Sheffield City Council

Sheffield Health and Social Care
NHS Foundation Trust

NHS

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2009/10

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Contents

1. Statement from Chair and Chief Executive

It is our great pleasure to introduce this Annual Report for 2009/10, our second one as a Foundation Trust. It contains a wealth of information about the Trust's performance which we will not attempt to summarise. As you will see from Section 5, the Trust performed very well against the national standards set for all NHS organisations by the Care Quality Commission and those set for Foundation Trusts (FTs) by Monitor, the Foundation Trust regulator. This should not be taken as an indication of complacency, as we always emphasise that the endeavour to improve the quality of our services is a never ending one.

Some of the highlights from the year include:

- The successful registration of all Trust sites with the Care Quality Commission;
- The amazing success of the Improving Access to Psychological Therapies (IAPT) Programme which has exceeded all of its targets and is a national leader in enabling people to return to work;
- Successful tenders for the Substance Misuse and Intermediate Care contracts;
- The award of 'Green' ratings by Monitor for the our Governance and Mandatory Services;
- The start of work on the Acute Care Pathway to improve quality and prepare for a mental health tariff;
- The excellent work done throughout the organisation in preparation for the flu pandemic;
- The regional, national and international leadership in service development being demonstrated by our Executive Directors.

Sincere thanks to everyone in Sheffield Health and Social Care NHS Foundation Trust (SHSC) who has contributed to this outstanding record of work in 2009/2010.

During 2009/10 we continued to benefit from our new status as a Foundation Trust. A clear example of this is the effective work of our Council of Governors which, after only two years in existence, has become a key part of the Trust's strategic development and governance structures. As representatives of our membership, the 43 Governors bring the voices of the public, the people who use our services, their carers, our staff and other major partners, as well as their own experience, directly into the strategic planning process. For example, Governors have played a very important role in setting the Trust's quality objectives. We are very grateful indeed to the Governors for the commitment they have demonstrated to the Trust and its services and for the considerable efforts that many of them have made to the development of SHSC.

We promised that the change to Foundation Trust status would not reduce our commitment to the Care Trust ethos. The Board of Directors remains fully committed to a close partnership with Sheffield City Council and we know that this belief in the necessity of a health and social care partnership is shared by staff throughout the organisation. It can be seen at work in our joint service provision in Learning Disabilities, Mental Health and Substance Misuse. It will be extended further as we develop a joint approach to employment promotion and partnership working in other areas aimed at creating seamless services.

Looking forward there is no doubt that the NHS is set for challenging times financially and we will not be able to escape from that. It is more vital than ever before that those within the organisation, and those we work in partnership with, hold firm to our strategic vision and shared values, especially the core principle that people who use our services will achieve their full potential and lead fulfilled lives in their community. It is this vision and our striving, in partnership with a wide range of people and organisations, that will ensure our success and the effectiveness of the services that we provide.

Professor Alan Walker
Chair

Kevan Taylor
Chief Executive

2. About Us

This Annual Report outlines the developments and improvements in our clinical services over our first full year of operation as an NHS Foundation Trust. We also report on the key information used to monitor and measure our performance during the period.

Who we are

We were initially established in 2003 as Sheffield Care Trust. On 1 July 2008, we became authorised to operate as Sheffield Health and Social Care NHS Foundation Trust. We are the main provider of a comprehensive range of general and specialist mental health and social care services to individuals and their carers or families in Sheffield.

With an annual income of about £116 million and more than 3,000 members of staff, we provide:

- Mental health services for adults and older people;
- Services for people with learning disabilities;
- Services for people with drug and alcohol problems;
- A wide range of other specialist services, such as for people accessing maternal mental health, gender dysphoria services and psychology for people with physical health problems.

We also offer a full range of services at sites near to where people live. These aim to provide care and treatment to individuals and their families and help people maintain their independence to continue with their day-to-day lives as much as possible. We provide a range of in-patient and residential services for individuals who cannot be appropriately helped in a community-based setting. Within our learning disability services, we work closely with a large number of supported living settings/residential care homes in partnership with housing associations.

Many of the people we help are visited in their own homes by members of staff and some people attend our clinics to see nurses, social workers, therapists or doctors. We give treatment, care and help on an individual or group basis where support and guidance is provided. We also work alongside GPs and other staff in local health centres, or with staff from other organisations, often in the voluntary sector.

We often see people for short periods of time, providing advice and treatment which helps resolve the person's problems. For people with more serious longer term difficulties, we will support and work with them for a number of years.

As a Foundation Trust, we continue to work in partnership with Sheffield City Council and have formal agreements with them to provide a range of social care services on the Council's behalf. Through these arrangements, we have made good progress in developing 'integrated' services for the people of Sheffield – an important goal that is shared by ourselves and the City Council.

We have placed great importance on working with other organisations to deliver integrated health and social care services to local people. In doing so, we have aimed to reflect and provide for the diverse needs of the people and communities of Sheffield.

3. Our Strategic Vision

Our vision is that people using our services will achieve their full potential, and enjoy fulfilled lives in their community.

To achieve this, we will support and enable our staff to provide services that are world-class in terms of:

- Empowerment
- Safety
- Effective outcomes
- User experience
- Efficient use of our resources
- Social inclusion

We will collaborate with others to combat stigma and promote social justice.

Strategic Principles:

Fulfilled Lives
We will support people who use our services in all aspects of their lives, recognising where our key strengths lie and where we will work with others.

Working for the Trust should be a fulfilling experience for all our staff.

Ambition
To support people who use our services and our staff we will support and encourage their own ambitions.

We will fundamentally reflect a positive spirit of hope and a culture of continuous improvement.

Wellbeing
We will focus on wellbeing which encompasses the physical, emotional, psychological and spiritual wellbeing.

Real lives are within the context of the families and communities in which we live. We will work with and support families, carers and communities.

Empowerment
Our services will be based on a spirit of partnership that maximises the choice and control people have over their lives and the services that they receive.

We will support the development of peer-led services both within our organisation and in partnership with existing and emergent peer-led services.

Partnership
The strength of our organisation will be built on sound internal partnerships between clinicians and managers and between front-line services and support services.

Our focus on wellbeing will require strong and close partnership with other health and social care providers in both primary and secondary settings, and also with voluntary, community and faith groups and organisations.

Social Inclusion
Our services will constantly aim to reduce social exclusion and promote social inclusion for people who use them.

We recognise that there are a number of contrasting communities within Sheffield and that our approach to social inclusion will reflect this.

Leadership
We will actively support and develop leadership at all levels of our organisation.

Rational services
We will rationalise, simplify and improve access and care pathways. Standards will be explicit and specifically address the issues of equal access for people of all ages and all backgrounds.

Localisation
The quality of the experience and outcomes of our services is determined at local team level. Our organisational focus will be on supporting the primacy of the local team.

Our services will be tailored to recognise and reflect local need.

In order to support social inclusion and minimise exclusion, our services will be delivered as locally as possible where this is appropriate.

Focus on what we know works
Our services will reflect known evidence on effectiveness and will be designed on that basis.

Specialist services
All our services will be developed on a stepped care model. Secondary care services will support primary care and specialist services will support secondary care.

We will work to enable our organisation to develop and expand its range of specialist services.

4. Annual Quality Accounts

Part 1 – Statement on Quality from the Chief Executive

I am delighted to introduce the Trust's second annual quality report. The Trust is completely committed to providing high quality care and treatment.

The Trust published its Quality Framework in May 2009 (available on the Trust's website or hard copies are available from the Director of Quality.) In the Framework, the Trust re-affirms its core commitment to quality. It defines quality as '*health and social care that is service user centred, safe, effective and promotes equality and inclusion'.*

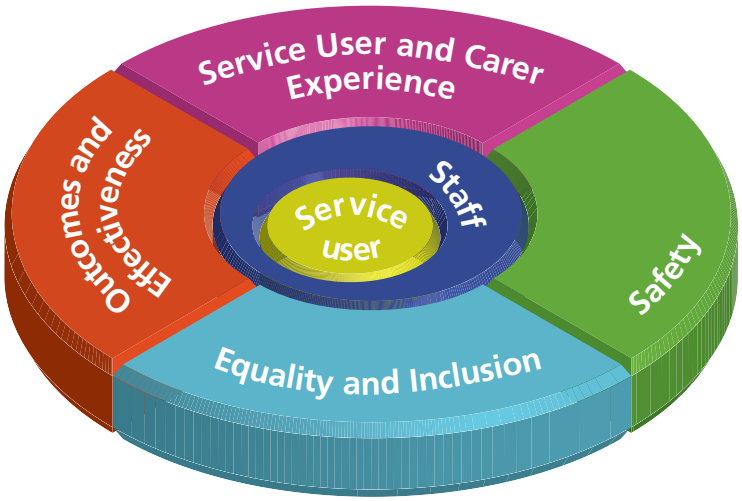


Diagram: The Trust's definition of quality

The service user is placed at the centre of this diagram, linked to staff, to indicate that the heart of quality lies in the interaction between service users and all the staff of the Trust.

All health and social care staff have a *duty of quality*: to meet standards and maintain a high standard of care, to strive to improve the quality of care.

I can show you many examples of good quality in the Trust's services, but I am not complacent and I know there is still work to do. For the last three or four years our Trust has developed robust procedures for the implementation of all NICE guidance relevant to mental health including establishing more than 20 implementation teams. This report will show you where we are doing well and where we need to make changes and improvements.

Some highlights in terms of quality improvements made over the last year have been

- The redesign of the acute care pathway with a focus on setting quality standards, measuring delivery and holding to account
- The successful development of the Productive Ward project on two wards has led to ward teams working together to find ways of working more efficiently so that more time is available for what staff really want to do – spend time working with service users. This project will be spread out to more wards over the next year
- Work in partnership with Sheffield Teaching Hospitals NHS Foundation Trust to make sure that when people with learning disabilities are admitted to hospital, their extra needs are identified and made known to staff on the wards
- The development of new models of care in recovery, rehabilitation and mental health with a much stronger focus on social inclusion, recovery and self directed support. The traditional day services are being replaced by the Sheffield Pathways and Access Community Engagement Service (SPACES) and will be changing more in the year ahead
- Service users of the Substance Misuse Service have worked with Patient Opinion to make sure that they can give feedback to the service – and the service has acted on what it has heard
- Many more people with dementia have been helped to live at home for longer, with a 27% reduction in admissions to long term care after the redesign of the dementia services, including closure of two wards and the successful development of a community based rapid response team
- Integration of the community teams working with older people with mental health problems means that services are more accessible, efficient and 'joined up' for the people who need them
- The programme of work aimed at preventing falls, led by the NICE Falls guidance implementation group, has included some innovative approaches such as engaging service users on older adults wards at risk of falling, through role play and other interactive approaches

- The great increase in the availability of psychological treatments in primary care for common mental health problems such as anxiety and depression through the new IAPT service – and the proven impact this service is having on people's mental health and wellbeing and their ability to return to work
- Team governance continues to thrive in the Trust, with every team producing a report on the quality of the service it provides at least annually. Service users and carers are involved in this work
- As you read through this Quality Account and the Trust's Annual Report, you will find other examples of work being done by staff, service users, carers and governors to improve the quality of care and treatment.

We have also been working to meet some challenges and improve our ability to make improvements to services in line with the requirements of external regulators and commissioners.

- During 2009/10, a new regulator for health and social care, the Care Quality Commission (CQC) came into being. The Trust prepared for registration with the CQC under its new regulations by informing and involving clinical staff and team managers in looking at the evidence for the quality of care and treatment, reporting at location level and not just Trust-wide. The Trust was fully registered for all activities in all areas from 1st April 2010 as a result of this work
- The final review of Trust services by the Care Quality Commission using the old 'Annual Health Check' process took place in Autumn 2009. The Trust scored 'good' for quality of care, which was a reduction from the previous year's score of 'excellent.' The reason for the lower score was underperformance in two areas:
  - Meeting the mental health needs of people with learning disabilities as measured on the 'Greenlight toolkit'
  - Delayed transfers of care
- Both issues were reviewed. The Trust has made significant progress on the Greenlight toolkit and is meeting the CQC expectations. It anticipates it will also meet the 'delayed transfers of care' measure, when this is announced by the CQC
- Work has begun to improve the serious incidents procedures in the Trust, to make sure that serious incidents are identified, reported, investigated and managed well, and that learning from serious incidents is shared effectively across all parts of the Trust. The aim of this important project is to reduce the overall harm caused by serious incidents and improve service user safety
- We will continue to work on the experience of safety, privacy and dignity on the wards by making sure we always have single sex sleeping and bathroom/toilet arrangements, women only lounges and safe and effective ways of managing any threat of violence or aggression. We will make sure that we ask service users about their experiences on the wards and that we learn from their feedback
- The Trust has set up five transformational Quality Innovation Productivity and Prevention projects to improve the efficiency and effectiveness of our services. These include reconfiguring in-patient services and community teams, improving our PICU facility and developing alternatives to acute admission. We have also developed new plans to improve efficiency and quality of care in dementia and learning disability services
- Following the agreement of the city wide Carers' Strategy, the Trust will be developing an action plan in 2010/11 to describe how it will take forward improvements to the support provided for carers.

The quality of the care and treatment we provide is reviewed by national regulators and by our commissioners.

- The Care Quality Commission said the quality of our care was 'good' in 2009/10 and registered us fully without conditions under their new registration system
- Monitor scored us as 'green' for governance and we met their quality of care indicators
- We scored 100% with the new indicators for quality improvement set by NHS Sheffield following the guidance of NHS Yorkshire and Humber (the 'CQUINs')
- We have met all the quality requirements of our commissioners during the year
- We meet regularly with NHS Sheffield and Sheffield City Council and we review safety and quality of services at these meetings

We will continue to work with service users and carers, our staff, members and governors and our partners in the city of Sheffield in the year ahead to make sure all our services are of the best possible quality.

This is how we will do it:

- We will listen to feedback from service users and carers. Whether complaints or compliments, patient meetings on wards or responses on questionnaires or surveys, we will listen to what you tell us and take action to make improvements
- We will include service users, carers, governors and LINKS in our new Quality Check meetings and visits to service areas
- We will equip our staff through training and professional development to provide good, safe, accessible care and effective treatment
- We are setting up a new web-based system called the Intelligent Board which brings together information about service user care and treatment, staff, safety and finances into a single system. The Intelligent Board will produce reports for the Trust Board of Directors, for our commissioners, for teams and directorates which can be used to measure quality, safety, effectiveness and efficiency
- We will continue to support and develop team governance
- We will increase our efforts to implement NICE guidance across all services in our Trust and extend the routine collection of data on outcomes and the experience of care.

