Children's NHS Foundation Trust.

Name	Title	Representing	Term of Office and Expiry
Lynn Myers	Community Mental Health Nurse	Nursing	3 years (Sept 09)
Sarah Hawnt	Gastroenterology Nurse		3 years (Sept 09)
Steve Jones	Psychologist	Other clinical	2 years (Sept 08)
Nigel Harrington	Finance Systems Analyst	Administrative, ancillary & management	2 years (Sept 08)
Sue Taylor	Paediatric Surgical Unit Office Manager	Administrative, ancillary & management	3 years (Sept 09)
John Goddard	Consultant Anaesthetist	Medical & dental	2 years (Sept 08)

Appointed Partner Governors

Nominated by partner organisations.

Name	Representing	Term of Office
Jayne Ludlam	Sheffield City Council	3 years (Sept 09)
Bruce Laurence	North Trent Primary Care Trusts	3 years (Sept 09)
Frances Cunning	Sheffield Primary Care Trust	3 years (Sept 09)
Colin McIlwain [1]	Yorkshire & Humber Strategic Health Authority	3 years (Sept 09)
Julie Dore	Sheffield 0–19+ Partnership Board	3 years (Sept 09)
Dean Howson		3 years (Sept 09)
Sylvia Johnson	Sheffield Hallam University	3 years (Sept 09)
Jerry Wales	Sheffield University	3 years (Sept 09)

[1] The position of the partner Governor for the Strategic Health Authority is currently under review following the withdrawal of representation by the partner organisation in January 2008.

9.3 REGISTER OF GOVERNORS' INTERESTS

All members of the Council of Governors have a responsibility to declare any relevant interests, as defined within the Trust's Constitution (para. 12.36). The Register of Governors' Interests is available from the Foundation Trust office, Sheffield Children's NHS Foundation Trust, Western Bank, Sheffield S10 2TH.

The Board is 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.sheffieldchildrens.nhs.uk

9.4 ATTENDANCE AT COUNCIL OF GOVERNORS' MEETINGS

The Council of Governors has met in full four times in the period April 2007-March 2008.

Dates of the meetings of the Council of Governors	Overall attendance
26 July 2007	75%
25 September 2007 (held prior to the Annual Members' meeting)	81%
15 November 2007	70%
23 January 2008	87%

Attendance of Directors at Council of Governors' meetings

Name and title	26.07.07	25.09.07	15.11.07	23.01.08
Lynn Hagger, Chairperson	✓	✓	✓	✓
Stephen Hunter, Chairman	n/a [1]	n/a	n/a	n/a
Alan Bamford, Non-executive Director	✗	n/a	n/a	n/a
Lee Bond, Director of Finance	✗	n/a	n/a	n/a
Jeremy Loeb, Director of Finance	n/a	✓ (designate)	✗	✗
Professor Nick Bishop, Non-executive Director	n/a	n/a	n/a	n/a
Derek Burke, Medical Director	✗	✓	✗	✗
Isabel Hemmings, Deputy Chief Executive	✗	✗	✓	✓
Peter Lamberton, Non-executive Director	✓	✓	✓	✓
Joe McNally, Non-executive Director	✗	✗	✓	✓
John Reid, Director of Clinical Operations and Nursing	✗	✓	✓	✗
John Turner, Non-executive Director	✓	✓	✓	✓
Chris Sharratt, Chief Executive	✓	✓	✓	✓
Gareth Watkins, Non-executive Director	n/a	n/a	✓	✓
Louise Wembridge, Director of Human Resources	✗	✓	✓	✓
David Williams, Non-executive Director	n/a	n/a	✓	✗

[1] n/a – not applicable

In addition the Annual Members' meeting was held on 25 September 2007. Meetings of the Council of Governors are attended by Non-Executive Directors and Executive Directors.

Name	Constituency	Attendance
Helen Cumper	Carer Governors	3/4
Elizabeth Harper[1]	Patient out of Sheffield	0/4
Harry Potter	Patient in Sheffield	3/4
Charlotte Hadfield[2]	Patient in Sheffield	0/1
Donna Adams[3]	Patient in Sheffield	2/3
Martha McFetridge	Public Governor – Doncaster	3/4
Chris Leatherland	Public Governor – Barnsley	4/4
Paul Jarvis	Public Governor – Rotherham	4/4
Barrie Otter	Public Governor – North Derbyshire/North Nottinghamshire	4/4
Stephanie Swain[4]	Public Governor – Parson Cross/Ecclesfield	4/4
Jan Bagge[5]	Public Governor – Shiregreen/Burngreave	0/2
Abdirahman Mohamoud[6]	Public Governor – Shiregreen/Burngreave	0/1
Sam Ramos-Pears	Public Governor – Arbourthorne/Manor/Darnall	1/4
Pat Barker	Public Governor – Mosborough/Handsworth	4/4
Ian Thompson	Public Governor – Mosborough/Handsworth	3/4
James Symonds	Public Governor – Greenhill/Gleadless	2/4
Sabine Vanacker	Public Governor – Rivelin/Sheaf	4/4
Jane Evans	Public Governor – Rivelin/Sheaf	2/4
Richard Newton	Public Governor – Hillsborough & Upper Don	4/4
Michelle Brown	Public Governor – Hillsborough & Upper Don	4/4
Nigel Harrington	Staff Governor – Administration/Ancillary/Management	4/4
Sue Taylor	Staff Governor – Administration/Ancillary/Management	4/4
John Goddard	Staff Governor – Medical/Dental	4/4
Lynne Myers	Staff Governor – Nursing	4/4
Sarah Hawnt	Staff Governor – Nursing	3/4
Steve Jones	Staff Governor – Other Clinical	4/4
Sylvia Johnson	Nominated Partner Governor – Sheffield Hallam University	3/4
Jerry Wales	Nominated Partner Governor – University of Sheffield	4/4
Frances Cunning	Nominated Partner Governor – Sheffield PCT	3/4
Bruce Laurence	Nominated Partner Governor – North Trent PCTs	4/4
Colin McIlwain[7]	Nominated Partner Governor – SHA	2/2
Jayne Ludlam	Nominated Partner Governor – Sheffield City Council	2/4
Julie Dore	Nominated Partner Governor – 0-19+ Partnership	2/4
Dean Howson	Nominated Partner Governor – 0-19+ Partnership	3/4

[1] Elizabeth Harper resigned effective 23.01.08

[2] Charlotte Hadfield resigned effective 26.07.07

[3] Donna Adams was elected as the next highest polling candidate effective 26.07.07

[4] Stephanie Swain stepped down 23.01.08 due to a Constitutional ineligibility to continue as public Governor (a house move out of the represented constituency)

[5] Jan Bagge resigned effective 15.11.07

[6] Abdirahman Mohamoud was elected as the next highest polling candidate effective 15.11.07

[7] Colin McIlwain was withdrawn by the SHA effective January 2008 as they no longer wish to have partner representation

9.5 THE RELATIONSHIP BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

The main conduit for Governors' views to be shared with the Board of Directors is through the formal meetings of the Council of Governors where the Chairman of the Trust presides over meetings. Executive and Non-executive Directors are invited to attend the formal meetings of the Council of Governors.

In addition, joint sessions were held in October 2007 and January 2008 which were attended by both Board members and Governors. The role of the Governor was the main point of discussion and proposals from the January meeting were formally agreed at the full meeting of the Council of Governors on 23 January 2008.

Since December 2007 Governors have been invited to attend joint visits to service areas with Board members. This is particularly useful in forming trusting relationships between the two groups.

Governors are also sent the public agenda for the Board of Directors meetings and invited to attend those meetings, should they so wish.

10. Board of Directors

Management of the Trust is centred on two corporate bodies:

10.1 THE BOARD OF DIRECTORS

The Board of Directors has overall responsibility for the direction and management of the Trust and for ensuring that all statutory requirements are met. Day to day management is delegated to the Chief Executive and Directors.

10.2 TRUST EXECUTIVE GROUP (TEG)

TEG brings together clinical directors and executive directors of the Trust in a corporate body which is responsible for the effective delivery of the strategy agreed by the Trust Board and for the operational management of the organisation.

10.3 COMPOSITION OF THE BOARD OF DIRECTORS

The Board of Directors comprises both full-time Executive Directors, and part-time Non-executive Directors who bring together a balance and breadth of experience and skills. The Executive Directors have at a senior level, both commercial and NHS experience in a range of subjects including finance, human resources, operations, management, medicine, nursing, strategic and operational planning, research, and governance. Their expertise is complemented by the skills of the Non-executive Directors in fields such as finance and strategic accounting, human resources, planning and sales and marketing, and legal frameworks.

During the year there has been opportunity to reconsider the balance, completeness and appropriateness of its composition whilst considering the appointments of the Chairman, two Non-executive Directors and the Finance Director, and the Board is satisfied that it can continue to function effectively with its current membership.

The Board of Directors comprises the Chairman, five Non-executive Directors, and six Executive Directors including the Chief Executive, with Non-executive Directors having the voting majority. The Trust also has other non-voting directors attending Board meetings as and when required to provide operational advice and support to the Board.

Name	Title	Start Date	Tenure
Lynn Hagger	Chairperson	1 Dec 98	31 Jan 08
Stephen Hunter	Chairman	1 Feb 08	31 Jan 12
Alan Bamford	Non-executive Director	1 Dec 99	31 Jul 07
Lee Bond	Director of Finance	Mar 03	3 Aug 07
Derek Burke	Medical Director	1 Feb 07	-
Professor Nick Bishop*	Non-executive Director	1 Dec 05	Resigned 31 Jul 07
Isabel Hemmings	Deputy Chief Executive	1 Dec 02	-
Peter Lamberton	Non-executive Director	1 Mar 05	28 Feb 09
Jeremy Loeb	Director of Finance (Deputy Chief Executive)	19 Nov 07	-
Joseph McNally	Vice Chairman Non-executive Director Senior Independent Director	15 Jan 97	31 Jul 08
John Reid	Director of Clinical Operations & Nursing	May 05	-
Chris Sharratt	Chief Executive	Jul 02	-
John Turner	Non-executive Director	1 Dec 02	31 Jul 10
Gareth Watkins	Non-executive Director	1 Nov 07	31 Oct 10
Louise Wembridge	Director of Human Resources	5 Sep 05	-
David Williams	Non-executive Director	1 Nov 07	31 Oct 10

*Professor Bishop's substantive post is that of Professor in Paediatric Bone Disease and Head of the University of Sheffield Academic Unit of Child health within the Medical School of Sheffield University. Professor Bishop is therefore not considered to be an independent director. All other appointments are considered to be independent.

10.4 BOARD MEMBERS – BACKGROUND INFORMATION

10.4.1 CHAIRMAN AND NON-EXECUTIVE DIRECTORS

Stephen Hunter – Chairman
(commenced 1 February 2008)

Stephen Hunter was appointed Chairman of the Foundation Trust in February 2008. He has 30 years of board level experience and a wealth of experience as a non-executive director, having worked for a range of organisations in the public, private, educational and voluntary sectors. He was appointed to the role of non-executive director at Sheffield Children's Trust in 1996 and served for three years prior to being appointed to the position of Chairman of South Yorkshire Ambulance Trust in 1999. This role was a challenging one and Stephen was asked by the Strategic Health Authority to instigate a major turnaround, which he successfully managed, taking the Trust from a failing position through to sustainability. During this time he became a mentor to newly appointed Trust Chairmen. He stepped down from this role in 2006 and has since concentrated his efforts on the reprographic company he owns.

His other commitments include his role as Chairman of Birkdale School and that of Associate Vicar at All Saints, Ecclesall. He has been a Magistrate for a number of years and is a Bench Chairman and Chairman's mentor.

Stephen has a high profile in the city and he has extensive networks in the public and private sectors throughout the region. These include the health, education and business communities. He clearly demonstrated real enthusiasm and commitment to working for the Trust, during the interview process. Personal strengths also include proven strategic thinking, leadership skills, strong interpersonal skills and the ability to assimilate information quickly.

Lynn Hagger – Chairperson
(1 December 1998 – 31 January 2008)

Lynn Hagger was appointed Chairperson of the Trust in 1998. Prior to this, she was a non-executive director at the Sheffield Teaching Hospitals NHS Trust after spending six years as Vice-Chairperson of the Sheffield Community Health Council.

She combined her role as Chairperson of the Trust with a career in academic law after five years in private practice. Prior to her career in law Ms Hagger had a career in social work. She gained her LLB at the University of Sheffield and this was followed by a Diploma in Legal Practice and an MA in Biotechnological Law and Ethics. The inclusion of company law and financial accounting in the Legal Practice course has proved particularly useful in considering the future direction of the Trust.

Ms Hagger has worked in a number of positions as a Lecturer in Law, working also at the Universities of Liverpool and Manchester.

In addition to her role as Chairperson of the Board of Directors, Ms Hagger attended the Trust's Audit Committee, and was Chairperson of the Clinical Governance Group and the Clinical Ethics Forum which she established in conjunction with the Medical Director. She was also Chairperson of the Performance and Finance Committee. Externally she was a member of the South Yorkshire Acute Trust Chairs Group, the Convenor of the Children's Alliance Chairs' Network and the National Acute Trust Chairs' Group. She has also served on the Board of the Foundation Trust Network where she was nominated to liaise with the Clinical Leads', Governance and Aspirant Trusts' sub-groups.

Joseph McNally – Vice Chairman and Senior Independent Director

Joseph McNally has been a non-executive director of the Trust for ten years. Mr McNally was formerly a Senior Police Officer who held senior positions in the West Midlands and West Mercia Constabulary and in South Yorkshire. He has substantial experience in Policy and Strategy development, and emergency planning and in the conduct of major investigations.

In addition to his role as Vice Chairman of the Trust Board, Mr McNally is a Member of the Audit Committee, and chaired this group from 1999 to 2005. He has also been a member of the Remuneration Committee since 1993.

Externally, Mr McNally served as a Best Value Inspector for the Audit Commission and as a CHAI Inspector. He was Formation Company Secretary and is now a Director of All Saints Educational and Recreation Company Limited. He is an Independent Appeal Panel Chairman for CORGI. He is an Associate Mental Health Act Manager. He has been a Governor of All Saints Roman Catholic High School since 1993, and between 1995 and 2006 was Chairman of Governors. He is Chairman of the Universities Chaplaincy Fund and is Vice President of an international organisation, Catenian Association. Mr McNally was also a Trustee and President of the South Yorkshire Branch of the British Red Cross.

Mr McNally has a Masters in Business Administration. He holds the Diploma in Legal Practice and was called to the Bar in 1998.

Senior Independent Director

The Board has appointed one of the independent non-executive directors to be the senior independent director. Mr McNally was appointed as Senior Independent Director (SID) by the Board of Directors at its meeting on 30 January 2007.

The principal responsibilities of this role are to:

- act as a conduit to the Board for the communication of stakeholder concerns when other channels of communication are inappropriate;
- act as a point of contact for Governors with concerns which have failed to be resolved, or would not be appropriate through the normal channels of the Chairman, Chief Executive and/or other Executive Directors; and
- act as an alternative point of contact for Executive Directors, if required, in

addition to the normal channels of the Chairman and/or the Chief Executive;

- meet with the other members of the Board as and when deemed appropriate.

Arrangements are currently in place for the selection of a new SID, as the tenure of the current incumbent comes to an end in July 2008. This will be done in consultation with the Council of Governors.

David Williams – Non-executive Director
(commenced 1 November 2007)

David is currently Chief Executive of SIG PLC, a listed company with annual sales of £2.2 billion. SIG is one of Yorkshire's largest companies, employing over 13,000 staff in 10 countries. His background, prior to joining SIG as Sales and Marketing Manager in 1983 was in Engineering. He has very strong business development skills and a good strategic mind with strong financial acumen. He shows clear evidence of commitment to public service in general and has a good awareness of issues facing the NHS and the Children's Foundation Trust in particular.

Other than his role within SIG, David has been a member of the Advisory Board of the Management School at Sheffield University for the last two years.

Gareth Watkins – Non-executive Director
(commenced 1 November 2007)

Gareth is a part-time senior partner at Nabarro's solicitors and is also a Deputy District Judge. He worked for British Coal from graduating until 1990, his final role being that of National Deputy Head of Litigation. He has always been attracted to extra-curricular activities in the public sector. He has been a school governor in the past and is currently president of his local Community Club. In addition to his legal expertise, he has specialist knowledge around Health and Safety and risk assessment. He is experienced in working in large commercial organisations and is also well versed in public sector policies. He has played a key role in meeting financial challenges in his own organisation in a very robust manner.

Alan Bamford – Non-executive Director
(1 December 1999 – 31 July 2007)

Alan Bamford has been a Non-executive Director of the Trust since December 1999. He retired as an Executive Director of Henry Boot and Sons PLC in 1997 after serving 27 years with the Company.

Prior to joining Henry Boot he served as a manager with the Shepherd Building Group and later as an Executive Director with Babcock Woodall Duckham Limited working on contracts throughout the UK and abroad. During his service with Henry Boot he assumed responsibility for all aspects of the business and served on the Parent Company Board and on several subsidiary company Boards covering UK construction, railway engineering, plant, international contracting, joinery manufacture and sale, inner city developments, training and foundry work. He was also responsible to the PLC Board for personnel, marketing and safety work throughout the group of companies.

His inner city work included the management of joint venture companies with Kirklees, Monklands and Tameside MBCs, whilst international work covered the management of joint venture companies in Hong Kong, Malaysia and Singapore. The Training Company had a close working relationship with a number of Government Departments in the UK and in Europe and the Far East.

Since 1997 Alan served as a Non-executive Director of Weston Park NHS Trust until the merger with the Sheffield Teaching Hospitals NHS Foundation Trust. He was Chairman of the Audit Committee. He joined the Board of Sheffield United Football Club in 1997 and has been responsible for several new developments at the club including a new Enterprise Centre and a new Youth Academy. He is responsible for local community liaison and is Chairman of the Academy Trust.

Alan served as a Governor of Sheffield Hallam University for six years, was President of the Sheffield Chamber of Commerce in 1992/3, led the City's Centenary celebrations in 1993 and was Chairman of the Special Olympics in 1993.

He was a founder member of Sheffield Regeneration which subsequently became Sheffield First and is still operating successfully.

Internally he was a member of the Audit, Remuneration, Human Resources and Health & Safety Committees.

Professor Nicholas James Bishop – Non-executive Director
(1 December 2005 – 31 July 2007)

Professor Bishop is Professor in Paediatric Bone Disease and Head of the University of Sheffield Academic Unit of Child health. He was appointed as a Non-Executive Director in 2005. Professor Bishop was appointed to the University in 1998. Prior to this he was Visiting Professor at Shriners Hospital for Children in Montreal and previously Clinical Lecturer at the University of Cambridge.

Peter Lamberton – Non-executive Director

Peter is Chairman of the Trust's Audit Committee, having been appointed in March 2005. He is a Fellow of the Institute of Chartered Accountants and a former partner in an international firm of Chartered Accountants with extensive knowledge of varied business and regulatory environments. He was Company Secretary, Head of Finance and Member of the Executive Board of the North Derbyshire Training and Enterprise Council. He is a voluntary Board Member of a substantial housing association, South Yorkshire Housing Association. He is a self-employed accountant and business consultant.

John Turner – Non-executive Director

John has been a Non-executive Director of the Trust since December 2002. Prior to his retirement he was an Under Secretary in the then Department of Education and Employment. In his last post he served as the Director of Jobcentre Services and Deputy Chief Executive of the Employment Service. In this and previous directing roles he was responsible for the business, budgetary and customer service performance of large-scale customer service operations and directed the successful

implementation of major, nationwide IT systems and infrastructure projects. He has wide experience of policy development and reviews and policy implementation, including through individual and multiple partnerships, and served as principal private secretary to two Secretary of States for Employment.

John is a member of the Trust's Audit Committee and the Information Management and Technology Strategy Group. He chairs the HR Strategy Committee and the Trust innovation Board.

John Turner is also a Member of the Civil Service Appeal Board and a voluntary trustee and board member of the national education and training charity, Rathbone.

10.4.2 CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS

Chris Sharratt – Chief Executive

Chris has been Chief Executive since April 2002, having been employed as Deputy Chief Executive for the previous six years. He has worked as a manager in the NHS for a period of 37 years joining as a management trainee in 1971. During that time he has worked in a variety of roles in acute, mental health, community and health authority organisations. Chris holds a first degree, and a Masters of Science (MSc) in Health Science Research and Technology Assessment from the Faculty of Medicine, University of Sheffield and Post Graduate Certificate in Health Economics from the University of Aberdeen. He is also a member of the Institute of Health Care Managers.

Chris is a member of many national and local committees. He is a founder member of the UK National Children's Health Alliance. For three years he was Chairman of the Sheffield Partnership for Children and Young People's Service, and was a member of the Executive Sponsors Group, comprising the Chief Executive of the City Council and Director of Services for Children and Young People, which was overseeing the development of partnership development in Sheffield. Chris is also a member of the International Organisation CHIEF, (Children's Hospital's International Executive Forum) and the Ministerial Implementation Group for 'Aiming High for Disabled Children'.

Lee Bond – Director of Finance
(March 2003 – 3 August 2007)

Lee was appointed Director of Finance in March 2003. He joined the Trust in 1994 as a graduate and has worked in a variety of positions within the Trust's Finance Department since his appointment. He qualified as a Chartered Management Accountant in 1997. Lee was responsible for all aspects of the Trust's financial management and also led the Trust's Information and IT functions and the Supplies function.

Derek Burke – Medical Director

Derek Burke qualified from The University of Birmingham Medical School in 1983. He undertook his training in Accident and Emergency Medicine in the West Midlands and Paediatric Accident and Emergency Medicine sub-speciality training at Birmingham Children's Hospital. He was appointed Consultant in Accident and Emergency Medicine at Sheffield Children's Hospital in 1997. He previously held the post of medical director from 1998-2001.

Isabel Hemmings – Deputy Chief Executive

Isabel joined the Trust at the end of 2002 and is responsible for the strategic development of services and performance management and has a lead role in relation to the Trust's partnerships with other organisations. She has worked in the NHS for 22 years, joining as a Management Trainee in 1986, and has worked in a variety of Management and Director level posts. Her career to date has mainly been in acute Health Care Management, but she has also worked in Community and Mental Health Care Services. Isabel is a member of the Institute of Health Service Management and has a Diploma in Health Services Management from the IHSM. She also has a Masters Degree in Health Services Management undertaken at the Nuffield Centre at Leeds University and has undertaken the Office of Public Management's Leaders for Health Programme.

Jeremy Loeb – Director of Finance (Deputy Chief Executive)
(commenced 19 November 2007)

Jeremy was appointed as Director of Finance on the 19 November 2007. He is a chartered accountant and joined the Trust from Barnsley Hospital where he was Director of Finance responsible for the financial aspects of its successful first wave Foundation Trust application. He has worked in both the public and private sectors. He was responsible for a national pilot project (at Freeman Hospital Newcastle) to involve doctors in resource management, and more recently was responsible for contract negotiation with commissioners using the legally binding contract.

John Reid – Director of Clinical Operations and Nursing

John was appointed to the Trust in May 2005, following a year on secondment in the same post. He qualified as a Nurse in 1980 and has worked for 25 years in the NHS, with several years in New Zealand and the Middle East. John progressed into NHS Management 15 years ago and has worked in a variety of management and clinical leadership positions during that period including a four year period at the Sheffield Children's NHS Trust. Prior to his current post, John was employed as acting General Manager of Children's Services at Leeds Teaching Hospitals NHS Trust. He is responsible for providing leadership for nursing staff in the Trust. He also has executive responsibility for Clinical Governance, Risk Management, Child Protection and leads the Diversity and Public Involvement Group.

Louise Wembridge – Director of Human Resources

Louise was appointed into post in September 2005. Having graduated in

Psychology, Mrs Wembridge worked for an Occupational Psychologist for two years before joining Northern Foods in 1987. Her career in this blue chip organisation spanned 17 years and included experience in a number of both generalist and specialist roles. Her role for the five years prior to joining the Children's Trust was as Personnel Director for one of Northern Foods Operating companies, the main focus of her role there being employee relations and organisational development. Mrs Wembridge is responsible for all aspects of the Trust's Human Resources, Learning and Development and Library Service functions.

10.4.3 PERFORMANCE EVALUATION OF THE BOARD OF DIRECTORS

The performance of the Board was reviewed during the year and the structure and membership and performance of its Committees was critically evaluated to ensure fitness for purpose. Plans are currently being developed to formalise the framework for assessment for the current year. Executive and Non-executive Director vacancies during the course of the year provided the opportunity for the skills set of the Board to be reviewed and refreshed through both the Nominations and Recruitment Committees (see section 12).