I declare that to the best of my knowledge the information included in the 2009/10 Quality Account provides an accurate picture of quality in the Trust.

I commend the Quality Account to you.

Kevan Taylor.

Kevan Taylor
Chief Executive Officer
May 2010

Part 2 – Priorities for Improvement and Statement of Assurance from the Board

What we did last year

As an NHS Foundation Trust we were part of the annual quality account pilot group so we produced a quality account for 2008/09.

Sheffield Health and Social Care NHS Foundation Trust set four quality objectives for 2009/10 in June 2009.

The Trust Board developed these objectives using the 5 step process described in the Trust's Quality Framework:

- Reviewed information gathered during the year from consultation with the Council of Governors and from two Trust-wide Improving Quality events for service users and carers. From this process it was determined what the priorities for quality improvement were for service users, carers, staff, members and governors
- Reviewed Trust data regarding quality performance, from both internal reports and reports from regulators and auditors
- As a result of details gained from this information, together with additional corporate knowledge, two questions required answering:
  - What do we *need* to change?
  - What do we *want* to change?
- From a series of iterations of these specific questions, four priority areas for quality improvement were agreed
- Finally these priority areas were turned into more specific, measurable objectives as noted below :

The four quality objectives for 2009/10 were:

- To achieve a target of four hours from referral to assessment for crisis referrals for service users in adult and older adult mental health care including dementia services
- To improve the satisfaction of people from black and minority ethnic groups with the cultural appropriateness and respect of the services they receive
- To improve the experience of privacy and dignity of people on the acute mental health wards (all ages) as reported by service users
- To reduce potential harm to service users from them being given the wrong drugs or wrong dosage when they move to a new team or ward.

How we performed on last year's objectives

1. Four hours wait from referral to assessment for crisis referral

Why we chose this objective:

Improving access to services, especially at times of crisis, is a priority for governors, service users and carers more generally (this was identified from Governors' meetings and Improving Quality events).

This information has been collected throughout the Yorkshire and Humber region during 2009/10 as part of the regional Commissioning for Quality and Innovation scheme (CQUINs). It reflects the Strategic Health Authority's vision of 'no waits for mental health' described in its Healthy Ambitions Plan. In future, therefore, the Trust's performance will be able to be compared with other trusts providing the same kind of service in the region.

There has been considerable work in the region throughout the year to agree clarity and a shared definition of the indicator. Initially other trusts were defining the target in very different ways which reflect the variety in which crisis care is provided. The first comparator data reported through CQUINs reflects this. For this reason, the Trust has chosen not to publish the benchmarking data for 2009/10.

While this work was in progress for adult mental health the Trust did not expand its reporting to include older people and those people referred to the dementia rapid response team. It intends to do so in 2010/11. Making sure there is no age discrimination against older adults is a priority for the Trust, its governors and members.

Action taken to deliver improvement target

The acute care pathway redesign is aimed at improving access to crisis services and includes monitoring performance on this target. An aim of the redesign is to ensure people in crisis are seen as quickly as possible by the right person. The new care pathway came into force in December 2009.

Outcome

Table 1 – % of service users meeting the 4 hour waiting time target

Trust	Quarter 1 09/10	Quarter 2 09/10	Quarter 3 09/10	Quarter 4 09/10
Sheffield Health and Social Care	Data not collected	47%	50%	59%

Comments

These figures should be seen as the initial baseline figures, to be built on in subsequent years. **It is proposed to continue and expand work to improve access to assessment in a crisis in 2010/11.**

2. To improve the satisfaction of people from black and minority ethnic (BME) groups with the cultural appropriateness and respect of the services they receive

Why we chose this objective:

Analysis of the demographic data on Insight and annual CQC census returns indicate a number of areas where black and minority ethnic service users are under, or over, represented. For example, men from African Caribbean backgrounds are more likely to be diagnosed with psychosis, admitted to acute wards and more likely to be detained under the Mental Health Act. A similar pattern is found nationally [see for example the Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP) studies reported by Fearon and his colleagues in 2006].

Improving the experience of people from BME communities was identified as a priority by service users and carers at an Improving Quality event.

Action taken to deliver improvement target

A series of programmes of work are underway to improve access and enhance the quality of care received by people from different BME groups:

1. Three Enhancing Pathways into Care (EPIC) programmes targeting the Pakistani, African Caribbean and Somali communities and their access to acute care
2. Emotional Wellbeing Service supporting Pakistani women and Yemeni men in mental health awareness and access to services in the community
3. Transcultural team delivering a clinical service and also building the capacity of colleagues in working with service users from minority ethnic groups.

A new BME Community Engagement Group, chaired by the Executive Director of Operations, has been set up to co-ordinate and prioritise the different work in the Trust in this area.

During the year, the Multi-Agency Assessment Template (MAAT) Probe voluntary sector group reviewed the quality of care for African-Caribbean people on the wards of this and other trusts in the North of England. They have presented their results to the Trust and received a commitment from the Chief Executive that their concerns will be addressed. An action plan has been drafted to deliver improvements in the use and application of restraint techniques and to make sure that there is greater use of occupational therapy and talking treatments.

An Improving Quality event took place in April 2010 and reported back to service users, carers and governors on what the Trust is doing to improve the quality of care and experience of BME service users.

Baseline data has been collected during the year so that the impact of these improvement initiatives can be measured. Measures being collected include the use of the Mental Health Act, restraint and seclusion for different ethnic groups.

Outcome

The Trust maintains good records of the ethnicity of service users so that it can analyse quality indicators by different ethnic groups, and is performing best in region on the CQUINs indicator for ethnicity recording (CQUINs Quarter 3 data).

Having this data is not an end in itself however, it allows the Trust to analyse other aspects of care which may be of concern, such as detention under the Mental Health Act and the use of restraint or seclusion.
The Trust monitors the use of restraint and seclusion on wards by ethnicity.

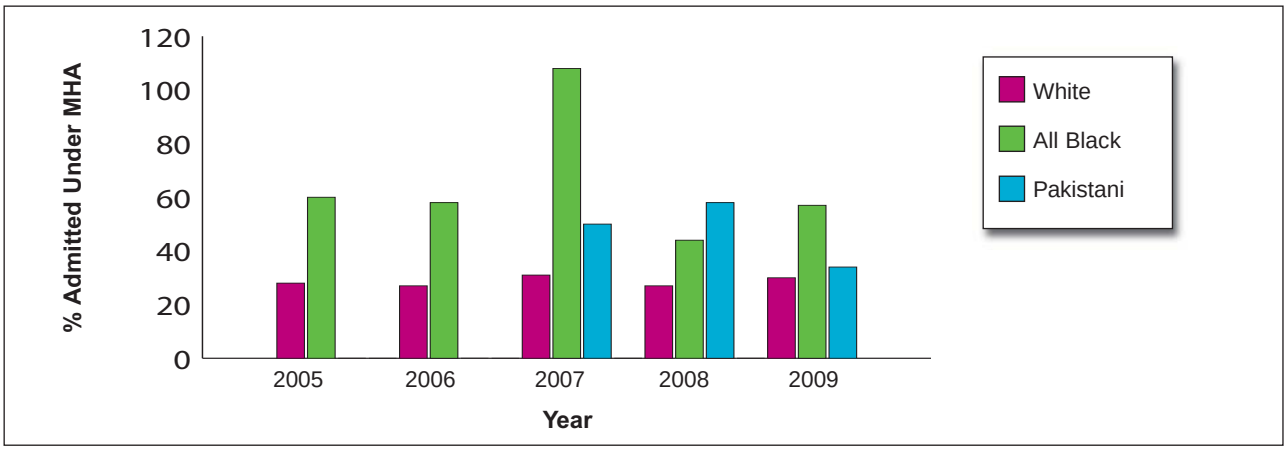
Table 2 – Use of seclusion on in-patient wards, by ethnicity, from SHSC records with 2001 census figures for Sheffield as comparator

Ethnic Group	2007-08	2008-09	2009-10	3 Yr Average %	2001 Census
White British	66.2%	67.4%	54.3%	62.7%	89.64%
Black African	13.5%	6.1%	9.5%	9.0%	0.59%
Black Caribbean	1.4%	6.8%	5.7%	5.1%	1.12%
Ethnicity Not Stated	1.4%	0.8%	13.3%	5.1%	
Other	0.0%	4.5%	7.6%	4.5%	0.44%
Mixed White & Asian	4.1%	2.3%	6.7%	4.2%	0.30%
Pakistani	4.1%	3.8%	1.9%	3.2%	2.71%
White Other	1.4%	4.5%	0.0%	2.3%	1.57%
Asian Other	2.7%	0.8%	1.0%	1.3%	0.48%
White Irish	1.4%	2.3%	0.0%	1.3%	0.72%
Chinese	2.7%	0.0%	0.0%	0.6%	0.52%
Black Other	1.4%	0.0%	0.0%	0.3%	0.13%
Mixed Other	0.0%	0.8%	0.0%	0.3%	0.26%

More information about the experience of people from BME communities in in-patient services for both mental health and learning disabilities services comes from an annual Census. This is carried out by the CQC (formerly the Mental Health Act Commission) on 31 March each year and began in 2005.

The national figures from the census indicate a rise in the number of people overall detained under the Mental Health Act since 2005. Service users who are detained under the Act formed 31.8% of admissions in 2009. For people from Black and Black British groups, the proportion of service users who are detained rises to 53.8% of admissions (MHMDS data NHS IC 2009). This difference is also found in Sheffield over the last five years:

Diagram 2 – People admitted under the Mental Health Act – percentage of all people admitted who were detained under the Act, for 3 main ethnic groups (information from annual CQC Census)



Comments

It is proposed to continue and expand work to improve access to assessment in a crisis in 2010/11. Early in 2010/11, the BME Community Engagement group will set clear and measurable objectives for improvement in the year ahead.

3. To improve the experience of privacy and dignity of people on the acute mental health wards (all ages) as reported by service users

Why we chose this objective

This area did not score well in a review of adult mental health in-patient services in 2008 and actions have been taken since then to improve service user experience of privacy and dignity on the wards. All the actions in the plan following the Healthcare Commission (HCC) Review have been completed. The Board wished to ensure that the experience of privacy and dignity was good for all ages and included people with learning disabilities.

During the year the annual CQC Patient Survey of in-patients highlighted that the Trust fell in the bottom 20% of mental health trusts nationally on sharing accommodation with a person of the opposite sex:

During your most recent stay, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

The Trust was concerned by the response and asked the Head of Practice Development and Safeguarding to investigate what might lie behind it.

Actions to deliver improvements

The Trust has assured that all its accommodation is single sex and sharing with members of the opposite sex does not happen. It has declared full compliance with Delivering Same Sex Accommodation census requirement. (March 2010).

Two project leads, a nurse and a service user, were employed on an innovative 'privacy and dignity' project. They engaged with service users and staff to identify and share good practice, highlight areas in need of development and design, in partnership, strategies to improve the service user experience. Additionally they talked to service users to try to understand what perceptions might lay behind the responses on the Annual Patient Survey. The survey was carried out in November 2009 and repeated in February 2010 and March 2010 (March results are not yet available).

Outcomes

Table 3 – Survey on in-patient service users

	Results - Nov 09	Results - Feb 10
Number of questionnaires issued	104	58
Number of questionnaires returned	47 (45%)	17 (39%)
Survey questions		
When you were first admitted to a bed on a ward, did you share a sleeping area with patients of the opposite sex?	Yes – 2 No – 44 No response – 1	Yes – 17 No – 0
While you were staying in hospital, did you ever share the same bathroom or shower area as patients of the opposite sex?	Yes – 3 No – 44	Yes – 2 No – 15
During your most recent stay, did you feel safe?	Yes – 38 No – 9	Yes – 13 No – 4

For all respondents who said they had shared a sleeping area or bathroom with a person of the opposite sex, the ward records were checked and it was found that this was not the case. There were indications from the interviews that some service users had been confused by or misunderstood the questions, for example

interpreting a question as to whether they would *mind* sharing with a person of the opposite sex. Further exploration in the interviews showed that in some cases, service users had chosen to use bathrooms allocated to the opposite sex, or that they had to go past members of the opposite sex to reach a bathroom or shower area. In November the ward had been undergoing bathroom refurbishment at the time of the survey, and no instances of sharing a bathroom or shower area were reported in the February survey.

The issues raised in response to the question about 'feeling safe' were:

- Concerns about safety of belongings
- Physical safety when other service users become agitated and aggressive
- Physical safety including female patients walking past male patients while in their nightwear
- Fears about sexual safety.

A second project, led by the Mental Health Citizens Advice Bureau, has seen a group of service users interviewing people on wards about their experience of care on the wards.

The Trust will continue to work with service users in the year ahead to understand why service users may not feel safe in hospital and agree ways to address the issue where possible.

4. To reduce potential harm to service users from them being given the wrong drugs or wrong dosage when they move to a new team or ward

Rationale

Medication errors present a significant risk of harm to service users and are more likely to occur on transfer between services and at the point of admission to acute care. The National Institute for Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) issued joint guidance on medicines reconciliation in 2007, as an important patient safety issue.

Actions to deliver improvement

The Trust is participating in the national Prescribing Observatory for Mental Health (POMH-UK) audit for medicines reconciliation. Baseline data has been collected and reported to the national audit group.

Outcomes

The results from the first POMH-UK baseline study show that the Trust was in the top quarter of the 42 mental health trusts nationally who participated in the study for documenting the medication prescribed prior to admission. The notes of 32 service users from eight clinical teams were audited. All service users had some record of their medication in their notes. Just under 60% of the service users had a record noting whether or not they were taking their medication as prescribed – this percentage is above the average in comparison with the other trusts. The study looked at different sources of information about medication, these were service users themselves, carers, GPs, community teams, also checking the actual medication brought into the ward etc. Where two or more sources were checked, discrepancies were found in about a quarter of the cases nationally, and a similar result was also found in Sheffield Health and Social Care NHS Foundation Trust information. The authors of the report point out that in most cases these discrepancies were not clinically significant.

Participation in studies like this assists staff to be vigilant about possible errors in medication on admission to acute wards, encourages them to check different sources of information and make sure people are given the right medication. The Trust will repeat this study in future years to see if it has made a real difference.

What we will do in the year ahead

Priorities for improvement for 2010/11

The Trust Board is proposing four quality objectives for 2010/11. It has built on last year's work to develop the first annual quality objectives and the consultation carried out with services users, carers, staff, members and governors. The Board and governors have reviewed all the Trusts priorities for development as part of the annual planning cycle. The quality accounts and priorities for quality objectives in 2010/11 were discussed at two meetings of the governors in April and May 2010.

SHSC defines quality as 'health and social care that is service user centred, safe, effective and promotes equality and inclusion'.

The Board wishes to set four quality objectives and to make sure these reflect the Trust's four components of quality. Two are a continuation from 2009/10 and two are new ones. The four objectives are:

- To achieve a target of 4 hours from referral to assessment for crisis referrals for service users in adult and older adult mental health care including dementia services
- To improve the satisfaction of people from BME groups with the cultural appropriateness and respect of the services they receive
- To make sure we are collecting, listening to and acting on views and feedback from service users and carers
- To improve the support, advice and care we provide to service users with regard to their nutritional needs.

Following feedback from the governors and the City Council Scrutiny Board, which was attended by LINks members, the Trust will also prioritise the question of access to a 24-hour phone line for service users, including people with dementia and their carers, through its business planning processes.

1. To achieve a target of 4 hours from referral to assessment for crisis referrals for service users in adult and older adult mental health care including dementia services

Lead: Jason Rowlands, Director of Planning and Performance

Why we chose this objective

Service users, carers and governors have told us how important it is to them that our services are accessible and that people do not have to wait for long when they most need help i.e. in a crisis. The acute care pathway has been redesigned with a new pathway implemented from December 2009 in an attempt to reduce the times people in an acute mental health crisis have to wait from being referred to when they are assessed.

It is also important to our NHS Sheffield commissioners, who have chosen to set it as a CQUIN (quality measure.)

The number of people (working age adults with acute mental health problems) waiting for less than four hours from referral to assessment was 59% at the end of 2009/10.

During the consultation on choice of objectives, there were strong representations from governors and LINks about the inclusion of people with dementia in the target, and the Trust has agreed that they will be included. Older people with mental health problems and people with learning disabilities will also be included from 2010/11.

Current situation:

Work began on this first objective last year with sound foundations laid which will be built on during the year ahead. The four hour wait from referral to assessment in a crisis was a CQUIN target for working age adults and considerable effort was put into the work regionally and in the Trust to define how the waiting time would be measured and make sure it could be measured. The Board wishes to see the impact of the recent changes to the acute care pathway in terms of reducing the waiting time for assessment in a crisis.

The Trust, in collaboration with NHS Sheffield, will set targets for year on year reductions in the waits for assessment in a crisis. For working age adults, the target for 2010/11 will be 80%.

At present, the waiting times from referral to assessment are not routinely collected for service users with dementia, older people or people with learning disabilities.

Actions planned:

The acute care pathway has been redesigned and is showing a positive impact on reducing waiting times in a crisis. For adults of working age, reports will be produced monitoring the performance of teams against the 80% target. Appropriate action will be taken by managers to address any shortfall.

During 2010/11 systems and procedures will be put in place and baseline figures established, so that targets for waits for older service users, including those with dementia, and for people with learning disabilities, can be set for 2011/12.

How we will measure success

For working age adults quarterly CQUIN reports will demonstrate whether or not the Trust meets the 80% target during the year.

For other groups of service users, progress on implementation of the plan will be reported quarterly to the Board. Robust baseline data will be produced by the end of the year so that an improvement target can be set for 2011/12.

2. To improve the satisfaction of people from BME groups with the cultural appropriateness and respect of the services they receive

Lead: Liz Johnson, Head of Patient Experience, Inclusion and Diversity with support from Clive Clarke as Executive Sponsor and chair of BME/Community Engagement group.

Why we chose this objective
This second objective also continues from 2009/10 so that there will be sufficient time to demonstrate an improvement. The reasons from last year remain valid, but the work already undertaken has clarified which areas need to be prioritised.

These are:

- To make sure people from BME communities are accessing services at an early stage and not only in crisis or when detained under the Mental Health Act
- To reduce the negative experiences of people from BME communities, specifically to reduce the use of restraint and seclusion, and to reduce the length of stay on acute wards
- To increase the positive experiences of people from BME communities, e.g. access to talking therapies and constructive activities.

We will also analyse the service user satisfaction measures and feedback we receive by ethnicity, to see if there are any differences for people from different ethnic groups that may need further attention.

Actions planned

1. Access at an early stage

- Analysis of the information shows that people from BME groups are already making good use of the Trust's Early Intervention services. This will continue to be monitored in 2010/11
- The IAPT service has reviewed its information and taken a number of actions to increase the uptake of talking therapies by people from BME groups, including partnership working and running talking therapies in voluntary and community organisations. It has also set up a city centre walk in service, as the national evidence has shown that that kind of initiative can improve access by people from BME groups. The impact of this work will be reported during 2010/11.

2. Reduction of negative experiences

- Following the Maat Probe feedback, the Trust is reviewing and improving its approach to the management of violence and aggression and the use of restraint
- An analysis of the reasons for people from BME groups having a longer stay in hospital will be completed during the year.

3. Increase of positive experiences

- Building on the IAPT work (described above) access to talking therapies in other trust services and their uptake by people from BME communities will be considered during the year
- Access to constructive activities, including access to employment, for people from different ethnic groups will be reviewed.

4. Staff training

- To deliver more training to staff on equality and on working with people from different cultures.

How we will measure success
A quarterly report to Board will measure the following

- Access to early intervention services by ethnicity
- Access to IAPT by ethnicity
- Progress on the review of Trust training in the management of violence and aggression, including use of restraint
- CQUIN results on – comparative use of restraint, seclusion, length of stay and detention under the Mental Health Act.

Measures on the uptake of talking therapies and constructive activities will be confirmed and added during the year.

We will analyse the service user satisfaction measures and feedback we receive by ethnicity, to see if there are any differences for people from different ethnic groups that may need further attention. Gender and age will also be considered.

Reports on numbers of staff receiving equality and cultural competence training will go to HR and Workforce Group quarterly. Results on the CQC staff survey will be analysed to see if there is an improvement in the numbers of staff reporting that they have received equality and diversity training.

3. To make sure we are collecting, listening to and acting on views and feedback from service users and carers

Lead: Tina Ball, Director of Quality

Why we chose this objective

Service user and carer feedback is essential for us to learn and improve as an organisation. We want to measure what people think of our services.

Current situation

We use the feedback we get from people raising complaints or concerns, and the positive feedback we receive too. We produce an annual report on complaints, copies of which are available from the Complaints and Litigation lead. The CQC Annual Patient Survey provides useful feedback for the Trust and action has been taken to try to improve in areas where the Trust scores relatively low in comparison with other trusts.

Many teams in the Trust collect feedback from service users via questionnaires, quick surveys or group meetings, which they use to inform practices to improve the quality of care and treatment. However, this does not happen in all teams in the Trust, and questionnaires or surveys are not always repeated.

Actions planned

The plan for 2010/11 is to ensure that all teams collect and make use of service user feedback, and that consistent measures are used for similar services. This will enable the formation of a strong foundation for improvement in future years.

A 'sharing good practice' event will be held in the year to demonstrate how service user feedback from questionnaires or outcome measures can be used to make a difference for service users, carers and staff.

Exit interviews for service users leaving the wards will be implemented.

Teams will be asked to use the information received from service user and carer feedback in their team governance reports and improvement plans.

How we will measure success

We will survey all teams early in the year to establish a baseline for the use of service user questionnaires or interviews at present.

Following the audit of current practice, good practice will be shared across the organisation and all teams will be expected to have carried out at least one set of questionnaires, surveys or interviews by the end of the year. The delivery of these questionnaires and the results found will be reported to the Board.

Team governance reports will be audited towards the end of the year for evidence that the service user feedback has been used in their production and for any improvement actions that have resulted from service user or carer feedback.

4. To improve the support, advice and care we provide to service users with regard to their nutritional needs

Leads: Tony Flatley, Lead Nurse supported by Jane Mckeown, Senior Nurse and Chair of NICE Nutrition Guideline implementation group

Why we chose this objective

Nutrition, the fourth objective, is a top priority for the Board and governors, with a strong belief that healthy eating is essential for both mental and physical health.
Our aims are:

- To prevent the malnutrition of vulnerable people in our acute or residential services
- To prevent or reduce obesity of people who may be at greater risk because of medication, their health condition or disability
- To improve the health and wellbeing of service users both physically and mentally
- To offer a choice of good and healthy food (where we provide it) as an important part of a positive experience for people using our services.

Current situation

The Trust already measures the use of nutritional screening tools for people admitted to acute care and it has achieved a figure of 90% for acute adult mental health in-patients and 84% overall in 2009/10. In 2008/09 the figures were 92% of adult inpatients and 81% across the Trust as a whole. The Trust will hope to see this improve in 2010/11. The provision of healthy menus is measured as part of the Patient Environment Action Teams (PEAT) assessments and all sites surveyed are currently scoring good or above on the food dimension.

Actions planned

Extend nutritional screening and assessment to all service areas.

Provide staff development programme for targeted areas relating to nutrition.

Improve menu planning and meal provision.

Improve the environment to support mealtime experiences in targeted areas.

How we will measure success

95% of in-patients aged 65 and over will have a nutritional needs assessment on admission and discharge.

A baseline will be established in 2010/11 from patient feedback regarding menus and meals provided.

There will be improved feedback from patient surveys regarding menus and meals provided in 2011/12.

How the 2010/11 priorities will be monitored, measured and reported

Action plans will be written to deliver each of these objectives, and will include clear outcomes, targets and time-scales. Leads have been identified for each objective.

Delivery of the action plans will be monitored by the Quality and Risk Group, reporting to the Board. Progress on the outcomes will form part of the Quality and Risk Dashboard report, which is presented on a monthly basis to the Board and Commissioners.

Statements of assurance from the Board

The following six statements serve to provide assurance that Sheffield Health and Social Care as a whole is:

- Performing to essential standards
- Measuring clinical processes and performance
- Is involved in national projects and initiatives aimed at improving quality.

Statement 1. Information on the review of services

During 2009/10 SHSC provided and/or sub-contracted 115 NHS services.SHSC has reviewed all the data available to it on the quality of care in seven of these NHS services. The income generated by the NHS services reviewed in 2009/10, represents 88% of the total income generated from the provision of NHS services by SHSC for 2009/10.

These figures are derived from the specific service headings in contracts with the Trust's commissioners. Contracts for training and those with a value of less than £100,000 have been excluded – some of the latter may not be covered by a formal contract.

The Trust reviews data on the quality of care with NHS Sheffield, Sheffield City Council and the specialist commissioners in regular contract and performance meetings. The other PCT commissioners who have relatively small contracts with the Trust have agreed to accept the quality review provided through NHS Sheffield as

Commissioner	Services commissioned	Number of services commissioned	Services formally reviewed with Commissioners	Services reviewed by Board
NHS Sheffield – mental health and learning disabilities	Directly commissioned patient services	37	37	37
NHS Sheffield – substance misuse commissioned via DAAT	Directly commissioned patient services	3	3	3
Sheffield Local Authority	Directly commissioned patient services	5	5	5
Other NHS PCTs	Directly commissioned patient services	60 + cost per case	0 – review of quality is via NHS Sheffield	60
Specialist Commissioners	Directly commissioned patient services	2	2	2
Housing Associations	Residential care services	8	0	0

assurance of the quality of service provided. The housing associations are responsible for the quality of care provided on their sites and registered as such under the Care Services Act.

We are actively working to develop and improve reporting on quality with the commissioners, for example by the use of CQUINs and other quality indicators.

In addition, the quality of care in all healthcare services was reviewed by the Trust Board as part of the process for CQC registration early in 2010. The quality of care for social care provision, currently registered under the Care Services Act, will be reviewed by the Trust Board in 2010/11.

All health and social care teams in the Trust produce annual team governance reports which are reviewed by their directorate senior management teams. Directorates' quality and performance is reviewed by the Trust's executive team in quarterly service reviews.

The data reviewed covers the Trust's four dimensions of quality – patient safety, clinical effectiveness, patient experience and equality & inclusion. Work is taking place to improve data collation and reporting through the new Trust web-based Intelligent Board system. However, it should be noted that to date, the amount of data available for review has not impeded effective review of the quality of care and treatment provided.

Statement 2. Participation in clinical audits and national confidential inquiries

During 2009/10, 13 national clinical audits and one national confidential enquiry covered NHS services that SHSC provides.

During that period the Trust participated in 92% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust was eligible to participate in during 2009/10 were as follows:

- Medication prescribed – POMH UK
- Side effects of depot antipsychotics – POMH UK
- Lithium Monitoring – POMH UK
- Metabolic side effects of antipsychotics – POMH UK
- Medicines reconciliation – POMH UK
- National Physical Health Audit
- Antipsychotic use in Learning Disabilities – POMH UK
- National Falls Audit
- Dementia
- Psychological therapies
- National Continence Audit
- National Health Service Litigation Authority (NHSLA) record keeping – standard 4
- National Electroconvulsive Therapy (ECT) Audit
- National Confidential Enquiry into Suicide and Homicide by people with mental illness

The Trust chose not to participate in the National Continence Audit.

The national clinical audits and national confidential enquiries that Sheffield Health and Social Care NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, are listed below

alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The Trust interprets this to mean as a percentage of the number of cases required nationally.

Name of audit / enquiry	Number of cases submitted	Number of cases submitted as % of number of registered cases required
POMH-UK – Medication prescribed	72	2%
POMH UK – Side effects of depot anti-psychotics	102	2%
POMH UK - Lithium Monitoring	560	19%
POMH UK - Metabolic side effects of anti-psychotics	125	3%
POMH UK - Medicines reconciliation	32	2%
National Physical Health Audit	30	2%
Antipsychotic use in Learning Disabilities – POMH UK	21	1%
National Falls Audit	Self assessment	1/173 Trusts
Dementia	30 patients / 20 carers / 20 staff = 70	2%
Psychological therapies	947	18%
NHSLA record keeping – standard 4	318	No target specified
National ECT Audit	12	1%
National Confidential Enquiry into Suicide and Homicide by people with mental illness	9 reported	No target – all cases meeting criteria were reported

The reports of 10 national clinical audits were reviewed by the provider in 2009/10 and SHSC intends to take the following actions to improve the quality of healthcare provided:

- All of the POMH UK audits were presented at the Trust-wide Audit Meetings where recommendations were made, e.g. sending out BNF prescribing cards. Re-audits are planned for all of these projects
- In terms of the Falls project, the Trust is currently benchmarking its falls data with other trusts. This audit was recently presented at a Regional Audit Conference in Wakefield
- A report has been received from the Royal College for the ECT audit and shows good compliance to the standards
- With regard to record keeping all teams received their results on laminated cards and the project was presented at a number of forums. A re-audit is almost done for this
- The national audit of psychological therapies is currently being written up.