The Executive Directors are subject to an annual appraisal which takes the form of a Personal Development Review with the Chief Executive. This incorporates a review of performance against objectives and a number of competencies from the NHS Leadership Qualities framework which are viewed as critical to success in these key roles. Objectives and personal development goals are then agreed for the following year. The Executive Directors' performance is discussed in detail at the annual Remuneration Committee meeting, involving the Chief Executive, Chairman and Non-executive Directors. The Chief Executive's performance was formally reviewed by the Chairman during 2007.

The Non-executive Directors' performance has been formally reviewed by the Chairman in 2007, however following the appointment of a new Chairman in February 2008 a review of the appraisal process for Non-executive Directors has been instigated. It is anticipated that the revised appraisal process will include a 360 degree assessment and a recommendation will be made to the Governors on this later in the year.

The Senior Independent Director has a key role to play in leading the appraisal process of the Chairman.

10.5 COMMITTEES OF THE BOARD OF DIRECTORS

There are a number of committees in place to ensure the Board works effectively. These include:

Audit Committee

Monitors financial probity and value for money. Please see section 11 for more detailed information on the role and function of the Audit Committee.

Nominations Committee

The Nominations Committee oversees the process of recruiting Directors. Please see section 12 for more detailed information on the role and function of the Nominations Committee.

Clinical Governance Committee

Assures the Trust Board that high quality services are provided in a systematic way across the Trust.

Risk Management Committee

Ensures effective systems are in place for the management of risk. The committee supervises the risk register and oversees health and safety, claims and complaints management.

Human Resources Committee

The Committee ensures effective arrangements are in place for the effective recruitment, development and retention of staff and for monitoring key HR performance indicators.

Clinical Excellence Committee

This Committee has responsibility for awarding local Clinical Excellence Awards to consultant medical staff.

10.6 REGISTER OF DIRECTORS' INTERESTS

All members of the Board have a responsibility to declare any relevant interests, as defined within the Trust's Constitution (para 13.22). The Register of Directors' Interests is available from the Finance Department, Sheffield Children's NHS Foundation Trust, Western Bank, Sheffield S10 2TH.

The Board is 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.sheffieldchildrens.nhs.uk**

10.7 ATTENDANCE AT BOARD OF DIRECTORS' MEETINGS

Name	Title	Apologies Received
Ms Lynn Hagger*	Chairperson	0
Mr Stephen Hunter**	Chairman	0
Mr Alan Bamford***	Non-executive Director	0
Mr Lee Bond****	Director of Finance	2
Mr Jeremy Loeb*****	Director of Finance (Deputy Chief Executive)	0
Professor Nick Bishop ***	Non-executive Director	0
Mr Derek Burke	Medical Director	3
Ms Isabel Hemmings	Deputy Chief Executive	3
Mr Peter Lamberton	Non-executive Director	0
Mr Joe McNally	Vice Chairman/Non-executive Director	3
Mr John Reid	Director of Clinical Operations and Nursing	3
Mr John Turner	Non-executive Director	2
Mr Chris Sharratt	Chief Executive	2
Mr Gareth Watkins******	Non-executive Director	2
Mrs Louise Wembridge	Director of Human Resources	4
Mr David Williams******	Non-executive Director	3

* left post 31 January 2008
** took up post 1 February 2008
*** left post 31 July 2007
**** left post 3 August 2007
***** took up post 19 November 2007
****** took up post 1 November 2007

Meeting Dates April 2007-March 2008

Date	Private	Public	Extra Ordinary
24 April 2007	✓	✓	
29 May 2007	✓	✓	
7 June 2007			✓
26 June 2007	✓		
31 July 2007	✓	✓	
28 August 2007	✓		
25 September 2007	✓		
23 October 2007	✓	✓	
27 November 2007	✓		
18 December 2007	✓		
29 January 2008	✓	✓	
26 February 2008	✓		
25 March 2008	✓		

Staff costs and numbers are included within section 6 of the Annual Accounts. The remuneration paid to the Chairperson, non-executive directors and senior managers are set out within the Remuneration Report in Section 15.

10.8 PROCESS FOR THE APPOINTMENT AND REMOVAL OF NON-EXECUTIVE DIRECTORS

Appointments to and removal from the posts of Chairman and Non-executive Directors are the responsibility of the Council of Governors. Following the procedures set out by the nominations committee, the recruitment committee assesses candidates for these posts and makes recommendations to the full Council in line with the Foundation Trust Constitution (para 13.2.1.1, and 13.6) and Schedule 7 of the National Health Service Act 2006.

11. Audit Committee

The Trust has in place, as part of its governance framework, a formal Audit Committee. This Committee reports to the Trust Board and meets at least three times per year, producing an annual report which is used as a source of assurance by the Trust Board when considering its mandatory declarations such as the authorising of the financial accounts and the signing of the overall statement of internal control.

The Audit Committee is made up of at least three Non-executive Directors, chaired by Peter Lamberton, with attendance at meetings by the Trust Chairman, Chief Executive, Director of Finance and representatives from External Audit, Internal Audit and the Trust's Local Counter Fraud Specialist, and Security representative.

11.1 ROLE OF THE AUDIT COMMITTEE

The Audit Committee's primary role is to independently contribute to the board's overall process for ensuring that an effective internal control system is maintained. A summary of the role of the Audit Committee is detailed below.

11.1.1 GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee reviews on an ongoing basis the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee reviews the adequacy of:

- all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

11.1.2 INTERNAL AUDIT

The Committee is responsible for ensuring that there is an effective internal audit function established which provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

11.1.3 EXTERNAL AUDIT

The Audit Committee reviews the work and findings of the External Auditor and considers the implications and management's responses to their work.

11.1.4 OTHER ASSURANCE FUNCTIONS

The Audit Committee also reviews the findings of other significant assurance functions, both internal and external to the organisation, and considers the implications to the governance of the organisation.

These include, but are not limited to, reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission, NHS Litigation Authority, Health and Safety Executive etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

The Assurance Framework is produced each year and is based closely upon the strategic objectives agreed by the board. The framework has a pre and post controls risk assessment carried out. This is agreed by the executive team and is used by the Board and the Audit Committee to provide assurance on the capabilities of the Trust to manage risk and inform the Statement of Internal Control. Quarterly updates on the framework allow that assurance to be maintained. The framework is subject to internal audit review and gap analysis.

The Committee also reviews the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Clinical Governance Committee and the Risk Management Committee.

The bulk of the work undertaken by external audit remains focussed on the annual financial reporting process. With this in mind the Audit Committee reviews the Annual Report and Financial Statements before submission to the Board, focussing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements and any significant adjustments resulting from audit

The Committee is also responsible for ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

11.2 AUDIT COMMITTEE MEMBERSHIP AND ATTENDANCE

Membership and attendance at Audit Committee meetings held between 1 April 2007 31 March 2008, is detailed in the table below:

		Dates of Meeting			
Members	**Designation**	**7.6.07**	**24.7.07**	**4.12.07**	**11.3.08**
Peter Lamberton (Chairman)	Non-executive Director	✓	✓	✓	✓
Alan Bamford	Non-executive Director	✓	✓	n/a	n/a
Joe McNally	Non-executive Director	✓	✓	✗	✗
John Turner	Non-executive Director	✓	✓	✗	✓
Gareth Watkins	Non-executive Director	n/a	n/a	✓	✓
David Williams	Non-executive Director	n/a	n/a	✗	✓
Attendees	**Designation**	**7.6.07**	**24.7.07**	**4.12.07**	**11.3.08**
Lynn Hagger	Trust Chairperson	✓	✓	✗	n/a
Stephen Hunter	Trust Chairman	n/a	n/a	n/a	✓
Chris Sharratt	Chief Executive	✓	✓	✓	✓
Lee Bond	Director of Finance	✓	✓	n/a	n/a
Jeremy Loeb	Director of Finance (Deputy Chief Executive)	n/a	n/a	✓	✓
John Pannell	Audit Commission	✓	✓	n/a	n/a
John Prentice	Audit Commission	✓	✓	n/a	n/a
Ian Saxton	Internal Audit	✓	✗	✗	✗
Adrian Lythgo	KPMG	n/a	n/a	✓	✗
Andrew Smith	KPMG	n/a	n/a	✓	✗
Stephen Bower	KPMG	n/a	n/a	✓	✓
Ruth Vernon	Internal Audit	✓	✓	✗	n/a
Louise Ivens	Internal Audit	✗	✓	✓	✓
Robert Purseglove	Local Counter Fraud Specialist	✗	✓	✓	n/a
Karen Varley	Local Counter Fraud Specialist	n/a	n/a	✓	✓
Danny Boardman	Trust Security Advisor	✗	✓	✓	✓

11.3 EXTERNAL AUDIT

Following the Council of Governors' decision to market test the external audit services, KPMG were appointed as auditors for the 2007/8 financial year at the Council's meeting on 15 November 2007.

Work in the period to 31 March 2008 has predominantly focused on the annual accounts related work. This work which includes reviews of material systems, internal audit liaison, audit of accounts and examination of the annual report and publication of the audit certificate has been supplemented by additional work reviewing the statement of internal control and continued performance review of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources.

The total fee needed to deliver the audit programme in the period was £48,750. Of this, £32,050 related to Accounts work, £6,300 related to the statement of internal control, £5,100 to performance reviews and £5,300 for additional work in the form of follow up to previous reviews and the production of the management letter.

The Trust did not purchase any further services from the external auditors that are outside of Monitors' audit code. The Trust expects its external audit provider to act independently. Under the terms of engagement they are required to have control processes in place to ensure that this status is preserved and to notify the audit committee of any matter that could compromise the independence or objectivity of the audit team. This position is monitored by the audit committee and the auditor is required under ISA 260 to confirm this position in the annual governance report.

The auditor's reporting responsibilities for the Annual Report include:

a) Reporting an opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Independent Regulator as being relevant to the NHS Foundation Trust;

b) Reporting if the Accounting Officer's statement on internal control does not meet the requirements specified by the Independent Regulator or if the statement is misleading or inconsistent with other information the auditor is aware of from the audit of the financial statements;

c) Considering the implications for the audit opinion if the auditor becomes aware of any apparent misstatements or material inconsistencies between the annual report including the directors' report and the financial statements;

d) Certifying that the audit of the accounts has been completed in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by the Independent Regulator;

e) Considering the issue of a public interest report; and

f) Referring the matter to Monitor when an NHS foundation trust, or an officer or director of an NHS foundation trust, makes or is about to make decisions involving potentially unlawful expenditure or takes or is about to take potentially unlawful action likely to cause a loss or deficiency.

12. Nomination Committee

The membership of the Nomination Committee comprises the Chairman, the Chief Executive, two Non-executive Directors and the Director of Human Resources. During 2007, the Committee members were as follows:

Ms Lynn Hagger	**Chairperson**
Mr Chris Sharratt	**Chief Executive**
Mr John Turner	**Non-executive Director**
Mr Peter Lamberton	**Non-executive Director**
Mrs Louise Wembridge	**Director of Human Resources**

Meetings of the Nominations Committee were held on the 10.4.07 and 22.5.07. All Committee members attended the meetings and the Trust Secretary was in attendance.

The purpose of the Nominations Committee is:

- to oversee the process for the nomination of the Chief Executive for approval by the Board, and ratification by the Council of Governors.
- to oversee the process for the appointment of other Executive Directors.
- to lead the process for the identification and nomination of Non-executive Directors, including the Chairman.

In particular, the Nominations Committee:

- regularly reviews the structure, size and composition (including the skills, knowledge and experience) of the Board of Directors and makes recommendations to the Board with regard to any changes and appropriate process:
- ensures that there is a formal, rigorous and transparent procedure for the appointment of new Executive and Non-executive Directors to the Board which fit the criteria set out by the Nominations Committee, in particular;
  - to consider candidates from relevant backgrounds
  - to use open advertising or the services of external advisers to facilitate the search
- keeps under review the leadership needs of the Trust, both executive and non-executive, with a view to ensuring the continued capability of the organisation
- gives full consideration to succession planning in respect of Non-Executive Directors, taking into account the challenges and opportunities facing the Trust, and the skills and expertise required on the Board.
- prepares and recommend to the Recruitment Committee (Sub-Committee of the Council of Governors) all relevant information i.e. job description(s) and person specification(s) in respect of the Chairman and Non-Executive Directors.