The reports of 39 local clinical audits were reviewed by the provider in 2009/10 and SHSC intends to take the following actions to improve the quality of healthcare provided:

For example:

Compliance to NICE guidelines – Schizophrenia (Recovery & Rehabilitation)

- Assessment of occupational health needs
- Improvement of written information for service users
- Improvement in documentation of advance directives
- Increase the offer of family therapy and cognitive behaviour therapy.

A re-audit this year has shown that there has been an increase in the compliance to these guidelines in all these areas.

Suicide Audit

- Care Programme Approach (CPA) documentation in case notes
- Allocation to CPA (previously, to right level of CPA)
- Joint case review with Community Mental Health Teams (CMHTs) prior to discharge
- Explanations to service users about their medication
- Improved documentation of observations.

Since last year there have been improvements in these standards.

Physical Health Needs

The NICE guidance for Schizophrenia states that service users should have a Physical Health Check. This should happen in primary and secondary care.

- Physical health checks to be provided by the Sheffield Outreach Team (SORT), Hospital or GP
- Increase number of service users that have seen a dentist.

The re-audit has shown that:

- The total number of patients having a physical health check (either in hospital, by GP or SORT doctor) has increased from 77% to 83% in 2008.
- The percentage of patients that had seen a dentist has increased from 37% to 47%.

Violence and Aggression – NICE guideline

- Improve communication between staff and service users, especially at times of dissent
- Improvements to the environment.

Re-audit has shown improvement in the following areas:

- Handling dissent issues between healthcare staff and patients
- Patients seem more able to communicate with ward staff
- There have been some small improvements in aspects of the environment
- There has been a significant increase in staff that see the environment as more comfortable.

Further information on these and other local audits is available in the Trust's Annual Clinical Audit Report, available from the Trust's Clinical Audit Manager (jim.chapman@shsc.nhs.uk).

Statement 3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by SHSC in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 403.

(Please note that some studies' figures are the ones estimated in researchers' applications.)

Statement 4. Use of the CQUIN framework

A proportion of SHSC income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the SHSC and any person or body with whom they entered into a contract, agreement or arrangement for the provision of NHS services, through the CQUIN payment framework.

The amount of income in 2009/10 conditional on achieving CQUINs goals was £313,000. The associated payment received in 2009/10 was £313,000 as all agreed goals were met.

These goals were set as part of NHS Yorkshire and Humber 2009/10 regional CQUINs plan, which enabled the development of some regional benchmarking information.

During 2010 there has been the opportunity to develop more locally based CQUINs with NHS Sheffield, which the Trust has welcomed. Issues identified for prioritisation in 2010/11 include:

- Service user experience and quality of care, including aspects of physical health care
- Equality of access to services
- Improving access by reducing waits
- Pathway developments for dementia and for people with learning disabilities.

Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Executive Director of Finance.

Statement 5. Registration with the Care Quality Commission and periodic/special reviews

SHSC is required to register with the CQC and its current registration status is full registration for all activities across all locations. It has no conditions on registration. The CQC has not taken enforcement action against SHSC during 2009/10.

For the 2009/10 periodic review, the CQC will assess this Trust and other NHS providers on three assessments:

- Registration status, which will be constantly monitored and updated
- Achievement of the national priorities for 2009/10 which will be scored
- Quality of financial management in 2009/10 which will be scored.

The Trust has full registration for all activities across all locations, with no conditions. The scores for the last two elements are not yet available.

The periodic review replaces the previous Annual Health Check (AHC) – the AHC results for 2009 are reported in the section on compliance later in the report.

The Trust is subject to periodic reviews by the Care Quality Commission and the last review was in December 2009.

The CQC's assessment of SHSC following that review (Annual Health Check) was:

- good for quality of care, and
- good for use of resources.

The Trust intends to take the following action to address the points made in the CQC's assessment:

- Improve performance on the Greenlight toolkit (mental healthcare for people with learning disabilities)
- Reduce delayed discharges from in-patient services.

SHSC has made the following progress by 31 March 2010 in taking such action:

- Greenlight toolkit score is now reaching the CQC requirement
- Delayed discharges have been reduced to meet the CQC requirement.

SHSC has not participated in any special reviews or investigations by the CQC during the reporting period.

Statement 6. Information on data quality

SHSC submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patients' valid NHS number was 99.8% for admitted patient care;
- which included the patients' valid General Medical Practice Code was 99.4% for admitted patient care (14 patients out of 2,238 were not registered with a GP).

The Sheffield Health and Social Care NHS Foundation Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 72%.

SHSC was not subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission.

Part 3 – Other information

Overview of the quality of care

Progress on quality measures selected by the Board in consultation with stakeholders

Last year, the Trust chose a number of quality measures to assess itself. These reflected nation priorities and the Trust's own priorities for quality improvement.

Quality measures for patient safety

The Trust has chosen to report on Healthcare Acquired Infections (HCAIs), deaths by suicide of service users and falls resulting in an injury to a service user, as well as the national 'never events'.

Rationale

- MRSA and Clostridium-difficile infection rates continue to be very low on all Trust sites. Infections overall e.g. of diarrhoea and vomiting viruses are reducing.
- As a Trust working with people with serious mental health problems, we recognise that death from suicide or self harm presents a serious risk for a number of service users each year and is a source of fear for their families and friends. We have systems in place to assess and manage the risk of suicide or self harm. We also carry out a detailed investigation of all deaths from suicide and of serious self harm, to see if there is anything the Trust could do better and to learn for the future. These systems are currently being revised and improved. Information from the serious incident investigations is shared across the NHS and recommendations for improving the safety of services are made by the National Patient Safety Agency as a result. From this work, recommendations have been made for improving the safety of service users at times when they may be most at risk and most ill – in particular on the in-patient wards and in the seven days after leaving hospital.
- 'Never events' are very serious incidents that may have been preventable and are defined by the NPSA. The two that most apply to mental health and learning disabilities trusts are the death by hanging of an in-patient and misplaced naso-gastric tubes for feeding.
- Falls are the commonest cause of harm resulting to service users in this Trust and nationally for trusts working with older people, mental health and learning disabilities. The Trust has active work in progress to reduce the amount of harm suffered by service users as a result of falls.

All these measures are the same as last year, with one addition:

- The measure of whether service users received a seven day follow-up after discharge from hospital has been added to the patient safety indicators because this is a key recommendation from the NPSA to reduce the risk of suicide for people recently discharged from hospital care. It was reported as a clinical outcome last year.

All the figures are derived from Trust records.

Patient safety measures – results

Safety measure reported	2009/ 2010	2008/ 2009	2007/ 2008	Target if applicable	National benchmark	Data source	Standard national definition
MRSA bacteraemia cases acquired on residential and in-patient sites	0	0	0	Less than 1	N/A	Trust records	Yes
C-difficile cases acquired on residential and in-patient sites	0	2	3	To reduce		Trust records	Yes
'Never' events	0	0	1	0	N/A	Trust records	Yes
Suicide of in-patient or within 7 days of discharge from in-patient ward	1	0	1+1 narrative verdict	N/A	N/A	Trust records	
7 day follow-up of service users on CPA discharged from hospital – working age adults	97%	97%	95%	95%	N/A	Trust records	Yes
7 day follow-up of service users on CPA discharged from hospital – older adults	84%	96%	89%	N/A	N/A	Trust records	
Falls resulting in injury	490	503	539	N/A	N/A	Trust records	

Quality measures for clinical outcomes

The Trust has chosen to report on early intervention in psychosis, physical health checks for people with mental health problems, the number of people receiving Improving Access to Psychological Therapies (IAPT) and the effectiveness of IAPT treatments, and (new this year) minimising the delays in people being discharged from hospital and reducing emergency re-admissions.

Rationale

Early intervention is a critical part of getting effective treatment for psychosis – earlier specialist treatment has been shown to be associated with a better outcome for people who may be experiencing their first serious mental health problem.

There has been increasing recognition in recent years of the importance of maintaining good physical health when people have mental health problems. The Trust is committed to making sure that when people may be at their most vulnerable on admission to hospital, their physical health is assessed and treated as well as their mental health.

Two measures are provided to show the growth in the provision of effective, evidence based psychological therapies in primary care. The first is the number of people seen by the Improving Access to Psychological Therapies (IAPT) service, introduced in 2008. The second is the recovery rate – people who report that they have made a significant improvement on a series of standardised clinical outcome measures after treatment by the IAPT service.

Service user experience measures

The following information comes from the CQC Annual Patient Survey. The full survey results are published on the CQC website www.cqc.org.uk. Please note that the survey in 2009 was of in-patients only - in previous years there was a random sample of all service users with mental health problems. For this reason, we are not presenting historical figures in this part of the report, but the results from previous surveys are available on the CQC website. The Trust is not using the same service user experience measures selected from the Annual Patient Survey last year because several of them were not included in the 2009 survey report.

In 2009, the Trust scored in the top 20% on 11 questions and the bottom 20% on six items (out of a total of 38). The areas of underperformance were in response to the questions:

- Did you have a contact number for someone from your local mental health services to phone out of office hours?

Clinical outcome measures – results

Clinical outcome reported	2009/10	2008/09	2007/08	Target if applicable	Benchmark	Data source	Standard national definition
New cases receiving early intervention service	313	147	115	90		Trust records	
Physical health checks of acute adult mental health in-patients	90%	92%	82%	100%		Trust records audit	
Physical health checks – all Trust	84%	81%	Not measured	100%		Trust records audit	
Number of people treated by IAPT	6292		N/A	5357		Trust records	
IAPT recovery rate	47%	48% (part year)	N/A	N/A	50% achieved in national pilots	Trust records	Yes – clinical measure of 'caseness' as defined in IAPT outcomes guidance

- During your most recent stay, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?
- In your opinion, how clean was the hospital room or ward you were in?
- Was enough care taken of any physical health problems you may have?
- Notice of discharge from hospital
- Delayed discharge

The contact number for out-of-hours is a long-standing item where the Trust scores poorly. Action taken to address it includes giving service users contact details in their 'recovery folders' or on cards. The recovery folders have also enabled service users and staff to work together more closely around the discharge from the ward.

Actions to address the reports of sharing accommodation with a person of the opposite sex have been described in more detail earlier in this report, as this was the focus for a Trust quality objective for 2009/10.

A new physical health policy has been developed this year with greater emphasis on ensuring service users' physical health is checked and any concerns addressed.

The Trust plans to introduce service user experience measures or outcomes on a routine basis in 2010/11. A pilot study has taken place in learning disability services in 2009/10.

There was also a second pilot project in partnership with the CAB Mental Health Advocacy Service, this involved service user volunteers completing satisfaction questionnaires with in-patients. This has generated 110 completed questionnaires since December 2009 and plans are in place to use the results to support quality improvements on the wards.

Survey of in-patient service users	Based on service users responses to the survey, this Trust scored	How this score compares with other trusts
For questions about introduction to the ward	6.7/10	About the same
For questions about the ward	7.1/10	About the same
For questions about Psychiatrists	7.2/10	About the same
For questions about Nurses	7.1/10	About the same
For questions about medications	6.3/10	Better
For questions about care and treatment	6.9/10	About the same
For questions about talking therapies	6.9/10	About the same
For questions about activities	5.2/10	Better
For questions about physical heath checks	6.9/10	About the same
For questions about rights	7.1/10	About the same
For questions about leaving hospital	6.9/10	About the same
For questions about overall care	6/10	About the same

Performance against Key National Priorities and National Core Standards

Performance against indicators and thresholds in the Monitor Compliance Framework

As an NHS Foundation Trust, we are required to deliver our services in line with the following key quality standards. The following table summarises how we have performed over the year 2009/10.

Monitor Target	Threshold	2009/10 performance – Q3 figures to be updated
100% CPA patients receiving follow-up contact within 7 days of discharge from hospital	95%	97.2%
Minimising delayed transfers of care	No more than 7.5%	6.4%
Admissions to in-patient services who had access to crisis resolution home treatment teams	90% of all admissions	94.6%
Maintaining levels of crisis resolution teams set in 2003/06 planning round or subsequently contracted with PCT	Agreed levels	Met
New home treatment episodes	1,202	1,365

As a provider of health and social care services, responsible for the delivery of a range of statutory functions for the Local Authority under a Section 75 Partnership Agreement, we also assess our performance against a range of national priorities for social care and social services.

The Trust continues to perform well across a range of social care indicators. Our strong performance contributed to the Local Authority achieving three stars for its last review undertaken in 2008 for the year 2007/08, and levels of performance have been maintained.

Standards	Target / Aim	How We Did
Adults with mental health problems helped to live at home ● Proportion of the Sheffield population receiving support	5.1-5.4 %	Achieved
Adults with learning disabilities helped to live at home ● Proportion of the Sheffield population receiving support	5.2%	Achieved
Social care assessments ● Numbers of assessments completed within 4 weeks	72%	Achieved
Provision of social care package ● Numbers of packages introduced within 4 weeks of an assessment	81%	Achieved
Services for carers ● Provision of carers assessments, advice and support	Assessment against standards	Achieved
Delivery of equipment and adaptations within 7 days ● Equipment items to support independent living/ home care, delivered within 7 days of client being assessed	87%	Achieved

Compliance with CQC core standards

Our performance on quality and safety is reviewed and assessed by the CQC and we have performed consistently well over the last several years.

During the year 2009/10, the CQC assessed the Trust's overall performance for the previous year on the last Annual Health Check and concluded that:

- The quality of our services are good
- Our use of resources was good.

Issues highlighted as areas of potential concern over the quality of services were:

- delayed transfers of care (the number of service users experiencing a delay in proceeding towards their discharge from in-patient care)
- access and provision of mental health services for people with learning disabilities where progress towards a set of national standards, the Greenlight toolkit, was seen as too slow.

Both areas have been re-assessed and improvements have been made during the year.

The new registration system with the CQC was introduced during the year. The Trust was required to assess the health care services it provides across all its sites and declare whether or not it met the new core quality and safety outcomes or regulations. A new process was introduced in the Trust to collect and assess the evidence of compliance with the outcomes in all its locations. This saw the participation and engagement of clinical and service directors, managers and clinicians and the Trust Board.

As a result of this self assessment, the Trust chose to declare non compliance for two outcomes in some locations, as shown in the table below:

CQC declaration of compliance with core quality and safety outcomes by location

Declaration of compliance submitted to CQC in application for registration January 2010											
Key Compliant G Non-compliant R **Outcome No / Description**	**Locations**										
	Fulwood	**Longley**	**Michael Carlisle Centre**	**Forest Close**	**Forest Lodge**	**Wainwright Crescent**	**Grenoside**	**Assessment and Treatment Unit**	**Longley Meadows**	**Warminster Road**	**Rutland Road**
1 Respect and involve	G	G	G	G	G	G	G	G	G	G	G
2 Consent	G	G	G	G	G	G	G	G	G	G	G
4 Care and welfare	G	G	G	G	G	G	G	G	G	G	G
5 Nutritional needs	G	G	G	G	G	G	G	G	G	G	G
6 Co-operating with other providers	G	G	G	G	G	G	G	G	G	G	G
7 Safeguarding	G	G	G	G	G	G	G	G	G	G	G
8 Cleanliness and infection control	G	G	G	G	G	G	G	G	G	G	G
9 Medicines management	G	G	G	G	G	G	G	G	G	G	G
10 Safe and suitable premises	G	G	G	G	G	G	G	R	R	R	R
11 Equipment	G	G	G	G	G	G	G	G	G	G	G
12 Workers requirements	G	G	G	G	G	G	G	G	G	G	G
13 Staffing	G	G	G	G	G	G	G	G	G	G	G
14 Supporting workers	R	R	R	R	R	G	R	R	G	G	G
16 Assessing & monitoring quality	G	G	G	G	G	G	G	G	G	G	G
17 Complaints	G	G	G	G	G	G	G	G	G	G	G
21 Records	G	G	G	G	G	G	G	G	G	G	G

The reason for declaring non compliance with 'safety and suitability of premises' for four of the Trust's learning disability locations was to do with the physical properties of the buildings, including temperature and room size. There are active plans to re-provide these services in more suitable premises within three years, however, the Trust is concerned to make sure that the quality of care provided for service users does not suffer in the interim. It is actively managing the risk to service user safety and comfort, through the directorate risk register and local team reviews. It also seeks out regular feedback from service users and carers on all these sites, either through surveys or meetings of service users and carers.

The Trust declared non-compliance on a target relating to 'supporting workers' because of disappointing results on an audit of staff who had received a personal development review in the last year. This area was previously highlighted as weak through the annual CQC staff survey and action had been taken to make improvements, but the Trust audit showed that just under 50% of staff had received a PDR. An active programme of work is underway at time of writing with the aim of achieving 90% coverage by June 2010.

As a health and social care trust, SHSC also provides a number of social care services. Because of the CQC's transition time-scale these are still assessed under the old CSCI process. New procedures for social care registration will be introduced in 2010/11.

The Trust provides services to support people across Sheffield in the following services:

- Resource centres for older people – providing residential and day service respite breaks
- Supported living and short stay respite services for people with learning disabilities.

The following table summarises the positive position across the range of services:

Latest CQC registration quality rating for social care services provided by the Trust

Services	Assessed quality	Date of assessment
Day & Respite centres for older people		
Bole Hill View	Good	Oct 09
Foxwood	Good	July 09
Hurlfield View	Excellent	June 08
Kirkhill	Good	Feb 09
Norbury	Good	June 09
Supported living services for people with Learning Disabilities		
Supported Living Services	Good	May 09

How the organisation is developing quality improvement capacity and capability to deliver these priorities

This is what the Trust has done this year to develop quality improvement capacity and capability:

A. Improve quality assurance procedures

- CQC preparation and delivery of self assessment for registration – involving clinical staff and team managers, and reporting at location level, not just Trust-wide. Plans for ongoing 'quality check' meetings involving governors and LINks to review compliance with core safety and quality outcomes and regulations
- Strengthened governor, service user and carer involvement in quality review and determining priorities e.g. through setting the Trust quality objectives, Improving Quality events
- Improved dashboard reporting for Board on regulation, compliance and quality – so the Board and stakeholders including commissioners can see the current situation at a glance
- Continue to deliver team governance – and refining team governance reporting to take account of changes to regulation framework
- Development of Intelligent Board web-based datastore to support the provision of good quality information to support quality assurance and governance at all levels in the Trust.

B. Developing quality improvement procedures

In addition to the work described in the account of the Trust's quality objectives, a number of other projects have taken place during the year with a focus on improving quality:

- The redesign of the acute care pathway with a focus on setting quality standards, measuring delivery and holding to account
- Staff learning and development including the completion of a review and actions taken to improve training systems and administration
- The Productive Ward project, having been piloted on two wards, is now being rolled out across the Trust. It is resulting in small, but very positive and significant improvements to allow time to care
- Improvements to the serious incident procedures to make sure serious incidents are identified, reported, investigated and managed well, and that learning from serious incidents is shared effectively across all parts of the Trust. The aim of this project is to reduce the overall harm caused by serious incidents
- Falls prevention work – for example, innovative approaches to engaging service users on older adults wards at risk of falling, through role play and other interactive approaches.

Part 4 – How the Quality Account was developed

Review of progress and impact of last year's Quality Account

The Trust completed an annual quality account in 2008/09. It has reviewed progress on the quality objectives set then and continued with the same quality indicators where this was possible. It was decided it was not appropriate to report on the same patient experience indicators because of changes to the coverage and questions in the CQC Annual Patient Survey. It has recognised the need to develop better measurement systems for service user experience and set this as a priority quality objective for 2010/11. It believes the quality objectives need to be more specific and more measurable and has sought to improve this area. It has also recognised the need for routine and systematic reporting to the Board on delivery of the four quality objectives in 2010/11.

Involvement and engagement in determining the content of the 2009/10 Quality Account

The Board and governors reviewed priorities and improvement areas as part of the annual planning cycle in the autumn of 2009. From this work, the Trust's vision and strategic objectives were refreshed and ideas from this work were taken forward into the process of developing this year's Quality Account.

Guidance on the structure, content and process for quality accounts was published by the Department of Health in February 2010 and by Monitor in March 2010.

A first draft of the Quality Account including a 'long list' of potential quality objectives was presented to March Board for discussion. Following the Board meeting, some amendments were made and version 2 was circulated to key stakeholders for comments. The key stakeholders were:

- NHS Sheffield
- Sheffield City Council (through its Health and Community Care Scrutiny and Policy Development Board)
- Sheffield LINks
- The Governors of the Trust
- The senior managers and clinicians of the Trust.

Stakeholders were asked in particular for their views on the proposed quality objectives as part of a process of gaining consensus about the priority areas for improvement.

The Quality Account was discussed at two meetings of the Governors. There was a lively discussion at both meetings which demonstrated the overwhelming commitment of governors to quality in the Trust.

The Governors agreed in general with the four quality objectives proposed by the Trust Board. They valued the emphasis on rapid access to health in a crisis and physical health (especially nutrition). The majority agreed that the experience of people from black and minority ethnic (BME) groups should be a priority, given the evidence that indicates people from BME communities may have a poorer experience of care than others. The need to continue work on privacy, dignity and safety was noted. They made strong representations that older people and those with dementia, and their carers, should be included more e.g. in the waiting times priority. They wanted the question of a 24-hour phone line to be addressed. There was a debate about the service user feedback objective, with the opinion expressed that the Trust should be doing this already, but a general view that this must be a key foundation for improving services in future.

As a result of these discussions with the governors and feedback from the other stakeholders (described below) amendments were made to the draft Quality Accounts at April and May Boards.

The final version of the Quality Accounts was approved by Board on 1 June 2010. Some minor typographical errors were found on subsequent proof reading and corrected by the Director of Quality and approved by the Executive Director of Finance prior to publication.

Annex - Statements from NHS Sheffield, Scrutiny Committee and LINks

NHS Sheffield

The draft Quality Account was sent to NHS Sheffield and the following statement was received:

Statement from NHS Sheffield
We have had opportunity to review the draft version of this report and confirm that it represents an accurate and comprehensive picture of the Trust's work on the quality of their services. We enjoy a positive and constructive relationship with the Trust in relation to the quality and performance of their services, with a contract that sets out clear quality

standards and mechanisms to ensure those standards are met, and we have confidence in the Trust's work, as set out in these Quality Accounts.

Our strategy for improving health and health services in Sheffield, Achieving Balanced Health, sets out clear priorities for ensuring that, wherever possible, patients can be looked after in their own homes and that, where treatment in hospital is required, they have access to services which offer excellence in terms of clinical outcomes and patient experience. NHS Sheffield is fully committed to continuing its close co-operation with the Trust over the coming year on these important issues.

Received from: Tim Furness, Deputy Director of Strategy, Sheffield PCT, 19 May 2010

SHSC response:
The Trust notes and welcomes the statement from NHS Sheffield.

Scrutiny Board

The draft Quality Account was presented to Sheffield City Council Health and Community Care Scrutiny and Policy Development Board on 19 April 2010.

The meeting minutes record the Board's discussions and the following resolution:

'The Board requests that the following details are incorporated within the Quality Account: i) the involvement of service users in carrying out patient surveys ii) a 24/7 crisis team telephone helpline for dementia and iii) waiting times for assessment;
b) the section on dignity in care be expanded
c) the Director of Quality be requested to provide information as to the nature of the physical health checks carried out on admission, and
d) the Scrutiny Policy officer be requested to add carer breaks and respite care to the Board's work programme for future consideration.'

SHSC response:
i) Service users, carers and governors will be involved in visiting service areas and talking to service users and staff about the quality and safety of care as part of the new Quality Checks process, described in the Quality Account. Service users have also carried out the surveys of privacy and dignity on the wards led by the mental health CAB and by the Trust during 2009/10 continuing into 2010/11
ii) the issue of the 24 hour phone line has been noted and will be addressed by the Trust's business planning processes
iii) waiting times for assessment have been set as a quality objective for 2010/11 and the actions to be taken are described in the report
b) more has been added on privacy and dignity in care
c) the Director of Quality will supply the information requested

Statement from LINks

LINks members were present at and contributed to the City Council Scrutiny Board discussions. The Director of Quality and Board Secretary met with LINks to introduce and discuss the Quality Accounts content and process. A draft Quality Account was sent to LINks who have reviewed it and sent the following statement:

Comments on the Sheffield SHSC Quality Accounts 2009/10

For this commentary Sheffield LINk has considered the draft Quality Account document received on 25 March 2010 provided by SHSC.
General comments
The guidelines DoH, Gateway Ref no 13463 states that Quality Accounts should show where improvements are required and this is not obvious from the document.
Page 17/18
Not enough detail for the public to understand what the physical health policy involves and how it is of benefit to patients. The results of the national survey do not give enough detail to make a judgement about them, this also applies to the pilot project with Capital mental health.
Page 19/20/21
Compliance with CQC core standards – This section is written with the assumption that the public know the details, reference is made to performance over previous years but no comparison results are evidenced. The Annual Health Check by CQC concluded the Trust is "Good", this is not the top category therefore reference should be made in a way understandable to the public on how the Trust aims to attain "Excellent" from CQC.
The lack of information about support for carers especially carers of people with dementia is noted. The public are interested to know how this Trust supports carers' breaks, the quality of those breaks and the quantity available.

14 May 2010
Mike Smith
Chair
Sheffield LINk

SHSC response:
We will send a copy of the final version of the Quality Accounts to LINks for further feedback.

General comments:
We believe that we have now indicated where improvements are required in the introduction and in the selection of quality objectives for improvement.

Physical health
We note that this is an area of common concern for LINks, the governors, Scrutiny Board and the Trust, which has summarised its approach in the Physical Health Policy (2008). We have added some more detail to quality account and also set a quality objective on nutrition, which is a key component of both physical and mental health.

Service user surveys
We accept that we need to expand on the existing service user surveys and have set this as a quality objective for 2010/11. We have also provided more information on the pilot CAB project. We have added a reference to the CQC website where interested parties can find the full results for the annual CQC Patient Surveys.

CQC compliance
We have added more explanation and detail. The changes in the CQC mean that the Annual Health Check will not be repeated and so we cannot improve the score from 'good' to 'excellent' in future. However, we intend to maintain full registration with the CQC and set up the continuous programme of reviewing CQC outcomes through the Quality Check meetings. We have invited LINks to join the Quality Check meetings and they have indicated their willingness to attend.

Support for carers
This is an area the Trust will be working on in 2010/11 and we have added an item of introduction on it.

Part 5 – Publication of the Quality Accounts

The Quality Account will be published on NHS Choices and the Sheffield Health and Social Care Trust website (www.shsc.nhs.uk) by 30 June 2010. Copies will be sent to the stakeholders consulted in its development, to Monitor and to the external auditors.

As part of the Trust's Annual Report, it will be laid before Parliament by 7 July 2010.
Printed copies will be available from the Trust Board Secretary and distributed at the Annual Members Meeting on 20 September 2010.

5. Performance Review

5.1 Performance overview

Contracted service provision
Within each of our contracts with those who purchase our services for the benefit of the people of Sheffield, we have a range of activity targets that we have agreed to meet in the delivery of those services. The table below provides an overview of our performance against the targets set in our contract with NHS Sheffield, the main purchaser of our services.

NHS Sheffield Activity for 2009/10	Planned	Actual
Adult Mental Health Services		
Bed nights – all in-patient services	27,706	34,375
Community contacts – clients' homes, community centres	41,610	44,076
Day Service – attendances/community contacts	20,197	20,646
Specialist Mental Health Services – Community contacts – clients' homes, community centres	53,888	58,292
Older Adult Mental Health Services		
Bed nights – all in-patient services	21,685	20,862
Community contacts – clients' homes, community centres	51,461	56,191
Day Service – attendances	5,300	5,047
Learning Disability Services		
Bed nights – in-patient services/respite care	6,390	6,009
Community contacts – clients' homes, community centres	12,065	12,309
Substance Misuse		
In-patient detoxification – bed nights	1,564	1,623
Community contacts – clients homes, community clinics	13,000	13,913
Improving Access to Psychological Therapies		
Clients receiving services	5,357	6,285

We performed well in respect of our commissioned levels of service activity. Overall, we over-performed in a number of service areas which resulted in additional contractual payments being received to the value of £54,000.

In addition to this, we were able to expand our provision within our in-patient services for adult rehabilitation and intensive care during the year. This has resulted in an increased service capacity, more patient care provided locally and an extra £221,000 income to us.

The above summary highlights some areas of under-performance. These were in line with service areas undertaking re-design plans and no significant concerns are highlighted due to the under-performance.