As from end of July 2007 the Trust had two Non-executive Director vacancies, which the Nominations Committee spent time considering how best to fill. A range of options was considered and the conclusion was that an Executive Search agency should be used to support the process. The Recruitment Committee supported this recommendation and was involved in selecting Odgers Ray and Berndtson, market leaders in their field with strong knowledge of the catchment area, out of three possible agencies. As part of the process an advertisement was placed in the Sunday Times, as the media primarily used for Board level appointments. The advertisement and executive search process resulted in the successful appointment of two new Non-executive Directors, David Williams and Gareth Watkins.

The tenure of the Chairperson ended on 31 January 2008 and the process for appointing a successor began in September 2007 to allow sufficient time to identify a suitable candidate. The process again involved using Odgers Ray and Berndtson and advertising in the Sunday Times. The recommendation of the Recruitment Committee to appoint Stephen Hunter was ratified at the Council of Governors meeting on 10.1.08.

In addition to the Non-executive vacancies, the Trust had a vacancy for the Director of Finance position during the year. This role was advertised in the Health Service Journal and successfully appointed to in August 2008.

13. Membership

13.1 ELIGIBILITY

The Trust has three constituencies of membership set out in the Constitution. Patient, public and staff membership, these classes are broken down further into sub-constituencies. Constituencies for the membership are shown in full in the table below.

CONSTITUENCY	SUB CONSTITUENCY
Patient Membership	Patients living in Sheffield
	Patients living outside of Sheffield
	Carers of patients
Public Membership	Sheffield - Parson Cross / Ecclesfield
	Sheffield - Shiregreen / Burngreave
	Sheffield - Arbourthorne / Manor / Darnall
	Sheffield - Mosborough / Handsworth
	Sheffield - Greenhill / Gleadless
	Sheffield - Rivelin to Sheaf
	Sheffield - Hillsborough & Upper Don
	Barnsley
	Doncaster
	Rotherham
	North Derbyshire / North Nottinghamshire
Staff Membership	Medical & Dental
	Other Clinical
	Nursing
	Administration, Ancillary & Management

- To be eligible to become a **public member** a person must be over 14 years of age and live within the specified boundaries. Boundaries are co-terminus with Local Authority electoral wards; a full breakdown is available in the Constitution (available on the website www.sheffieldchildrens.nhs.uk).
- To become a **patient member** in the sub-constituencies 'Patient living in Sheffield' and 'Patient living out of Sheffield' on application a person must be over 14 years of age and under 19 years of age and they must have been a patient of the Trust within the last five years.
- To become a **carer member** of the Trust the person must be over 14 years of age and a carer of a patient when they apply for membership.
- To be a **staff member** a person must be employed by the Trust on a contract with a length of more than 12 months. Staff employed by another organisation who exercise functions on behalf of the Trust are also eligible to become members for example University staff employed on an honorary contract.

13.2 DEVELOPING OUR MEMBERSHIP

"To develop a membership community that is representative of the diversity of the communities we serve, promoting their involvement and securing the contribution of children & young people and our staff."

CONSTITUENCY		SUB CONSTITUENCY	Number of Members as at 31 March 2008
Patient Membership		Patients living outside of Sheffield	302
		Patients living in Sheffield	451
		Carers of patients	1,478
		Sub-total	**2,231**
Public Membership	In Sheffield	Parson Cross / Ecclesfield	240
		Shiregreen / Burngreave	189
		Arbourthorne / Manor / Darnall	197
		Mosborough / Handsworth	355
		Greenhill / Gleadless	217
		Rivelin to Sheaf	499
		Hillsborough & Upper Don	262
	Out of Shefield	Barnsley	252
		Doncaster	286
		Rotherham	260
		North Derbyshire / North Nottinghamshire	424
		Sub-total	**3,181**
Staff Membership		Medical & Dental	274
		Other Clinical	389
		Nursing	637
		Administration, Ancillary & Management	605
		Sub-total	**1,905**
		Grand Total	**7,317**

13.3 A SUMMARY OF THE MEMBERSHIP STRATERGY

The Trust recognises that members are a valuable resource and that having an effective membership community is important to the success of the Foundation Trust. The vision for the Trust in 2007/8 is summed up with the following statement.

"To develop a membership community that is representative of the diversity of the communities we serve, promoting their involvement and securing the contribution of children & young people and our staff."

This vision is underpinned by the following principles:

Importance of partnership

The Trust has a good track record of working in partnership with both health and non-health community stakeholders with regard to children's and young people's services. Membership provides opportunities to obtain views and feedback so that service delivery can best meet the changing needs and priorities of local communities. The Trust will continue to develop two-way communication processes to seek and receive comments and feedback from members.

Representative membership

As a Trust that serves mainly an urban population, ensuring that membership is reflective of the diversity of the communities it serves is important. The Trust is committed to developing a profile of membership that is representative of age, sex and ethnicity of its local communities.

Contributions of children and young people

As a provider of services for children and young people, parents and guardians are often the proxies for the views of our patients. However, the Trust recognises that young people and our older patients have valuable contributions and is committed to promoting and encouraging their involvement. The inclusion of a Young Associate membership group is one method the Trust has chosen to take this forward; Young Associates are members under the age of 14 who cannot participate in elections but have their own website designed by their peers as a vehicle to share their views.

Contribution of staff

The staff in the Trust are our biggest asset; their support, commitment and dedication has and will continue to enable the organisation to thrive and to adapt to the changes whilst maintaining the highest clinical standards. Staff membership provides the Trust with a formal means of supporting the ongoing engagement and involvement of all staff in influencing the future of the organisation.

An assessment of the membership

The Trust has a target for 2011 to reach 10,000 members. Incremental targets have been put in place to reach that figure and over the previous year the Trust has worked on building up the membership base in the public and patient constituencies. An additional 540 public and patient members have joined the Trust in the year to help reach that the overall target.

In efforts to ensure that the membership is reflective of the local populations the Trust has monitored the growing membership figures against census data around age, gender and particularly ethnicity.

The Trust is pleased to report that the membership overall has high numbers of young members with 29% of members aged between 14 and 21. To attract younger members specific events targeted at that age group have been successful.

The Trust has carefully monitored the ethnic breakdown of the membership by collecting data on ethnic origin through the membership application form. With an extremely diverse local population the Trust is pleased to state that it has been able to ensure that the membership is broadly representative of the ethnic breakdown of that population.

13.4 MAKING CONTACT

Members can contact the Council of Governors and the Board of Directors at any time through the year via the Foundation Trust office. Contact details are provided to members through membership literature, the Trust's website and on notice boards around the Trust sites.

For questions or comments to be directed to the Board of Directors or the Council of Governors write to:

Foundation Trust office
Sheffield Children's
NHS Foundation Trust
Western Bank
Sheffield
S10 2TH

Email ftoffice@sch.nhs.uk

Telephone 0114 226 0678

Visit the Trust's website for more information on the Board of Directors and Council of Governors.

Details of the meetings of the Council of Governors and meetings of the Board of Directors held in public can be found on the Trust's website
www.sheffieldchildrens.nhs.uk

14. Public Interest Disclosures

The Trust values the views of users, the public and its staff and has established ways of communicating with major stakeholders on the development of services and for responding to comments and complaints. This feedback is extremely valuable to the Trust and we seek to make improvement to services in the light of comments received. Our systems for involving users and the public are described in section 6.8. The Trust has also effective systems for communicating and consulting with staff, and these are described in section 4.8.

Over the last year the Trust has consulted with the Local Authority Overview and Scrutiny Committee (OSC) for Children's Services, in particular in relation to its compliance with health care standards. The Trust also participated in a whole Health Community Scrutiny exercise undertaken by the Sheffield City Council in November 2006.

The Trust has also formally consulted with its staff on a number of occasions during the year including consultation on new policies and procedures as well on the reconfiguration of some services.

It is recognised that information relating to Trust policies and financial performance will also be of interest to the public. The Trust is subject to The Freedom of Information Act 2000 which was created to make the work of public bodies as open and as transparent as possible. There are references throughout this report relating to different Trust policies, particularly within the background information section. Performance against the national "better payment practice code" is also detailed within section 8.1 of this report and note 7.1 of the accounts. For full copies of these documents or to find out more about the Trust work please visit our web-site: **http://www.sheffieldchildrens.nhs.uk/foi/index.php**

15. Remuneration Report

The Trust applies the principles of good corporate governance in relation to Directors' remuneration as defined in the Companies Act and the Directors' Remuneration report Regulations 2002 as interpreted for the context of NHS Foundation Trusts.

Details of the remuneration paid to the Board members, including the elements making up the remuneration, are set out in the tables below. This information has been subject to audit.

The Trust Board of the NHS Trust moved directly to the Board of Directors of the Foundation Trust with Executive appointments continuing under permanent contracts. Remuneration for 2007/8 has been set at an appropriate level to recognise the significant responsibilities of Directors in Foundation Trusts and to attract individuals with the necessary experience and ability.

Remuneration of Executive Directors

Remuneration for Executive Directors is determined by the Remuneration and Terms of Service Committee, a sub-committee of the Board of Directors. Membership of the Committee comprises the Chairman, up to three Non-executive Directors and the Chief Executive. The Remuneration Committee meeting was convened on 28 August 2007 at which all Committee members were present.

Chairperson John Turner (Non-executive Director)

Members Lynn Hagger (Trust Chairperson)
Chris Sharratt (Chief Executive)
Peter Lamberton (Non-executive Director)
Joe McNally (Non-executive Director)

The Remuneration Committee determines the range and conditions of service and contractual arrangements and also reviews the performance of the Chief Executive and Executive Directors. Annual objectives for Executive Directors are agreed with the Chief Executive and individual performance is reviewed by the Remuneration Committee.

Remuneration of senior managers

		Financial Year 1 April 07 - 31 March 08		
Name	**Title**	**Salary (bands of £10,000) £'000**	**Other remuneration (bands of £5,000) £'000**	**Benefits in kind Rounded to the nearest £100**
Christopher Sharratt	Chief Executive	120 - 130	N/A	0
Isabel Hemmings	Deputy Chief Executive	90 -100	N/A	0
Lee Bond	Director of Finance	30 - 40	N/A	0
Jeremy Loeb	Director of Finance (Deputy Chief Executive)	30 - 40	N/A	0
Louise Wembridge	Director of Human Resources	70 - 80	N/A	0
John Reid	Director of Clinical Operations and Nursing	80 - 90	N/A	0
Derek Burke	Medical Director	20 - 30	115 - 120	0
Lynn Hagger	Chairperson	20 - 30	N/A	0
Stephen Hunter	Chairman	0 - 10	N/A	0
Alan Bamford	Non-executive Director	0 - 10	N/A	0
Nick Bishop	Non-executive Director	0 - 10	N/A	0
Peter Lamberton	Non-executive Director	0 - 10	N/A	0
Joseph McNally	Non-executive Director	0 - 10	N/A	0
John Turner	Non-executive Director	0 - 10	N/A	0
Gareth Watkins	Non-executive Director	0 - 10	N/A	0
David Williams	Non-executive Director	0 - 10	N/A	0

Lynn Hagger's term ended 31 January 2008
Stephen Hunter's term began 1 February 2008
Lee Bond's term ended 3 August 2007
Jeremy Loeb's term began 19 November 2007

Pension Benefits of Senior Managers

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in lump sum at age 60 (bands of £2,500) £'000	Pension lump sum at age 60 at 31 March 2008 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2008 £'000	Cash Equivalent Transfer Value at 31 March 07 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Employers Contribution to Stakeholder Pension To nearest £100
Christopher Sharratt	Chief Executive	5 - 7.5	17.5 - 20.0	160 - 165	971	828	85	0
Isabel Hemmings	Deputy Chief Executive	2.5 - 5	7.5 - 10.0	65 - 70	328	273	33	0
Lee Bond	Director of Finance	0 - 2.5	0 - 2.5	40 - 45	155	137	3	0
Jeremy Loeb	Director of Finance (Deputy Chief Executive)	0 - 2.5	2.5 - 5.0	75 - 80	435	330	28	0
Louise Wembridge	Director of Human Resources	0 - 2.5	2.5 - 5.0	5 - 10	33	17	11	0
John Reid	Director of Clinical Operations and Nursing	2.5 - 5	12.5 - 15.0	75 - 80	400	304	62	0
Derek Burke	Medical Director	0 - 2.5	0 - 2.5	105 - 110	532	492	19	0

Non Executive Directors - do not receive any pensionable remuneration.

Cash Equivalent Transfer Value (CETV) - The CETV is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Lee Bond's term ended 3 August 2007
Jeremy Loeb's term began 19 November 2007

Increases for Executive Directors for 2007/8 were in line with those received by senior staff throughout the Trust. Director remuneration is not subject to performance conditions. Contracts are substantive. Notice periods are six months. There are no non-cash benefits or elements of remuneration that are not cash.

Remuneration of Non-executive Directors

The remuneration for the Chairman and Non-executive Directors is determined by the Remuneration Committee of the Council of Governors. Non-executive Directors receive no benefits or entitlements other than fees and are not entitled to any termination payments. Membership of the Council of Governors Remuneration sub Committee is as follows:

Lynn Hagger (Chairperson - Term ended 31 July 2008)
Pat Barker (Public Governor)
Frances Cunning (Partner Governor)
Nigel Harrington (Staff Governor)
Chris Leatherland (Public Governor)
Ian Thompson (Public Governor)

The Director of Human Resources attends the meeting to provide advice and support. The Governors also invited input from the Chief Executive during the course of the meeting which was convened on 22 January 2008

The Governors were given information from a range of sources to support the decision making process including a salary benchmarking exercise from Hays HR and a survey from the Foundation Trust Network on remuneration for Chairmen and Non-executive Directors.

The Trust does not make any contribution to the pension arrangements of Non-executive Directors. Details are given in the above table.

15.1 REMUNERATION POLICY

With the exception of the Executive Directors, and of the Trusts Doctors, all employees of the Trust, including senior managers, are remunerated in accordance with the National NHS Pay Structure, Agenda for Change. It is the Trust's policy that this will continue to be the case for the foreseeable future. The Trust's Doctors are paid in line with nationally determined pay-scales, notably driven by the Consultant contract.

Performance assessments offered by the Chief Executive and Chairman are based upon individuals' appraisals and a consideration of progress against the Trust's annual corporate objectives. This system is not one of performance-related pay. Directors do not receive bonus payments for successful achievement of objectives.

This process is supported by independent reviews of comparable NHS and other public sector organisations' salaries. Assessments of relative competitiveness are felt to be useful as part of the Board's retention programme for its most senior managers.

NHS Foundation Trusts must disclose the remuneration paid to senior managers, that is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust".

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is accounted for as a defined contribution scheme where the cost of the scheme is equal to the contributions payable for the accounting period. (See also Accounting Policy number 1.2 in the notes to the Trust's annual accounts)

Chris Sharratt
Chief Executive Date: 6 June 2008

16. Independent Auditors' Report

INDEPENDENT AUDITORS' REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

Opinion on the financial statements

We have audited the financial statements of Sheffield Children's NHS Foundation Trust for the year ended 31 March 2008 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Council of Governors of Sheffield Children's NHS Foundation Trust ('the Trust'), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

As described on page 65 the Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor.

Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the year ended 31 March 2008. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

We review whether the statement on internal control on pages 66 to 70 reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read the information contained in the Annual Report and the Directors' Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Basis of audit opinion

We conducted our audit in accordance with the National Health Service Act 2006 and the Code of Audit Practice issued by Monitor, 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.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us 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 our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view of the state of affairs of Sheffield Children's NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended; and
- the information given in the Directors' Report is consistent with the financial statements.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

KPMG LLP
1 The Embankment
Leeds
LS1 4DW

6 June 2008

17. Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Sheffield Children's NHS Foundation Trust.

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

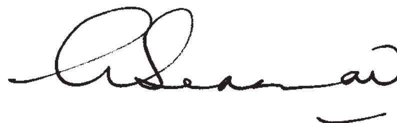
Under the National Health Service Act 2006, Monitor has directed the Sheffield Children's NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Children's NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

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



Chris Sharratt Chief Executive

Date: 6 June 2008

18. Statement on Internal Control – Year ended 31 March 2008

SCOPE OF RESPONSIBILITY

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

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

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

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the scheme are complied with.

CAPACITY TO HANDLE RISK

LEADERSHIP

The Board of Directors is responsible for the management of key risks. The Board receives details of key risks on a monthly basis through Board reports and through its discussions at Board meetings, the agenda having been set to reflect the Assurance Framework in operation within the organisation.

This process is supplemented on a quarterly basis when the quarterly self assessment of financial, activity and service risks are made for submission to the Independent Regulator, Monitor. The arrangement serves to reinforce the Board's understanding of its key business risks in the context of its strategic direction.

The executive team is responsible for the operation and assessment of the risk register throughout the organisation.

The process of risk management is assigned the highest priority by the Board of Directors. The Chief Executive as the accounting officer has delegated the overall responsibility for risk management throughout the Trust to the Director of Clinical Operations and Nursing where it is aligned with overall responsibility for clinical governance. Financial risk management and responsibility for Information Governance remains the responsibility of the Director of Finance.

TRAINING AND GUIDANCE ON MANAGEMENT OF RISK

Training and guidance on risk management is provided to all staff when they join the Trust as part of the induction process. In addition to this the Trust provides mandatory annual update training for all staff, including the Executive Directors in risk management. This training has to be attended once a year and is provided by the Trust twice a month. The requirement for additional training is informed by the provision of an annual performance review for every member of staff.

Staff are trained to manage risk in ways which are commensurate to their authority and duties. This includes the recording and managing of events that have happened as incidents, near misses, claims or complaints, as well as participating in risk assessment processes for clinical, organisational and financial risks.

This programme of training and appraisal provides a basis for ensuring that awareness of risk management is maintained. Dissemination of the risk management policies and procedures occurs through electronic and paper based systems.

The Trust uses the information from incident reporting, the risk register and patient complaints to review and amend activities in a way that leads to improvement and higher levels of safety for patients, staff and visitors.

THE RISK AND CONTROL FRAMEWORK

The Trust has a Risk Management Strategy in place which includes sections on risk identification, analysis, and evaluation. The full strategy has been distributed throughout the Trust and is available on the intranet.

Risk evaluation is based on a grading matrix of likelihood and consequence. This produces a risk score to enable the risk to be prioritised against other risks. The score is then used to determine the level within the organisation responsible for its management. Each directorate is responsible for identifying and updating its own risks although these do feed through on a monthly basis, via the risk management committee, to the corporate risk register.

In line with NHS policy the Trust has spent time developing and implementing an assurance framework as a mechanism for assessing risk and control at the very highest level.

As part of this process the Trust identifies its key strategic aims and underpinning these aims a larger number of operational or directorate level objectives.

Against these objectives the Trust has considered the risks preventing the achievement of the objectives together

with the associated controls in place and the sources of assurance, which can be identified, through which the controls can be seen to be effectively working.

The end result of this process of an assessment by the Board of Directors of those areas where gaps in control exist and a consideration over what measures, if any, the Trust would wish to introduce in order to reduce the identified risks. Action plans are then prepared and used to mitigate areas of risk identified.

As detailed earlier, this top-down process is supplemented by a review of the most significant risks facing the Trust from the risk register with all risks being subjected to the application of the same risk grading matrix.

Risks to information are being managed through the use of the NHS Information Governance toolkit. In addition work has been undertaken since December 2007 to provide further assurance on the adequacy of information management controls as part of the Information Governance Assurance Programme.

Incidents relating to the loss of personal data in 2007/8 are summarised in tables 1 and 2 below:

Table 1

SUMMARY OF SERIOUS UNTOWARD INCIDENTS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2007/8				
Date of Incident (month)	**Nature of incident**	**Nature of data involved**	**Number of people potentially affected**	**Notification steps**
Feb 2008	Theft of inadequately protected electronic storage device from former employee's home	Unnamed patient movement and gait study records held with consent for research purposes.	100 est.	Not practical because unnamed records
Further action on information risk	The Trust will continue to monitor and assess its information risks, in light of the events noted above, in order to identify and address any weaknesses and ensure continuous improvement of its systems. Planned steps for the coming year include further implementation of encryption devices on laptop computers.			

Table 2

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2007/8		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	None
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	None
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	Two incidents confined to hospital premises
IV	Unauthorised disclosure.	None
V	Other	None

The organisation has in place a formal structure to ensure that clear, unambiguous lines of accountability and communication exist within the organisation in order to facilitate a risk based approach to Trust actions.

The Board of Directors is supported by a number of formal sub-committees. These comprise the following:

HUMAN RESOURCES COMMITTEE

Facilitates the further development of the Trust's Human Resources strategy and ensures that key strategic objectives are translated into tangible action plans against which progress is monitored.

AUDIT COMMITTEE

Reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation.

Reviews the findings of other significant assurance functions both internal and external to the organisation and considers governance implications for the organisation.

CLINICAL EXCELLENCE AWARDS COMMITTEE

Convened annually to make recommendations to the Board of Directors on the awarding of Employer based clinical excellence awards.

NOMINATIONS COMMITTEE

Oversees the process of recruiting Executive Directors and leads the process for the identification and nomination of Non-executive Directors including the Chairman.

A feature of all these committees is that they are chaired by a Non-executive Director and contain Executive Director representation. Non-executive Directors provide the organisation with a means to effectively challenge the actions of the Executive Officers. Non-executive Directors are appointed to the Board of Directors via the Recruitment Committee. (This Committee comprises members of the Council of Governors, and is a sub-committee of the Council of Governors).

These various committees are accountable in their actions to the Board of Directors.

The operational management of the Trust is delegated to the Trust Executive Group which reports directly to the Board of Directors via the Chief Executive. Decisions taken by the Trust Executive Group are informed by risk management principles.

PUBLIC INVOLVEMENT IN RISK MANAGEMENT

The views of our public stakeholders are very important to the Trust. Learning from many varied sources external to the Trust enables the organisation to develop practices in a way which is responsive to genuine need.

As a Foundation Trust the organisation aims to make best use of its membership and of its Council of Governors. The Council of Governors is engaged at every opportunity to ensure that the Trust's operational strategy is being developed in line with membership expectations.

Foundation Trust Governors have reviewed the Trust's evidence of compliance with the Healthcare Commission's Annual Healthcheck. Individual Governors selected areas of interest or concern to them and examined as many standards, in as much detail as they required to satisfy themselves of compliance. The findings were later discussed and a collaborative statement was agreed at a full meeting of the Council of Governors on 10 April 2008.

The level of public and patient involvement in the provision of services provides assurance that the Trust is not operating in isolation and is trying, wherever possible to put the needs of children and their families at the centre of our services.

Examples of where public stakeholders are being actively engaged by the Trust in an effort to bring continuous improvement to the organisation:

- use of patient surveys to indicate areas for improvement
- the continued work of the Patient Carer Advisory Group (previously the Parent and Patients' Council),
- the Trust's support of the Patient and Public Involvement Forum,
- the development of the Patients Advice and Liaison Service
- the involvement of the Patient Care Advisory Group in Patient Environment Action Team (PEAT) inspections

PARTNERSHIP INVOLVEMENT IN RISK MANAGEMENT

The Trust is engaged in close partnership with other organisations in Sheffield regarding the delivery of services for children and young people. The Sheffield 0-19+ Partnership is the organisation through which agencies work together to co-ordinate the planning and delivery of services for children and young people. Representatives of Sheffield Children's NHS Foundation Trust are involved in the 0-19+ Partnership and committees accountable to the Partnership. The 0-19+ Partnership is not a corporate body in its own right but supports the collaboration of a range of agencies including Primary Care Trusts, the Sheffield City Council, Police and Voluntary Sector providers.

Aligned to this is our commitment to and participation in the Sheffield "First" structure, which aims to promote involvement in the co-ordination of services across public and commercial organisations. The city has implemented and is further developing its Local Area Agreement to support multi-agency approaches to improving Sheffield as a city.

The Trust works closely with other providers of specialist paediatric services within the UK. These relationships are limited to information sharing, benchmarking of services and a co-ordinated approach to the implementation of national policy such as the introduction of Payment by Results.

The Trust also works closely with neighbouring Foundation Trusts within South Yorkshire and North Derbyshire in

order to manage relationships and ensure clarity of service provision as clearly as possible. As a member of the Foundation Trust Network the Trust is also able to participate in a national forum which helps influence and manage the implementation of national policy where it relates to NHS Trusts.