Our services and income
We provide a range of services, covering direct care services, training and teaching and support functions.

The following table provides an overview:

Commissioner	Services commissioned	Income £000	% of income
Clinical Services			
NHS Sheffield	Directly commissioned patient services	66,755	57.62
Sheffield Local Authority	Directly commissioned services	5,207	4.49
Other NHS Primary Care Trusts	Directly commissioned patient services	5,171	4.46
Other clinical Income	Directly commissioned services	8	0.00
	Clinical services income – sub total	**77,141**	**66.58**
Other services			
Strategic Health Authorities, Primary Care Trusts, Department of Health, etc.	Education, training, research and development	7,018	6.06
NHS Sheffield, Other NHS Primary Care Trusts, Foundation Trusts, NHS Trusts and WGA organisations	Non Patient Care services	19,517	16.85
Housing Associations	Residential care services	11,041	9.53
Other Income		1,139	0.98
	Other income – sub total	**38,715**	**33.42**
Total	**Grand total**	**115,856**	

5.2 Partnerships with staff

Our Staff recommended our organisation as a place to work and a place for a relative to receive treatment in the NHS staff survey, putting us in the top 20 per cent of similar Trusts on this Key Finding.

Communication and staff engagement

Our Staff Governors, staff representatives and staff themselves are involved in initiatives that are focused on delivering quality services. As a Trust, we encourage local teams to improve their services, with supervisors and managers attending the Leadership Development Forum to discuss objectives and service developments. Our Chief Executive produces a Bulletin several times a year and uses informal emails to all staff about topical issues. Feedback is encouraged and our intranet site includes an 'Ask an Executive' facility for staff to use in raising queries with our senior management team. More formal processes include the consultation and negotiation forums with staff representatives. Our new Strategic Leadership Group which focuses on service improvement engages clinicians and managers in a drive to deliver change to clinical services more proactively.

Staff Survey

The NHS Staff Survey provides feedback about organisational performance across a range of

Table 1

	2008/2009		2009/2010		Trust Improvement/ Deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Response rate	48%	55%	56%	55%	✔ Better than last year
Top 4 Ranking Scores					
Percentage of staff working extra hours	58%	64%	55%	63%	**No significant change**
Work pressure felt by staff	2.94	3.03	2.87	3.02	✔ Better than last year
Staff intention to leave jobs	2.4	2.6	2.4	2.58	**No significant change**
Staff recommendation of the Trust as a place to work or receive treatment	Key Finding was not calculated in the 2008 Survey	Key Finding was not calculated in the 2008 Survey	3.61	3.43	**Key Finding was not calculated in the 2008 Survey**
Bottom 4 Ranking Scores					
Percentage of staff agreeing that they have an interesting job	79%	81%	76%	82%	**No change**
Percentage of staff appraised with personal development plans in the last 12 months	49%	62%	48%	67%	**No change**
Percentage of staff having equality and diversity training in last 12 months	28%	35%	28%	42%	**No change**
Impact of health and well-being on ability to perform work or daily activities	Key Finding was not calculated in the 2008 Survey	Key Finding was not calculated in the 2008 Survey	1.71	1.62	**Key Finding was not calculated in the 2008 Survey**

relevant issues. The results are now focused on the pledges for staff within the NHS Constitution, which are:

Pledge 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

Pledge 2: To provide all staff with personal development, access to appropriate training for their jobs, and line manager support to succeed.

Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

In 2008, the four top indicators were a smaller number of staff intending to leave their jobs, with a higher percentage of staff recommending the Trust as a place to work and believing the Trust provides equal opportunities for career development. More staff had received job related training than in other mental health trusts. Two main areas for positive action were appraisals and health and safety training. The results for 2009 are shown in Table 1 (previous page).

Our ability to deliver well structured appraisals and development plans for staff remains a challenge. This was highlighted in the Care Quality Commission registration process as well. Teams will be monitored more closely to ensure the rate of achievement meets the objective of all staff having feedback through appraisal, being supported by their supervisor and having the right skills for their job.

The Trust began a review of learning and development activity in 2009 which will provide a clear focus on essential training activity to ensure the Trust underpins its service delivery with safe and competent staff. The staff survey indicates that health and safety and diversity training are areas of poor performance by comparison with other mental health trusts and will be an area for improvement in 2010.

5.3 Partnerships with the people who use our services and their carers

We believe that the people who use our services and their carers should be in control of their own decision making, and should be involved in decisions that affect their lives. In 2009/10, we developed our Quality Framework. This embeds experience of the people who use our services and their carers as one of four key imperatives for assuring quality and places the people who use our services alongside staff at the heart of this framework. In 2009/10, we continued to work with the people who use our services and their carers in a number of different ways as well as starting to develop an overarching patient and public involvement framework.

In 2009/10, the Trust:

- Developed its relationship with Sheffield's Local Involvement Network (LINk)
- Held regular 'Improving Quality' events attended by the people who use our services and their carers and led by Trust Executives. These were an opportunity to develop and discuss potential and developing quality improvement initiatives alongside the people who use our services and their carers. They were also an excellent opportunity for Trust Executives to hear the priorities that the people who use our services and their carers have
- Worked with partner agencies in the statutory and voluntary sector in the development of the city wide carers' strategy. The Trust continues to develop this partnership as it draws up the organisational action plan linked to the strategy
- Maintained the proactive Patient Advice and Liaison Service (PALS) and has continued to embed PALS within Trust's services and support initiatives to develop diverse use of the service
- Developed positive working relations with Patient Opinion and the Trust intends to develop this over the next 12 months
- Maintained the embedding of the involvement the people who use our services and their carers across the Trust, with continued involvement in service forums, recruitment, training and service development plans.
- Worked with the people who use our services and their carers in developing new ways of supporting involvement and participation, for example through the SUN:RISE and Partners in Improving Quality initiatives.

Worked alongside the people who use our services to identify quality improvements through the privacy and dignity and improving information projects.

5.4 Learning Disabilities

The last financial year has been a time to enhance the Joint Learning Disabilities Services for people with the most complex needs, bring together the final teams as part of the joint service, strengthen work with primary and secondary care and start to develop our approach to Self Directed Support.

Over the year, the integrated working of the joint service has made it possible to deliver some key improvements. These are leading to better outcomes for people with learning disabilities and complex needs such as challenging behaviour, mental health problems or profound and multiple disabilities.

The service has been able to develop support packages for young people with very complex needs coming through transition from children's services or leaving the assessment and treatment unit, enabling them to be supported in Sheffield rather than out of the city. Working closely with local authority colleagues in the joint service, we have seen the embedding of intensive interaction for people with profound and multiple learning disabilities which is particularly effective in the newly enhanced day centre facilities.

The north health support teams joined up with social workers to form the North Community Learning Disability Team at its new base on Love Street. The employment day service is also based at Love Street, with service users providing reception services and facilities, helping to form an integrated environment.

The catering team from the employment service opened Café 7 at Fulwood House (the Trust's Headquaters). Both Café 7 and Love Street are providing opportunities for work experience for people with learning disabilities and the service is working towards paid posts at each location.

The Self Directed Support agenda has been a key driver for much of the work done over the last year and we are advanced with the development of models for delivering personalised services. This will be a key theme for the coming year ahead and beyond.

Work with primary and secondary care is leading to improved health outcomes for people with learning disabilities. New jointly developed protocols in the teaching hospital now identify people with learning disabilities on admissions via the case register so they can be supported to have a quality experience in the service. This work has been recognised nationally as good practice.

Quality improvement has been a focus over the year, with clinical outcome measures developed in specialist teams, an audit of service completed for people with autism and service users involved in regular reviews of accommodation services.

Detailed planning work with families accessing respite and an outline business case for new specialist assessment and treatment services has enabled us to agree a plan with the Care Quality Commission that will lead to new facilities over the next two years.

5.5 Substance Misuse – Drug and Alcohol Services

2009/10 has been an extremely successful year for Substance Misuse Drug and Alcohol Services.

While the services have continued to make excellent progress in clinical innovations and performance delivery, they have also successfully secured a new three/five year contract with the commissioners, Sheffield Drug and Alcohol Action Team, following robust procurement exercises.

The successful tender outcome saw the Trust develop and provide a new harm reduction service for the city from 1 April 2010, supporting some of the most vulnerable and problematic drug users in the city, and their family members. The Substance Misuse

Directorate will be working in partnership with the national charity, Turning Point, as well as utilising formal support from Sheffield Teaching Hospitals NHS Foundation Trust to develop complementary care pathways.

To deliver the new contracts, innovative clinical and managerial reporting structures have been established to ensure optimum use of staff skill and expertise.

Other key successes for 2009/10 include:

- The welcome appointment of Dr Ruta Rele as the new consultant psychiatrist for the service
- Green light dashboard for national key performance indicators
- Maintained reduced waiting times for access to the specialist alcohol service from six months to three weeks
- Working in collaboration with other agencies to increase the number of problematic drug users entering treatment in Sheffield
- Increased numbers entering residential rehabilitation in support of abstinence based models of recovery
- Proactive work with commissioners and the National Treatment Agency in support of the national recovery agenda Project

5.6 Acute, Community and Primary Care Directorate – Adult Mental Health

Over the year, the Acute, Community and Primary Care directorate has continued to focus on service initiatives which achieve more effective outcomes for people experiencing mental health problems as well as supporting the culture of continuous quality improvement.

The service has developed and is currently implementing the pathway into acute care. It integrates standards and measures that help clients to move through the acute care system and supports continuous measurable improvement in client satisfaction. The care pathway will be used to record variations from good practice and identify any gaps in the care of an individual.

There has also been considerable work on improving the quality of in-patient care. This has focused on delivering individual care plans for patients, improving safety and providing more activities for patients. Additionally four discharge co-ordinators have been appointed to assist and support effective discharge.

In the community, the directorate has further developed services in line with the National Institute for Clinical Excellence (NICE) guidelines, so that treatment offered is based on best practice and evidence. In addition, the community mental health services have stepped up the volume of activity, with increases of 8 per cent in face-to-face contacts for community mental health teams and more than 40 per cent in the number of patients treated in the home.

Sun:Rise is the new network set up for the people who use our services in order to improve the range of ways that they can become involved with the Trust.

The directorate was successful in the Trust Excellence Awards, with one service-user volunteer winning an award for their work with the ‘Ship Shape’ Art Group. A number of directorate staff were nominated for the Trust’s own ‘SHSC Excellence Awards’ by their colleagues, managers and the general public, with two being awarded for the inpatient category.

Members of staff across the directorate took part in a wide range of projects aimed at improving the quality of care provided to the people who use our services. In-patient staff put a renewed focus on providing therapeutic activities. The Intensive Treatment Service ward activity co-ordinator ensures that patients have activities all day, including gym sessions and movie nights.

The South East Primary Care Pilot Mental Health Integration Project is an initiative which sees the Trust working in partnership with the Central GP Consortium. The project began in June 2009 and has been piloted for 12 months. Seven GP practices within the south-east of Sheffield have received mental health liaison workers as an additional resource.

The role of the new liaison workers is to provide advice and consultation to staff within primary care as well as offering short term input to the people who use our services and for those whose needs may not be currently met by the existing mental health resources within primary care. Their role also supports appropriate mental health referrals at the interface of primary and secondary care, helping people to access secondary care mental health services. The project will be evaluated and the findings will be available from August 2010.

Further implementation of the talking treatments strategy is being progressed following successful establishment of the specialist tertiary care team for people suffering from obsessive compulsive and body

dysmorphic disorder. The purpose of the specialist teams will be to provide tertiary care services for people suffering from specific problems in line with the NICE guidelines. Development of teams treating clients referred for post traumatic stress disorder, personality disorder, anxiety and depression will be taken forward over the coming year.

Future Developments

Self Directed Support (SDS) – a brief overview on this national policy initiative is provided in section 5.7 of this report.

Governance – team governance is being reviewed in line with the requirements of the Care Quality Commission (CQC). Team governance reports will be further developed to include information which contributes to the evidence required to meet the CQC 'Standards and Outcomes'.

5.7 Recovery, Rehabilitation and Specialist Mental Health Services – Adult Mental Health

The directorate was successful in gaining the contract for the provision of new Community Recovery Service, which will replace current Adult Day Services.

The service has made significant and positive changes over the year, rationalising management arrangements and staffing levels, while moving to a greater focus on outreach work with clients. Over the coming year, the service will fully implement the changes still required to meet the new specification for the 'Sheffield Pathways and Access Community Engagement Service' (SPACES). The community recovery model places a much stronger focus on social inclusion and recovery than the traditional day service model and on those who need focused help in redeveloping a life outside their home, as well as assisting in the individual's recovery process.

Implementing Self Directed Support (SDS)

SDS is a new way of arranging and funding social care services that gives people who use mental health services much more choice and control over the services they receive by providing a personal budget. This is being rolled out gradually across Sheffield and our Trust is responsible for introducing SDS for adults with mental health problems who meet the 'Fair Access to Care' social eligibility criteria.

A pilot has shown benefits for many of the people who use our services and training is now being provided for community mental health teams.

Cognitive Behavioural Therapy and Family Interventions

Plans are being made to improve the provision of Cognitive Behavioural Therapy (CBT) and Family Interventions in the 'Early Intervention', 'Sheffield Outreach' and 'Continuing Needs' community mental health teams. Staff knowledge and skill levels are being enhanced via a training programme to enable CBT informed practice and family interventions. Delivery of structured family interventions will be piloted over the 12 months from March 2010 before being rolled out to the remaining teams.

Eating Disorders Service

The Eating Disorders Service is a joined up multidisciplinary specialist tertiary service dedicated to helping people suffering from disorders such as bulimia and anorexia. The service works with the client to maintain weight, stabilise bingeing or purging behaviour and improve diet. Ensuring that high quality eating disorder services are available for the local

population has been strengthened by the recruitment of a consultant psychiatrist and a psychologist to the existing team.

Pinecroft and Forest Lodge additional beds

Pinecroft Ward provides a rehabilitation and recovery service for people with severe and enduring mental health needs. Bed numbers have recently been increased from 12 to 17. These will, in part, be available for clients currently treated out of Sheffield who are clinically ready to return. A further three beds have been commissioned at the Forest Lodge low secure facility, primarily for the South Yorkshire population.

Gender Identity Service

The Gender Identity Service, based at Porterbrook Clinic, is taking more patient referrals following agreement with the Specialist Commissioning Group. The service plans to recruit additional staff to the clinical team in the near future.

5.8 Dementia (older adults)

The newly reconfigured services have been operational for 15 months and 2009/10 has been a year of consolidation and evaluation. Ongoing staff development and supervision systems have been a major priority.