The organisation continues to attend regular meetings held by the Strategic Health Authority to consider issues across the health authority and/or health and social care community areas.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

RESOURCE MANAGEMENT

The Trust has successfully worked alongside other specialist hospitals to achieve changes to the national tariffs to ensure that these hospitals are appropriately reimbursed for the type of clinical activity undertaken. Whilst this has resolved the immediate funding concerns, the introduction of a revised method of classifying cases for tariff purposes from 2009/10 could reduce income. The Trust will continue to work with other specialist Trusts and the Department of Health to ensure that impact of the new system is fully assessed to avoid creating further instability.

The Trust is looking to make the necessary productivity and efficiency gains through which sustained service provision can be achieved. It is exploring the use of 'lean management' techniques to improve patient safety and efficiency.

SOURCES OF ASSURANCES

During the year the Board has received regular reports informing of the economy, efficiency, and effectiveness of the use of resources. Reports detailing the financial clinical and performance of the organisation during the period are regularly produced with traffic light systems in place to flag areas for concern where they exist. These reports are produced by the Executive officers of the Trust.

Internal Audit continues to review systems and processes in place during the year and publishes reports detailing specific actions to ensure economy, efficiency and effectiveness of the use of resources is maintained. The outcome of these reports and the recommendations therein are also graded according to their perceived level of risk to the organisation, therefore assisting management action.

This process has been supplemented by the external audit reports which assessed the Trust's resources in terms of its economy, efficiency and effectiveness.

The Board of Directors also received assurances on the use of resources from outside agencies including Monitor and the Healthcare Commission. Monitor requires the Board of Directors to self assess on a quarterly basis and scores the organisation using a traffic light system.

REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, having taken account of reports from the Audit Committee, the Clinical Governance Committee, the Finance and Performance Committee and Risk Management Committee.

Participation of the Non-executive directors in chairing all of the Trust's formal committees such as the Clinical Governance Committee, the Risk Management Committee and the Audit Committee provides important additional assurance over the opinions being reported.

My review is also informed by:

- Audit reports prepared independently by both the internal and external audit agencies, in particular, the annual audit letter produced by KPMG.
- The published results of the quarterly performance management processes undertaken by Monitor.
- The annual performance indicators published by the Department of Health.
- The published results of the Healthcare Commission's report concerning Hospital services for Children in which the Trust was judged as 'Excellent'.
- The Board of Directors' declaration of compliance against the Standards for Better Health Core Standards: based upon detailed self assessments completed by the organisation. This assessment has been subjected to independent validation by the following bodies: Internal Audit, FT Governors, Patient and Public Involvement Forum, Local Overview and Scrutiny Committee and the Sheffield Safeguarding Board.
- Independent reviews undertaken on behalf of the NHS Litigation Authority in respect of clinical negligence and risk pooling, which enabled the trust to achieve level 1 under the new assessment process.
- Achievement of Improving Working Lives, Practice Plus accreditation in respect of workforce management.

I believe that the above systems and controls provide assurance that the Trust is able to identify risks, quantify gaps in controls and bring these quickly to the attention of the Council of Governors.

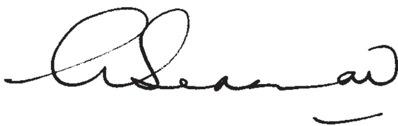
The Trust has put in place processes to enable it to monitor waiting times as part of its plans to achieve the 18 week target by December 2008. Suitable computer based tracking systems are still at an early stage of development and the Trust will rely on an interim method for monitoring of the 18 week pathway for each patient. Whilst this process is controlled, it remains an area of risk.

The Trust receives an MRI service from the University of Sheffield. A failure of the scanner in March 2008 resulted in four breaches of the six week diagnostic wait target. The existing contingency plan for equipment failure is being reviewed.

Plans are in place to strengthen the medical records service following a review in 2007/8.

Following a review of information governance, as noted earlier, an action plan is being implemented to strengthen controls over data.

With the exception of the loss referred to in table 1 detailed on page 67 of the Statement of Internal Control, no significant loss of control has occurred in 2007/8.



Chris Sharratt Chief Executive

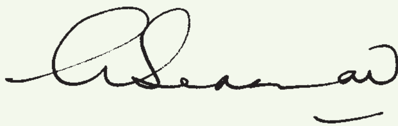
Date: 6 June 2008

19. Annual Accounts

FOREWORD TO THE ACCOUNTS

SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

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



Chris Sharratt Chief Executive

Date: 6 June 2008

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2008

	NOTE	2007-08 £000	2006-07 (8 Months ended 31/3/2007) £000
Income from activities	3	**87,057**	52,406
Other operating income	4	**10,532**	6,532
Operating expenses	5-7	**(91,367)**	(55,383)
OPERATING SURPLUS		**6,222**	3,555
Loss on disposal of fixed assets	8	**(57)**	(315)
SURPLUS BEFORE INTEREST		**6,165**	3,240
Finance income		**804**	333
Finance costs - interest expense	9	**0**	0
Other finance costs - unwinding of discount	17	**(10)**	(9)
SURPLUS FOR THE FINANCIAL YEAR		**6,959**	3,564
Public Dividend Capital dividends payable		**(1,432)**	(924)
RETAINED SURPLUS FOR THE YEAR		**5,527**	2,640

The notes on pages 76 to 100 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 MARCH 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
FIXED ASSETS			
Intangible assets	10	**493**	400
Tangible assets	11	**50,390**	43,707
		50,883	44,107
CURRENT ASSETS			
Stocks	13	**835**	727
Debtors	14	**7,088**	5,812
Cash at bank and in hand	19.3	**13,236**	8,356
		21,159	14,895
CREDITORS: Amounts falling due within one year	16	**(10,628)**	(9,351)
NET CURRENT ASSETS		**10,531**	5,544
TOTAL ASSETS LESS CURRENT LIABILITIES		**61,414**	49,651
CREDITORS: Amounts falling due after more than one year	16	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(450)**	(549)
TOTAL ASSETS EMPLOYED		**60,964**	49,102
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	18	**36,401**	36,401
Revaluation reserve	18	**11,073**	5,835
Donated asset reserve	18	**5,052**	4,003
Income and expenditure reserve	18	**8,438**	2,863
TOTAL TAXPAYERS' EQUITY		**60,964**	49,102

The financial statements on pages 71 to 100 were approved by the Board on 6 June 2008 and signed by:

Chris Sharratt Chief Executive

Date: 6 June 2008

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2008

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Surplus for the financial period before dividend payments	**6,959**	3,564
Unrealised surplus on fixed asset revaluations	**5,618**	0
Increase in the donated asset reserve due to receipt of donated assets	**1,130**	285
Reductions in the donated asset reserve due to depreciation	**(413)**	(229)
Total recognised gains for the financial year	**13,294**	3,620

CASH FLOW STATEMENT
FOR THE YEAR ENDED 31 MARCH 2008

	NOTE	2007-08 £000	2006-07 (8 Months ended 31/3/2007) £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	19.1	**9,970**	11,443
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**732**	333
Net cash inflow from returns on investments and servicing of finance		**732**	333
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(4,170)**	(3,328)
Payments to acquire intangible assets		**(220)**	(111)
Net cash outflow from capital expenditure		**(4,390)**	(3,439)
DIVIDENDS PAID		**(1,432)**	(924)
Net cash inflow before financing		**4,880**	7,413
FINANCING			
New public dividend capital received		**0**	793
Net cash inflow from financing		**0**	793
Increase in cash		**4,880**	8,206

NOTES TO THE ACCOUNTS

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2007-08 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK Generally Accepted Accounting Practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Accounting Period

The accounts of the Foundation Trust have been drawn up for the year to 31 March 2008. Following the change of NHS Trust status to NHS Foundation Trust on 1 August 2006, the income and expenditure and cashflow comparative figures in these accounts are for an eight month period only.

1.3 Accounting Convention

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

1.4 Acquisitions and Discontinued Operations

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

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

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

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

(d) Operations not satisfying all these conditions are classified as continuing. Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.5 Income Recognition

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

Where the provision of a health care service has commenced before and is still continuing at the year end the income relating to the patient activity is accrued for these partially completed patient spells. The accrued income is calculated based on the number of incomplete spells accrued at an average tariff for that type of procedure and the accounting treatment is in accordance with FRS 5 and Urgent Issues Task Force (UITF) 40.

Sheffield Children's NHS Foundation Trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology in 2005-06 (at that time the Trust was an NHS Trust). To manage the financial impact of the change on the Trust and its commissioners, the Trust has received transitional relief payments from the Department of Health during the move to full tariff operation. These payments have been based on the outcome of the rebasing exercises undertaken in 2004-05 and 2005-06 and have been received in each of the years 2005-06, 2006-07 and 2007-08 on a reducing basis of 100%, 50% and 25% in each year respectively.

1.6 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.7 Tangible Fixed Assets

1.8 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

- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

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

1.9 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. 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. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are revalued using professional valuations in accordance with FRS 15 every five years. A two to three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken during the year as at the prospective valuation date of 31 March 2008. The revaluation undertaken as at that date was accounted for on 31 March 2008.

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.

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

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount. Operational equipment is restated to current value each year by the indexation of asset values which is calculated in accordance with national indices. Revaluation is effected from 1 April each year and is ordinarily applied for the full financial year.

1.10 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 Private Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Foundation Trust, respectively.

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

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

Engineering Equipment
5 years-15 years

Furniture
10 years

Office & IT Equipment
5 years

Medical Equipment
5-15 years

Mainframe IT Installation
8 years

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

1.11 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 amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment in 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 and amortised over the shorter of the term of the licence and their useful economic lives.

Intangible software licences are depreciated on current cost evenly over an estimated life of five years.

1.12 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 sale proceeds of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.13 Investments

No fixed asset or current asset investments are held by the Foundation Trust. Bank and Postmaster General's Office (PGO) deposit accounts which have seven day or less access are treated as liquid resources in the cashflow statement.

1.14 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value.

1.15 Cash, Bank and Overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS Foundation Trust's cash book. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "finance income" and "finance costs - interest expense" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.16 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 and its resulting in a product or services that will eventually be brought into use; and

- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Sheffield Children's NHS Foundation Trust is unable to disclose the total amount of research and development expenditure charged in the Income and Expenditure account separately as some research and development activity cannot be separated from patient care.

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

1.17 Provisions

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

1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable. Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 22 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation 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 NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17.

Since financial responsibility for clinical negligence cases transferred to the NHSLA on 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in the year ended 31 March 2008 relates to the Foundation Trust's contribution to the Clinical Negligence Scheme for Trusts.

1.20 Non-clinical Risk Pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation 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 when the liability arises.

1.21 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 NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme under FRS 17. Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the trust commits itself to the retirement, regardless of the method of payment.

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary. However, the last published valuation relates to the period 1 April 1994 to 31 March 1999. The valuation as at 31 March 2003 has not yet been published and it is not expected that it will be published before the 2007-08 NHS Foundation Trust accounts are prepared. Betwen valuations, the Government Actuary provides an update of the scheme liabilities which is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually.

1.22 Value Added Tax

Most of the activities of the NHS Foundation 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.

1.23 Corporation Tax

The NHS Foundation Trust has carried out a review of its potential tax liability in respect of its non-health care activities. At present all activities are either ancillary to the Foundation Trust's patient care activity or are below the de minimus level at which corporation tax is due.

1.24 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.

1.25 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.26 Leases

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

1.27 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust. A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.28 Losses and Special Payments

Losses and special payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 Financial Instruments

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when,

and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

Classification and measurement

Financial assets are categorised as 'Loans and receivables'. Financial liabilities are classified as 'Other financial liabilities'.

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

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise cash at bank and in hand, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised at fair value, net of transaction costs.

Financial liabilities

All financial liabilties are recognised at fair value, net of transaction costs incurred. They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities.

Impairment of financial assets

At the balance sheet date, the Foundation Trust assesses whether any financial asset, other than those held at 'fair value through income and expenditure', is impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset. A bad debt provision is used by the Foundation Trust for the impairment of receivables and its value is assessed at the year end by reference to an aged debt analysis between NHS and non-NHS debts at the balance sheet date plus any known further individual receivables whose recovery is judged to be doubtful.

2. SEGMENTAL ANALYSIS

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

3. INCOME FROM ACTIVITIES

3.1 Income from activities comprise:	2007-08 Total £000	2006-07 (8 Months ended 31/3/2007) Total £000
Elective income	**15,225**	9,482
Non elective income	**14,032**	8,645
Outpatient income	**13,489**	8,044
Other type of activity income*	**40,945**	24,065
A&E income	**2,919**	1,679
PbR transitional relief	**363**	472
Private patient income	**84**	19
	87,057	52,406

* Other activities income includes income for community services £2,543,000 (2006-07 £1,604,000), mental health services £6,987,000 (2006-07 £4,197,000), critical care services £6,039,000 (2006-07 £3,010,000), blood products income £1,996,000 (2006-07 £1,713,000) and cost per case activity including drugs, bone marrow transplants and scoliosis £5,437,000 (2006-07 £2,645,000).