Early indications show that the service changes are having a positive effect in key performance areas. The table below provides comparison of the old service with the new.

	January - June 2007	January - June 2009
Acute dementia admissions	56	53
Average length of stay (days)	120	60
Long term care placements	44	32
Patients returning home (%)	10	20
Staff sickness rates (%)	17.5	4.9
Violent incidents	149	133

A 27 per cent reduction in admissions to long term care has been a real highlight. The discharge facilitator and effective gate keeping by consultants and rapid response teams (172 completed outcomes

working with patient and carer in the first half of 2009) have had a positive impact on both admissions to the in-patient area and length of stay.

Cost efficiency has improved – thanks to the drop in staff sickness absence which has reduced the need for temporary staff. Despite the high degree of complexity of patients admitted, more patients are returning home than previously, reflecting both a better environment for people with dementia and staff developing skills and working practice.

The success of the new service has led to proposals for a rapid response/discharge team to work with the casualty and medical admissions unit to reduce lengths of stay at the Northern General Hospital.

5.9 Functional Mental Illness (older adults)

Working in partnership with other organisations has achieved excellent results this year. The integration of health and social care provision by the older adult Community Mental Health Teams (CMHTs) was successfully completed in September 2009 and the benefits are already being realised. This is not an end point but part of an ongoing process to improve integrated working for the benefit of people using the service and their carers, easier referral routes into the service and more efficient and effective use of local authority and NHS resources.

The service is currently working on how best to gather effective feedback on the changes. This

integrated provision will also greatly facilitate the introduction of personalised social services, or Self Directed Support, as this national initiative rolls out during the next financial year.

The Department of Health has set six criteria for integration – all of which must be met – but the integration process is not specified. It is a very complex procedure which has been approached in many different ways throughout the country. A national survey to find the most effective method of integration shortlisted our CMHTs to the final 18 in the country, and then down to the final four. This means that our Trust's integration process could potentially inform national best practice.

A collaboration between the provider arm of the Primary Care Trust, Sheffield Teaching Hospitals NHS Foundation Trust, and our Trust for an NHS Sheffield tender for a modernised intermediate care community service (known as 'Care in your own bed') achieved a successful result. The contract has been awarded to the partnership, which also includes a fourth partner, SERCO Health, a private company with extensive experience in service transformation.

Following the award of the contract in December 2009, very detailed work has been undertaken between the four partners for a start date of the new service from April 6, 2010. A seven month transition phase from the old service to the new will be followed by the transformation programme to deliver the full vision for the modernised service over the next three to five years.

The Psychological Therapy Strategy has been advanced in a number of areas:

- Training on Obsessive Compulsive Disorder for all CMHTs and input to the whole age range pilot of the tertiary clinic;
- Introduction of work study and case discussion group for senior practitioners;
- Introducing psychological well being groups in our in-patient areas.

Modernisation work to develop alternatives to admission into acute beds for older adults with a functional mental illness are continuing, in partnership with local authority and NHS commissioners. There is also close collaboration between older adult services and adults of working age services to ensure that age equality aspects are properly considered and implemented. This is imperative in the light of forthcoming equalities legislation and the significant increase in the numbers of older people over the next few years. Discussions with the voluntary sector about partnership working to increase efficiency and effectiveness, especially in the light of Self Directed Support, are also underway.

5.10 Therapy Services

Therapy Services continues to deliver high quality occupational therapy, arts therapies, chaplaincy and integrated complementary therapies across a range of service areas both internal and external to the Trust.

The service continues to take a lead on employment and health, contributing to delivery of the city-wide social inclusion target 'PSA 16' to support more people with mental health conditions into employment, and leading on work to meet the 'Mindful Employer' charter.

Therapy Services staff are frequently key instigators of social inclusion developments and partnerships, and examples of this last year include the 'Growing Hope' exhibition of service users art work at the Winter Garden and the 'Ecominds' allotments links with Forest Lodge. Work on the 'Hillsborough Walled Garden' project this year also resulted in a 'Sheffield in Bloom' gardening award.

Across the wider health and social care community of Sheffield, Therapy Services staff played a major part in the successful tender for the new community intermediate care service. They are also taking significant roles in the development plans, including the clinical model, for the new service to start in April 2010.

Therapy services staff strive to develop their skills and share their expertise in a range of settings. Two occupational therapists successfully applied for clinical research masters' awards, and arts therapists in neuro-rehabilitation presented at a national conference. In addition, the service has been playing an important public health advisory role on the NICE guidelines for older people, occupational therapy and activity.

In 2010/11 key pieces of work will include leading on the development of an arts strategy and further plans to meet employment targets.

Chaplaincy and Spiritual Care

The Chaplaincy and Spiritual Care service is part of the Therapy Services directorate. Last year saw considerable changes to the service, including the reorganisation of the department in response to the Trust's strategic objectives and towards providing a high quality service centred on the needs of the people who use our services and their carers.

The last year saw all posts in the department filled with permanent staff and a commitment to high levels of governance. As well as continuing to provide support to individuals who use our services, their carers and staff, the department's objectives are:

- To be a focus for excellence in spiritual and religious care throughout the Trust;
- To proactively develop spiritual and religious care throughout the Trust;
- To work with faith communities and complementary agencies to strengthen their ability to support and embrace people with mental health difficulties, learning disabilities and alcohol and substance misusers.

In practice, this has included delivering significant amounts of training to staff on the assessment of spiritual strengths and needs, hosting a meeting between the Chief Executive and faith community leaders and chairing the Spirituality Strategy Group.

On the ground, the department has become a multi-faith service, it has developed the learning disabilities chaplaincy and it now additionally provides significant input to dementia services.

The department continues to sharpen its focus as it seeks to deliver both quality and value. Plans for the coming year will include further commitment to the 'Spirituality Champion' model, implementation of the use of Insight for client records, and working to improve the interface between the Trust and faith communities.

The department has received great support from the Trust's leadership, which has enabled it to engage more deeply with the Trust's corporate image.

5.11 Psychological Services

In November 2009, Psychological Health Sheffield (PHS) changed its name to Psychological Services, bringing it more into line with the Trust's directorate structure. This coincided with the permanent appointment of a Director of Psychological Services who now reports to the Executive Director responsible for operational delivery and the Director of Strategic Development.

The use of psychological services in the UK is rising and is now at a higher level than ever before across the general population. From 1 July 2009 practitioner psychologists became statutorily regulated by the Health Professional Council (HPC) for the first time. All clinical and organisational psychologists employed by our Trust are registered with the HPC.

On behalf of South Yorkshire, our Trust hosts the Doctor in Clinical Psychology programme which had an excellent accreditation report from the British Psychological Society (June 2009). The accreditation team noted that *"the programme's attention to maintaining a high level of quality is outstanding*." The Director of Clinical Practice has also been responsible for delivering Improving Access to Psychological Therapies (IAPT) supervisor training for the Yorkshire and The Humber Strategic Health Authority. Up to 80 participants have been trained or are due to be trained in the academic year 2009/10. The training has been acknowledged at a national level as being a model of good practice.
In 2009/10, Psychological Services successfully provided a diverse range of services across South Yorkshire and our staff continue to play a key role in new developments in the region. Psychological Services contributed to the Mental Health strand of NHS Sheffield's Pathway Redesign Project "Better Outcomes for Patients" and is leading on a multiagency project to improve services to people with 'Medically Unexplained Symptoms'.

As part of our commitment to the development of effective biopsychosocial models of care, staff continue to be involved nationally and locally in designing innovative care pathways and good practice guidelines, such as "Dementia and People with Learning Disabilities Guidance", jointly produced by the British Psychological Society and the Royal College of Psychiatrists.

In conjunction with the Director of Organisational Development, the Head of Organisational Psychology and Workplace Wellbeing has been a major contributor to the Trust's strategic objective of developing shared leadership in our Trust, including developing the Service Improvement Through Collaborative Leadership programme.

Clinical psychologists have also played a significant role in leading on the successful implementation of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards, ensuring we uphold the human rights of some of the most vulnerable adults in the Trust's care.

5.12 Improving Access to Psychological Therapies

There has been substantial growth in the availability of psychological treatments for common mental health problems over the last year, predominantly in the areas of depression and anxiety.

The Improving Access to Psychological Therapy (IAPT) service is now half way through a three year plan to improve access to psychological therapies. Some of the achievements in the last year have been:

- More than 7,000 people entered treatment in 2009/10;
- A choice of a range of psychological therapies (guided self help, Cognitive Behaviour Therapies, counselling) through any GP practice in Sheffield;
- Since November 2009, access to the IAPT services from a range of voluntary sector organisations such as Mind, Sheffield Women's Therapy, Share Psychotherapy, Southey and Owlerton Area Regeneration, Roshni Project, Yemini Community Association, Manor & Castle Development Project, Sharrow Community Forum and Zest;
- The setting up of an Employment Advisor pilot, in partnership with Sheffield Occupational Health Advisory Service, meaning that people using the service can get help with retaining or obtaining employment;
- More than 300 people were able to return to work after they used the service. This means that the IAPT service is a net benefit to the economy in Sheffield;
- Around half of the people who use our service are meeting the clinical definition of moving to recovery when they leave the service – with the vast majority benefiting from positive improvements in their wellbeing;

- The setting up of a stress control evening class, running throughout the year. About 80 people attend each one;
- The opening of a new city-centre base where people can refer themselves for treatment without having to go to their GP.

5.13 Corporate Services

Environmental matters – Sustainability and carbon reduction

The facilities directorate continues to be actively involved in reducing the Trust's carbon footprint. Examples during 2009/10 include the introduction of a vehicle tracking system for the Trust's transport and equipment service's fleet of vehicles and the installation of low energy lighting across areas of the Michael Carlisle Centre and Forest Lodge site. Within its sustainability commitment, the Trust continues to utilise the Sheffield District Heating System at a number of our properties whilst 14 per cent of the electricity we purchase is supplied through renewable resources. Plastics, cardboard, paper waste and electronic goods all contribute to our recycling efforts.

Capital and Estate Rationalisation

In line with our Integrated Business Plan, the Trust continued to rationalise its estate through the sale of the Beighton Hospital site and several residential properties. The capital receipts raised are to be reinvested in future service developments.
Although no major single items of capital work were carried out during the year, the Trust endeavoured to maintain the current standard of its estate through the provision of several small capital schemes with respect to service development, property maintenance and patient and staff safety.

Patient Environment

The Trust achieved its best results to date with respect to the annual NHS Patient Environment Audit (PEAT), rating no less than 'Good' for all areas of its in-patient environment and 'Excellent' for food service and privacy and dignity.

Facilities Directorate

Within its annual development plan, the facilities directorate introduced modern software systems to supplement the Trust's estate management and cleaning requirements. Use of these systems is expected to provide the basis for more informed management and strategic policy decisions and is aimed at delivering improved efficiencies, customer satisfaction and efficient use of future resources.

Through its Facilities Management Partnership arrangement, the facilities directorate continued to assist NHS Sheffield in the management of its estate, purchasing function and transport and telecommunication requirements.

Human Resources Directorate

During the year, the Human Resources directorate supported the Trust in recruiting 21 apprentices in health and social care and business administration. Apprenticeships have a key role to play in supporting workforce needs, raising skills and addressing future workforce requirements such as varied skills and the challenges of an aging workforce.

The Trust's apprentices work alongside mental health nurses, occupational therapists, drug workers and managers to learn more about the many job roles in the NHS. The Trust works in partnership with Sheffield City College, which provides the learning and accreditation through NVQs and technical certificates. Apprenticeships are now accessible for all ages and are used to train both new and existing employees. The Trust will be employing more apprentices in the coming year.

Corporate Affairs Directorate

A new Company Secretary was appointed in September 2009 following the retirement of his predecessor during the same month. The new Company Secretary took up office in November 2009, thereby ensuring continued provision of corporate governance support to the Trust's Board of Directors and the Council of Governors.

5.14 Financial Performance

This section provides commentary on the Trust's financial performance and overview of accounting processes, capital plans and income required.

The Accounts for the period 1 April 2009 to 31 March 2010 are included in full under Section 15 of this report.

Overview of Financial Performance

The Foundation Trust established on 1 July 2008 has now completed its first full year under the Monitor regime. There have been a number of issues which have required strong management and leadership. These primarily related to the delivery of the Trust's first Annual Plan objectives. These have been delivered, although the cost improvement required has not all been delivered recurrently.

The Trust has exceeded its planned forecast of a £1,720,000 surplus and achieved a surplus of £2,127,000 with Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £6,480,530.

The Foundation Trust enablement to keep cash, together with the sale of the Beighton Community Hospital and other Trust properties during 2009/10, and the reduced spending on capital during the year, has strengthened the cash position and overall financial position.

Performance against the national "better payment practice code" which requires the organisation to pay all valid non-NHS invoices within 30 days of receipt or the due date, whichever is the later, is 86%.

Income

In the 12 months covered by this report, the Trust generated income totalling £115,855,855 (excluding the profit on the sale of assets).

	***Total 01.04.08 – 31.03.09 £'000**	**Total 01.04.09 – 31.03.10 £'000**
Income from Activities	74,155	77,140
Other Operating Income	36,668	38,716
Total Income	**110,823**	**115,856**
Operating Expenses	(107,219)	(111,434)
Profit on disposal of fixed assets	11	293
Interest & Other Financial Costs	132	35
Public Dividend	(2,815)	(2,337)
Asset Impairment	(210)	(286)
Surplus	**722**	**2,127**

*Full year for both years to aid comparison, however, this 12 month period includes two accounting periods. In terms of Final Accounts, the comparator is for the nine month period as a Foundation Trust only.

Financial Performance

As an NHS Foundation Trust, we are able to generate and carry forward any surplus made and these surpluses will be used to maintain, where appropriate, and enhance the quality of services that we provide. The surplus will also ensure future financial stability, especially over the next few years, in order to mitigate the impact of the current adverse economic climate.

It is pleasing to note that the surplus is slightly higher than that identified in the Annual Plan, although some of this has been, in part, the result of non-recurrent benefits from the sale of several surplus Trust properties. This is not expected to be the case for 2010/11 onwards and, therefore, the financial plan reflects this situation and the Trust has identified only the minimum surplus required to enable it to be able to maintain the current quality of services.

Cash Flow Management

The Trust has adopted a revised Treasury Management Policy and reviewed its cash and working capital management. The aim is to ensure that cash management is brought into line with the Foundation Trust requirements which are based on commercial cash management arrangements.