3.2 Private patient income	Base Year (2002-03) £000	2007-08 £000
Private patient income	88	**84**
Total patient related income	49,290	**87,057**
Proportion (as a percentage)	0.2%	**0.1%**

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

3.3 Income from activities	2007-08 £000	2006-07 (8 Months ended 31/3/2007) £000
NHS Foundation Trusts	**5,815**	2,094
NHS Trusts	**465**	548
Strategic Health Authorities	**0**	0
Primary Care Trusts	**76,528**	46,665
Local Authorities	**792**	0
Department of Health – grants	**0**	0
Department of Health – other	**2,921**	2,420
NHS Injury Scheme (was Road Traffic Act)*	**126**	83
Non NHS:		
- Private patients	**84**	19
- Overseas patients (non-reciprocal)	**86**	14
- Other**	**240**	563
	87,057	52,406

* NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.
** Other non NHS income of £240,000 is income received for tests provided.

The Department of Health income above is made up as follows:

	2007-08	2006-07
- Payment by Results (PbR) clawback arrangements and other relief	**405**	967
- Market Forces Factor (MFF)	**2,451**	1,453
- Other income	**65**	0
	2,921	2,420

4. OTHER OPERATING INCOME

4.1 Other operating income	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Research and development	1,424	1,244
Education and training	6,250	3,546
Charitable and other contributions to expenditure	709	1,056
Transfers from donated asset reserve in respect of depreciation, impairment and disposal of donated assets	413	229
Non-patient care services to other bodies	783	406
Other*	953	51
	10,532	6,532

* Other income now includes catering income £465k.

5. OPERATING EXPENSES

5.1 Operating expenses comprise:	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Services from NHS Foundation Trusts	2,565	1,150
Services from NHS Trusts	742	566
Services from other NHS Bodies	212	264
Executive directors' costs	583	456
Non-executive directors' costs	67	32
Staff costs	64,000	39,433
Drug costs	3,597	2,151
Supplies and services – clinical (excluding drug costs)	7,954	5,143
Supplies and services – general	742	469
Establishment	1,958	1,117
Transport	78	53
Premises	3,028	1,732
Increase in bad debt provision	248	31
Depreciation and amortisation	2,755	1,764
Fixed asset impairments	810	0
Audit fees – statutory audit and regulatory reporting	58	45
Audit fees – further assurance and other services	48	22
Clinical negligence	713	474
Other*	1,209	481
	91,367	55,383

* Other expenses include consultancy fees £301k, project expenditure and redundancy payments £307k, and interpreter fees and estates materials £181k.

5.2 Operating leases

5.2.1 Operating expenses include:	**2007-08**	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Hire of plant and machinery	**48**	27
Other operating lease rentals	**244**	170
	292	197

5.2.2 Annual commitments under non-cancellable operating leases are:

	2007-08 Land and buildings £000	**2007-08 Other leases £000**
Operating leases which expire:		
Within 1 year	**260**	**44**
Between 1 and 5 years	**1,039**	**68**
After 5 years	**645**	**0**
	1,944	**112**

6. STAFF COSTS AND NUMBERS

6.1 Staff costs	**2007-08**			2006-07 (8 Months ended 31/3/2007)
	Total	**Permanently Employed**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**52,778**	**49,375**	**3,403**	32,564
Social Security costs	**4,419**	**4,134**	**285**	2,800
Employer contributions to NHSPA	**6,338**	**5,930**	**408**	3,844
Agency/contract staff	**1,048**	**0**	**1,048**	681
	64,583	**59,439**	**5,144**	39,889

Staff costs totalling £260,765 (2006-07 £163,000) have been capitalised as part of fixed assets in note 11.1.

Employer contribution rates to the NHS pension scheme are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation on which contribution rates were rebased (31 March 1999) employer contribution rates from 2003-04 were set at 14% of pensionable pay and employees pay contributions at 6% (manual staff 5%) of their pensionable pay.

6.2 Average number of persons employed

	2007-08			2006-07 (8 Months ended 31/3/2007)
	Total	**Permanently Employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Medical and dental	**295**	**254**	**41**	256
Administration and estates	**330**	**325**	**5**	331
Health care assistants and other support staff	**179**	**179**	**0**	184
Nursing, midwifery and health visiting staff	**416**	**416**	**0**	426
Nursing, midwifery and health visiting learners	**5**	**5**	**0**	6
Scientific, therapeutic and technical staff	**263**	**253**	**10**	255
Bank and agency staff	**41**	**0**	**41**	38
Other	**1**	**1**	**0**	1
Total	**1,530**	1,433	97	1,497

6.3 Employee benefits
The Trust has not provided any non-pay group benefits to staff in this financial period.

6.4 Retirements due to ill-health
During the year ended 31 March 2008 there were 6 (2006-07 2) early retirements from the Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities for ill-health retirements will be £400,000 (2006-07 £159,000) for the year. This information has been supplied by NHS Pensions. These retirements represented 3.50 per 1,000 active scheme members.

7. BETTER PAYMENT PRACTICE CODE

7.1 Better Payment Practice Code – measure of compliance

	2007-08	2007-08
	Number	£000
Total non-NHS trade invoices paid in the year	29,492	18,183
Total non-NHS trade invoices paid within target	28,322	17,099
Percentage of non-NHS trade invoices paid within target	96%	94%
Total NHS trade invoices paid in the year	2,423	11,782
Total NHS trade invoices paid within target	2,201	10,718
Percentage of NHS trade invoices paid within target	91%	91%

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

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

There were no claims arising under this legislation in the year ended 31 March 2008.

8. LOSS ON DISPOSAL OF FIXED ASSETS

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

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Loss on disposal of plant and equipment	(57)	(315)
	(57)	(315)

9. INTEREST

The Trust did not incur any interest charges between 1 April 2007 and 31 March 2008 and had interest receivable of £804k in the same period.

10. INTANGIBLE FIXED ASSETS

	Software Licences £000	Total £000
Gross cost at 1 April 2007	782	**782**
Additions purchased	220	**220**
Additions donated	20	**20**
Disposals	(17)	**(17)**
Gross cost at 31 March 2008	**1,005**	**1,005**
Amortisation at 1 April 2007	382	**382**
Provided during the year	142	**142**
Disposals	(12)	**(12)**
Amortisation at 31 March 2008	**512**	**512**
Net book value		
- Purchased at 1 April 2007	400	**400**
- Donated at 1 April 2007	0	**0**
- Total at 1 April 2007	**400**	**400**
- Purchased at 31 March 2008	473	**473**
- Donated at 31 March 2008	20	**20**
- Total at 31 March 2008	**493**	**493**

11. TANGIBLE FIXED ASSETS

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

	Land	Buildings excluding 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
Cost or valuation at 1 April 2007	4,066	34,074	537	14,734	67	3,718	162	**57,358**
Additions purchased	90	1,315	678	964	5	288	90	**3,430**
Additions donated	0	67	167	668	81	103	24	**1,110**
Impairments	0	(1,056)	0	0	0	0	0	**(1,056)**
Reclassifications	302	638	(999)	55	0	4	0	**0**
Other revaluations	1,403	1,857	0	110	0	0	0	**3,370**
Disposals	0	0	0	(1,197)	0	(11)	0	**(1,208)**
Cost or valuation at 31 March 2008	**5,861**	**36,895**	**383**	**15,334**	**153**	**4,102**	**276**	**63,004**
Depreciation at 1 April 2007	0	958	0	10,497	67	2,057	72	**13,651**
Charged during the year	0	1,536	0	711	0	352	14	**2,613**
Impairments	0	(246)	0	0	0	0	0	**(246)**
Other revaluations	0	(2,248)	0	0	0	0	0	**(2,248)**
Disposals	0	0	0	(1,146)	0	(10)	0	**(1,156)**
Depreciation at 31 March 2008	**0**	**0**	**0**	**10,062**	**67**	**2,399**	**86**	**12,614**
Net book value								
- Purchased at 1 April 2007	4,066	30,114	388	3,400	0	1,646	90	**39,704**
- Donated at 1 April 2007	0	3,002	149	837	0	15	0	**4,003**
Total at 1 April 2007	**4,066**	**33,116**	**537**	**4,237**	**0**	**1,661**	**90**	**43,707**
- Purchased at 31 March 2008	5,861	33,405	383	3,946	5	1,589	168	**45,357**
- Donated at 31 March 2008	0	3,490	0	1,326	81	114	22	**5,033**
Total at 31 March 2008	**5,861**	**36,895**	**383**	**5,272**	**86**	**1,703**	**190**	**50,390**

11.2 Analysis of tangible fixed assets

	Land £000	Buildings excluding dwellings £000	Assets under construction and payments on account £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Total £000
Net book value								
- Protected assets at 31 March 2008	5,574	36,278	0	0	0	0	0	**41,852**
- Unprotected assets at 31 March 2008	287	617	513	5,272	86	1,703	190	**8,668**
Total at 31 March 2008	**5,861**	**36,895**	**513**	**5,272**	**86**	**1,703**	**190**	**50,520**

11.3 Assets held at open market value

Of the totals at 31 March 2008, none of the assets relating to land, buildings and dwellings were valued at open market value.

11.4 Assets held under finance leases and hire purchase contracts

At the balance sheet date the Foundation Trust was not committed to any finance leases or hire purchase contracts and hence no depreciation was charged in the period relating to such items.

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

	Total £000	Protected £000	Unprotected £000
Freehold	42,756	41,852	904
TOTAL	**42,756**	**41,852**	**904**

11.6 Impairment of Assets

	£000
Over specification of assets	810
TOTAL	**810**

12. FIXED ASSET INVESTMENTS

At the balance sheet date the Foundation Trust was not holding any fixed asset investments.

13. STOCKS

	31 March 2008 £000	31 March 2007 £000
Raw materials and consumables	**835**	727
TOTAL	**835**	727

14.1 DEBTORS

	31 March 2008 £000	31 March 2007 £000
Amounts falling due within one year:		
NHS debtors	**5,425**	4,100
Provision for irrecoverable debts	**(565)**	(623)
Prepayments and accrued income	**577**	594
Other debtors	**1,297**	1,362
Sub Total	**6,734**	5,433
Amounts falling due after more than one year:		
NHS debtors	**354**	379
Sub Total	**354**	379
TOTAL	**7,088**	5,812

14.2 Provision for impairment of NHS debtors

	2007-08 £000	2006-07 £000
At 1 April	**369**	
At start of new FT period		87
Provision for debtors impairment	**21**	311
Debtors written off during the year as uncollectable	**(62)**	(26)
Unused amounts reversed	**(226)**	(3)
At 31 March	**102**	369

14.3 Analysis of impaired debtors

	2007-08 £000	2006-07 £000
Ageing of impaired debtors		
Up to three months	**1,596**	2,693
In three to six months	**84**	121
Over six months	**14**	0
TOTAL	**1,694**	2,814
Ageing of non-impaired debtors past their due date		
Up to three months	**0**	0
In three to six months	**13**	123
Over six months	**51**	45
TOTAL	**64**	168

15. INVESTMENTS

At the balance sheet date the Trust was not holding any current asset investments.

16. CREDITORS

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

	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
NHS creditors	**2,576**	2,997
Other tax and social security costs	**1,422**	1,257
Capital Creditors	**524**	1,265
Other creditors	**1,451**	1,353
Accruals and deferred income	**4,655**	2,479
Sub Total	**10,628**	9,351
Amounts falling due after more than one year:	**0**	0
TOTAL	**10,628**	9,351

Other creditors include £769,000 (31 March 2007 £682,000) outstanding pensions contributions at 31 March 2008

16.2 Loans and other long-term financial liabilities

The Foundation Trust has not taken out any loans and does not have any long term financial liabilities.

16.3 Prudential borrowing limit

The Foundation Trust is required to comply and remain within a prudential borrowing limit (PBL). This is made up of two elements:

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

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

The total long term borrowing limit set for the Foundation Trust by Monitor is £16,700,000 and the working capital facility approved by Monitor is £6,500,000.

As the Foundation Trust did not require any loans in the 12 month period to 31 March 2008, only the minimum dividend cover ratio is applicable, and the performance against this is shown below:

	Actual ratio 12 months to 31 March 2008	Approved PBL ratio 12 months to 31 March 2008
Minimum dividend cover	4.86	>1

This means that the Foundation Trust is able to meet its interest payment on its Public Dividend Capital 4.86 times from the surplus that was generated in the year.

16.4 Finance lease obligations

There were no finance lease obligations at the balance sheet date.

17. PROVISIONS FOR LIABILITIES AND CHARGES

	Pensions – other staff	Other legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2007	7	20	522	**549**
Change in discount rate	0	0	0	**0**
Arising during the period	0	18	0	**18**
Utilised during the period	0	(20)	(97)	**(117)**
Reversed unused	0	(4)	(6)	**(10)**
Unwinding of discount	0	0	10	**10**
At 31 March 2007	**7**	**14**	**429**	**450**
Expected timing of cashflows:				
Within 1 year	1	14	17	**32**
Between 1 and 5 years	3	0	80	**83**
After 5 years	3	0	332	**335**

The provision for legal claims is in respect of employer's liability and public liability cases made against the Foundation Trust. This figure is based on information provided by the NHS Litigation Authority which at present represents the Foundation Trust's best assessment of the likely future costs associated with processing the claims. The eventual settlement costs and legal expenses may be higher or lower than that provided.

The provision for other claims of £429,000 is in respect of injury benefit cases and the amounts have been calculated based on information provided by the NHS Pensions Agency. There are uncertainties surrounding these provisions as the amounts incorporate assumptions made concerning the life expectancy of the individuals.

All provisions are shown gross of back to back reimbursements due of £354,000, which are included within debtors at Note 14.

£1,824,000 is included in the provisions of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the Foundation Trust.

18. MOVEMENTS IN TAXPAYERS' EQUITY AND PUBLIC DIVIDEND CAPITAL

18.1 Movements in taxpayers' equity are made up of:

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Taxpayers' equity at 1 April 2007	**49,102**	45,541
Surplus for the year	**6,959**	3,564
Public dividend capital dividends	**(1,432)**	(924)
Fixed asset impairments	**0**	0
Surplus from revaluations of fixed assets	**5,618**	0
New public dividend capital received	**0**	793
Additions in donated asset reserve	**717**	56
Additions in other reserves	**0**	72
Taxpayers' equity at 31 March 2008	**60,964**	49,102

18.2 Movement in Public Dividend Capital

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Public Dividend Capital as at 1 April 2007	**36,401**	35,608
New Public Dividend Capital received	**0**	793
Public Dividend Capital as at 31 March 2008	**36,401**	36,401

18.3 Movements on reserves

Movements on reserves in the period comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Income and Expenditure Reserve £000	**Total £000**
At 1 April 2007	5,835	4,003	2,863	**12,701**
Transfer from the Income and Expenditure Account	0	0	5,527	**5,527**
Surplus on revaluations of fixed assets	5,278	340	0	**5,618**
Receipt of donated assets	0	1,130	0	**1,130**
Transfer of realised profits/(losses) to the income and expenditure account	(40)	0	40	**0**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	0	(413)	0	**(413)**
Other transfers between reserves	0	(8)	8	**0**
At 31 March 2008	11,073	5,052	8,438	**24,563**

19. NOTES TO THE CASH FLOW STATEMENT

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

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Total operating surplus	**6,222**	3,555
Depreciation and amortisation	**2,755**	1,764
Fixed asset impairments	**810**	0
Fixed asset reversal of impairments	**0**	0
Transfer from donated asset reserve	**(413)**	(229)
Other movements	**0**	72
Increase in stocks	**(108)**	0
Increase in debtors	**(1,204)**	8,604
Increase in creditors	**2,017**	(2,243)
Decrease in provisions	**(109)**	(80)
Net cash inflow from operating activities	**9,970**	11,443

19.2 Reconciliation of net cash flow to movement in net funds:

	2007-08	2006-07 (8 Months ended 31/3/2007)
	£000	£000
Increase in cash in the year	**4,880**	8,206
Change in net debt resulting from cashflows	**4,880**	8,206
Net funds at 1 April 2007	**8,356**	150
Net funds at 31 March 2008	**13,236**	8,356

19.3 Analysis of changes in net funds:

	Cash at 1 April 2007	**Cash changes in period**	**At 31 March 2008**
	£000	**£000**	**£000**
OPG cash at bank	8,226	4,943	**13,169**
Commercial cash at bank and in hand	130	(63)	**67**
	8,356	4,880	**13,236**

20. CONTRACTUAL CAPITAL COMMITMENTS

Commitments under capital expenditure contracts at 31 March 2008 were £2,988,000 (31 March 2007 £139,000). £2,839,000 is committed for the Foundation Trust's High Dependancy Unit scheme, a further £110,000 for the support services changing room scheme and the remaining £39,000 is for smaller miscellaneous items.

21. POST BALANCE SHEET EVENTS

No material issues have arisen since the balance sheet date.

22. CONTINGENCIES

	31 March 2008	31 March 2007
	£000	£000
Contingent liabilities (gross value)	**(6)**	(8)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(6)**	(8)
Contingent assets	**0**	0

23. RELATED PARTY TRANSACTIONS

Sheffield Children's 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 Children's NHS Foundation Trust. Governors of the Foundation Trust had the following related party transactions.

Name of Body	Relationship	Debtor balance at 31 March 2008 £000	Creditor balance at 31 March 2008 £000	Income for year 2007-08 £000	Expenditure for year 2007-08 £000
Sheffield Teaching Hospitals NHS Foundation Trust	One governor has a partner who is a governor of this Foundation Trust	849	1,780	2,274	5,091
Derbyshire County PCT	One governor is the Director of Public Health at this PCT	234	18	5,165	8
Sheffield Hallam University	One governor is employed by this body	0	0	0	30
Sheffield City Council	One governor is a member of the council	119	2	792	513
Total		**1,202**	**1,800**	**8,231**	**5,642**

At 31 March 2008 funds to the value of £1,039,000 (31 March 2007 £1,094,000) were held on Trust. There were no outstanding expenditure commitments. The responsibility for the management of these funds remains with the Sheffield Hospitals Charitable Trust, a registered charity within whose accounts the transactions are reported.

During the year ended 31 March 2008 the Foundation Trust also received revenue and capital funding from the Sheffield Children's Hospital Charity, a registered charity that exists to support and enhance the work of the Sheffield Children's NHS Foundation Trust and its reputation as a regional centre of excellence for the research, prevention and cure of childhood illnesses. In the year ended 31 March 2008, the charity raised a total of £1,742,000 (year ended 31 March 2007 £1,375,000). Four members of the Foundation Trust's senior management team are also Trustees of the charity (one of whom is a member of the Trust Board).

24. PRIVATE FINANCE TRANSACTIONS

Sheffield Children's NHS Foundation Trust is not involved in any Private Finance Transactions.

25. FINANCIAL INSTRUMENTS

Credit Risk

Credit risk is the risk of financial loss to the Foundation Trust if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Foundation Trust's debtors.

Exposure to credit risk

The carrying amount of financial assets represents the maximum credit exposure. Therefore, the maximum exposure to credit risk at the balance sheet date was £6,583,000 (2006-07: £5,441,000) being the total of the carrying amount of financial assets.

Credit quality of financial assets and impairment losses

The movement in the allowance for impairment in respect of trade debtors during the year is disclosed in note 14.2.

The ageing of non-impaired trade debtors past their due date at the 31 March 2008 is disclosed in note 14.3.

Market Risk - Interest Rate Risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Foundation Trust's income or the value of its holdings of financial instruments.

All of the Foundation Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Foundation Trust's financial assets that are currently subject to a variable rate is cash held in the Foundation Trust's main bank accounts and in a short term deposit account. The Foundation Trust is therefore not exposed to significant risk of fluctuations in interest rates.

At the balance sheet date, the interest rate profile of the Foundation Trust's interest bearing financial instruments was:

25.1 Floating and fixed rate financial instruments

	Floating rate	Fixed rate
	£000	£000
Financial assets denominated in £ Sterling	**13,236**	6,583
Financial assets denominated in other currencies, restated in £ sterling	**0**	0
Financial liabilities denominated in £ sterling	**0**	(5,850)
Financial liabilities denominated in other currencies, restated in £ sterling	**0**	0
Gross financial assets at 31 March 2008	**13,236**	**733**
Financial assets denominated in £ sterling	**8,356**	5,441
Financial assets denominated in other currencies, restated in £ sterling	**0**	0
Financial liabilities denominated in £ sterling	**0**	(6,754)
Financial liabilities denominated in other currencies, restated in £ sterling	**0**	0
Gross financial assets/(liabilities) at 31 March 2007	**8,356**	**(1,313)**

25.1a Financial assets by category

	31 March 2008	31 March 2007
	£000	£000
Assets as per balance sheet		
Investments	**0**	0
Finance lease receivables	**0**	0
NHS debtors	**5,214**	3,856
Accrued income	**72**	223
Other debtors	**1,297**	1,362
Cash at bank and in hand	**13,236**	8,356
Total at 31 March 2008	**19,819**	**13,797**

25.2 Financial liabilities by category

	31 March 2008	31 March 2007
	£000	£000
Liabilities as per balance sheet		
NHS Creditors	**2,576**	2,997
Other creditors	**1,975**	2,618
Accruals	**1,299**	1,139
Loans	**0**	0
Finance lease obligations	**0**	0
Total at 31 March 2008	**5,850**	**6,754**

Fair Values of Financial Instruments

Trade and other debtors
The fair value of trade and other receivables is estimated as the present value of future cash flows, discounted at the market rate of interest at the balance sheet date if the effect is material.

Trade and other creditors
The fair value of trade and other payables is estimated as the present value of future cash flows, discounted at the market rate of interest at the balance sheet date if the effect is material.

Cash and cash equivalents
The fair value of cash and cash equivalents is estimated as its carrying amount where the cash is repayable on demand. Where it is not repayable on demand then the fair value is estimated at the present value of future cash flows, discounted at the market rate of interest at the balance sheet date.

The fair values for each class of financial assets and financial liabilities together with their carrying amounts shown in the balance sheet are as follows:

25.3 Fair values of financial assets

	31 March 2008 Book Value £000	**31 March 2008 Fair value £000**	31 March 2007 Book Value £000	31 March 2007 Fair Value £000
Investments	**0**	**0**	0	0
Finance lease receivables	**0**	**0**	0	0
Trade debtors	**6,583**	**6,583**	5,441	5,441
Cash at bank and in hand	**13,236**	**13,236**	8,356	8,356
Total	**19,819**	**19,819**	13,797	13,797

25.4 Fair values of financial liabilities

	31 March 2008 Book Value £000	**31 March 2008 Fair value £000**	31 March 2007 Book Value £000	31 March 2007 Fair Value £000
Trade creditors	**5,850**	**5,850**	6,754	6,754
Loans	**0**	**0**	0	0
Finance lease obligations	**0**	**0**	0	0
Total	**5,850**	**5,850**	6,754	6,754

Liquidity Risk

Liquidity risk is the risk that the Foundation Trust will not be able to meet its financial obligations as they fall due.

The Foundation Trust's net operating costs are incurred under service agreements with the local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Foundation Trust largely finances capital expenditure through internally generated funds and from loans that can be taken out up to an agreed borrowing limit. The borrowing limit is based upon a risk rating determined by Monitor, the Independent Regulator for Foundation Trusts and takes account of the Foundation Trust's liquidity. The Foundation Trust is therefore not exposed to significant liquidity risk.

The following are the contractual maturities of financial liabilities, including estimated interest payments:

25.5 Maturity of Financial Liabilities

	31 March 2008 £000	31 March 2007 £000
Less than one year	**5,850**	6,754
In more than one year but not more than two years	**0**	0
In more than two years but not more than five years	**0**	0
In more than five years	**0**	0
Total	**5,850**	6,754

26. LOSSES AND SPECIAL PAYMENTS

There were 62 cases of losses and special payments totalling £133,000 paid during the year ended 31 March 2008 (17 cases totalling £39,152 during the 8 months ended 31 March 2007).

There were no cases where the net payment exceeded £250,000.

27. PUBLIC DIVIDEND CAPITAL DIVIDEND

The Foundation Trust is required to pay a public dividend capital dividend at a rate of 3.5% of average relevant net assets.