The cash balance at the end of March 2010 was £11.0m, and the Trust has an agreed working capital facility of £8.1m.

Capital Investment

The Trust investment in capital expenditure for 2009/10 was £0.913m. The spending of capital has been minimal this year as the organisation undertook a review of its existing strategy to meet the challenges facing the Trust due to the economic downturn and nil or minimum growth for the next few years. There is currently a review being undertaken of building usage as part of the Acute Care Reconfiguration, the Learning Disability Service Strategy and office based services. On this basis, capital funds are being saved until the whole estate has been reviewed as part of this work.

Long Term Borrowing

Monitor, the Independent Regulator for Foundation Trusts sets the approved long term borrowing limits for all Foundation Trusts from the date of their authorisation. These limits are revised every year. The Trust's approved long-term borrowing limit for 2009/10 was set at £22.7m. During the year the Trust has not borrowed against this limit.

Key Financial Risks

Part of the Foundation Trust governance process requires Foundation Trusts to submit, to Monitor, an annual plan and quarterly and other adhoc reports on their financial performance, governance and mandatory services. On the basis of these submissions, Monitor assigns a quarterly or annual risk rating (as the case may be) to each Foundation Trust. The risk ratings are designed to indicate the risk of a Foundation Trust's failure to comply with its terms of authorisation, which form the basis upon which each Foundation Trust derives its mandate to operate. In its regulatory oversight in the area of finance, Monitor uses a risk rating scale of 1 to 5, where 1 represents the highest risk 5 represents the lowest risk of failure to comply with a Trust's terms of authorisation.

Sheffield Health and Social Care NHS Foundation Trust has achieved a rating of 4 throughout the year 2009/10, as planned.

The Trust has a rigorous performance system in place through its structure of operational committees, Committees of the Board of Directors right through to the Board of Directors itself. Performance reports are monitored and reviewed on a monthly basis. The implementation of the Intelligent Board system will enhance this process.

Counter Fraud & Corruption

The Trust has a nominated Local Counter Fraud Specialist (LCFS) who is a specialist in this area. He reports both to the Head of Internal Audit Service and the Trust's Executive Director of Finance but also attends the Trust's Audit and Assurance Committee along with Internal and External Audit colleagues.

The LCFS has a high profile within the Trust and a web page which is kept up to date with actions completed and issues found. The officer regularly

provides group sessions at various locations across the Trust with many attendees and this is seen by the Audit and Assurance Committee as a major deterrent and preventative control against the perpetration of fraud in the Trust.

Any allegations of fraud are thoroughly investigated and full reports produced and discussed by the Audit and Assurance Committee.

Financial Challenge for 2010/11

Along with all other NHS organisations in operating in the current economic downturn, the Trust will be facing a series of challenges for the coming year. The main challenges are noted below:

- Achieve a further Cost Improvement Target of around £3m year on year;
- Provide a robust business case for services which are to be tendered for, including assisting NHS Sheffield to reduce their out of town placements for mental health services;
- Tackle high Reference Cost areas;
- Continue the work to introduce Service Line Reporting;
- Implement a pilot of the Payment by Results regime for mental health trusts, which is part of the Care Pathways and Packages National Group.

Cost Allocation and Charging Requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Management Costs

The management costs for the 2009/10 financial year are £5,907,672 (5.13% of income). The management costs are in accordance with Department of Health guidelines.

Going Concern

After making enquiries, the Directors have a reasonable expectation that SHCS 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.

Successful Transition to International Financial Reporting Standards

The Trust has successfully introduced the transfer to the International Financial Reporting Standards (IFRS) regime and was commended by its external auditors for having a robust and comprehensive implementation plan.

There are some challenges which will have to be managed to enable the Trust to grow and strengthen its finances and one of these will be a continual need to make cost improvements year on year. This has become even more important and urgent with regards to the general downturn in the economy. This year, the Trust has targeted those service areas which have a higher cost than comparable services in other Trusts and this will be the same for 2010/11, with a further higher efficiency target on Corporate Services.

6. Sustainability and Climate Change

Sustainability reporting

The NHS needs to be well prepared for the future and ensure future health services play a leading part in a sustainable society, despite the challenges of climate change.

The Trust recognises that its activities can have an affect on the environment and consequently the health and wellbeing of the community it serves. The Trust takes actions to improve these where practicable.

Sustainability Strategy

The Trust will identify and take action towards managing the environmental impact of its activities and maintaining sustainable development by meeting the requirements of all relevant legislation and Government targets, complying with the NHS Carbon Reducing Strategy for England 2009 'Saving Carbon, Improving Health', and by adopting and promoting good practice and the integration of environmental, social, political and economic considerations and impacts within its decision making.

Governance

The Trust has a Sustainable Development Policy. Within the policy, the Trust's Chief Executive has overall responsibility for sustainable development and an Executive Director has been delegated to have responsibility for sustainability issues. A Non-Executive Director will be identified as 'Sustainability Champion' to promote good carbon governance as a corporate responsibility of the whole Board. Implementation of the policy will be the responsibility of Directors and Heads of Service with advice and support from Facilities Directorate managers and other support services managers as appropriate. All Trust staff will be expected to co-operate in the implementation of sustainable development objectives, assist in meeting sustainability targets and participate in training initiatives to raise awareness of good practice.

The Trust has signed up to the NHS Good Corporate Citizenship Assessment Model and the Yorkshire & Humber Carbon Reduction Collaborative and will produce a Board approved Sustainable Development and Carbon Management Plan, setting out clear targets for measuring, monitoring and reducing carbon emissions. The Trust's Annual Plan will include a measure of carbon emissions and carbon management will be incorporated within whole-organisation's risk assessments and risk management.

The Trust will play a role within the local community by making longer term investments in carbon reduction and sustainability.

Summary Performance

During 2009/10 the Trust has generated overall reductions and savings in all areas with respect to waste production and its use of finite resources when compared to the 2008/09 period. Despite the harsh winter months of early 2010, it reduced its overall CO_2 production from the use of gas and electricity by 346 tonnes and has seen a 4,175 cubic metre reduction in its water consumption during 2009/10 and also a reduction in waste of 60 tonnes over the same period. All individual areas have generated a financial saving except the use of green heat where costs have increased by 10% despite only a minimal increase in consumption of 0.3%.

This has been achieved by more stringent control of the Trust's energy management technology, more emphasis on recycling, and good housekeeping procedures. Further reductions can be expected in the future by a commitment to 'Spend to Save' schemes, staff awareness training and procurement initiatives. A performance summary is provided in the table below.

Summary Performance

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£k)	Financial data (£k)
		2008/09	2009/10		2008/09	2009/10
Waste minimisation and management	- Absolute values for total amount of waste produced by the Trust - Methods of disposal (optional)	547 Tonnes	487 Tonnes	- Expenditure on waste disposal	81.683	75.4
Finite Resources	- Water - Electricity - Gas - Other energy consumption	43904 cubic metres 2129.5 Tonnes CO_2 2351.2 Tonnes CO_2 31.3 Tonnes CO_2	39729 cubic metres	- Water - Electricity - Gas - Other energy consumption	117.635 448.635 359.748 11.96	108.9 443.4 359.2 313.2

7. Equality and Diversity

7.1 Our Approach to Equality and Diversity

The Trust's identified lead for Equality and Diversity is the Director of Human Resources. However, the Chief Executive and other executives champion equality and inclusion as part of their day to day activities. Operational leadership and performance management sit within the organisation's Service Development Directorate. This directorate leads on ensuring quality and the way we do this is described in the organisation's 'Quality Framework'. Equality and Diversity is one of the key elements of the Quality Framework.

7.2 Publication Duties

In September 2009, the Trust published a Single Equality Scheme. This scheme describes how the organisation is meeting its equality duties and how it plans to continue to do this. The scheme is in place until 2012 but will be reviewed to respond to changes in equality legislation. The scheme has 10 objectives with a comprehensive action plan against each of these. The Single Equality Scheme integrated the organisation's equality schemes for race, gender and disability and incorporated organisational activity and objectives in relation to age, sexual orientation, religion or belief and gender reassignment.

Performance delivery in relation to the actions set out in the scheme is overseen through the Trust's Quality and Risk Governance Group. Progress in delivering the objectives is reported in the annual Equality and Human Rights Report. The Single Equality Scheme and annual reports are published on the Trust's web site.

We publish equality data annually in our Equality and Human Rights Report which uses data that is current on the 31 of March each year. This format has been used since 2007 and each year the organisation develops its reporting so that the data can be used to provide clear information and to plan actions in response. Before the report is published it is considered through the Trust's governance structures which cover quality in services (Quality and Risk Group), and employment (Human Resources and Workforce Group).

The Trust undertakes equality impact assessments on its organisational policies, covering all of the equality strands referred to above including race. The results of these equality impact assessments are published on our web site.

7.3 Workforce and Membership Profile

The Trust is required to collect and publish data relevant to race equality. Currently we also collect and report annually on data relevant to employees' age, disability and gender. In 2010/11 we intend to refresh our employee data to update data in the categories above and to also include data on sexual orientation.

Notes – membership data is collected in detail in order to reflect the increasing diversity of the Sheffield population. In order to show this data in relation to the overall population of Sheffield we have had to group the membership data as follows:

- Other includes Yemini and Vietnamese; African includes Somali.
- Data on age is compared to the population of Sheffield aged 15 and over as of 2001.

7.4 Key Priority Areas

7.41 Our Main Priorities for 2011/12

- To continue to develop our data collection and use this through governance structures to measure and inform improvements in quality relevant to equality, diversity and human rights
- To work creatively and more effectively to involve people who use our services but are seldom heard
- To maintain an intelligent and active approach to any issues arising from equality impact assessments in organisational policy development
- To review and respond in a timely way to proposed changes in legislation relevant to equality

7.42 Performance Against Our Priority Areas 2009/10

Our main priority in 2009 was to develop our Single Equality Scheme. We planned and undertook two benchmarking processes Index and the Disability Standard. Full details of our actions and achievements relevant to equality and human rights can be reviewed in our annual report.

Workforce and Membership Profile

	Staff				
	2007/2008	**2008/2009**	**2009/2010**		
Age					
Under 20	0.10%	0.36%	0.25%		
20 to 29	11.80%	13.49%	12.03%		
30 to 39	22.70%	22.94%	22.82%		
40 to 49	31.50%	31.78%	30.42%		
50 to 54	13.20%	12.77%	13.80%		
55 to 59	10.10%	9.72%	10.32%		
60 to 64	7.50%	6.79%	7.44%		
65 and Over	3.00%	2.14%	2.91%		
				Membership	**Sheffield Population**
Ethnicity				**2009/2010**	**Census**
White British	76.70%	76.44%	75.59%	84.87%	89.19%
White Irish	0.90%	0.91%	0.85%	0.61%	0.65%
Any Other White Background	1.90%	1.95%	1.87%	1.38%	1.39%
White & Black Caribbean	0.60%	0.55%	0.54%	0.37%	0.72%
White & Black African	0.80%	0.84%	0.82%	0.22%	0.14%
White & Asian	0.20%	0.19%	0.19%	0.27%	0.41%
Any Other Mixed Background	0.70%	0.84%	0.76%	0.39%	0.34%
Indian	1.70%	1.72%	1.68%	0.68%	0.59%
Pakistani	0.60%	0.58%	0.79%	1.63%	3.09%
Bangladeshi	0.20%	0.19%	0.16%	0.74%	0.37%
Any Other Asian Background	0.50%	0.55%	0.66%	0.91%	0.51%
Caribbean	1.70%	1.53%	1.58%	1.09%	1.01%
African	3.10%	3.25%	3.64%	2.09%	0.64%
Any Other Black Background	0.70%	0.52%	0.51%	0.51%	0.13%
Chinese	0.30%	0.26%	0.22%	0.25%	0.40%
Any Other Ethnic Group	0.80%	0.78%	0.82%	1.14%	
Not Stated	8.60%	8.87%	9.31%	2.84%	
Gender					
Female	**72.81%**	**72.77%**	**72.68%**	**62.10%**	**51.70%**
Male	**27.19%**	**27.23%**	**27.32%**	**37.90%**	**48.30%**
Recorded Disability					
Yes	**1.85%**	**1.82%**	**2.25%**		
No			**10.07%**		
Not Declared			**0.13%**		
Undefined			**87.56%**		

8. Foundation Trust Membership and the Council of Governors

The Council of Governors

The Trust's Council of Governors comprises 43 members, 32 of whom are elected from the Trust's membership with the rest being appointed from the Trust's partnership organisations. Since the start of the year, there have been five changes to the governors; three appointed, one public and one young service user/carer.

Council of Governors

Elected Public 8 Governors	2 Sheffield North East
	2 Sheffield North West
	2 Sheffield South East
	2 Sheffield South West
Elected Service User/Carer 16 Governors	10 Service Users
	4 Carers
	2 Young Service User/Carers
Elected Staff 8 Governors	1 Nursing
	1 Support Work
	1 Allied Health Professional
	1 Medical and Clinical
	1 Central Support Staff
	1 Psychology
	1 Social Work
	1 Clinical Support Staff
Appointed Governors 11 stakeholder organisations	4 Voluntary, Community and Faith Sector
	1 NHS Sheffield (Commissioners)
	1 Sheffield Hallam University
	1 University of Sheffield
	3 Local Councillors
	1 Staff Side (unions)

Governors play a vital role in the Trust's governance arrangements. They primarily carry out their role through the meetings of the Council of Governors, of which there were five in 2009/10.

All meetings of the Council of Governors are open to members of the public, except in instances where the Council, for reasons of confidentiality or other proper grounds, resolves to exclude members of the public from any part of or the whole of a Council meeting.

Whilst responsibility for oversight of the Trust's management and performance rests with the Trust's Board of Directors, the Council of Governors has specific decision making powers conferred upon it by the Trust's Constitution. These include:

- The power to appoint and remove the Trust Chair and other Non-Executive Directors
- The power to appoint, from amongst the Non-Executive Directors, the Vice Chair of the Trust
- The power to set remuneration and other terms and conditions of service of the Trust Chair and other Non-Executive Directors
- The power to appoint and remove the Trust's external auditors
- The power to approve the appointment of the Trust's Chief Executive.

By vesting of these levers of power in the Council of Governors, the Trust's Constitution provides important checks and balances between the power and influence of the Board of Directors and that of the Governors, who are the representatives of the Trust's members.

The Council of Governors also plays other important roles in the governance of the Trust by:

- Assisting the Board of Directors in setting the strategic direction of the Trust
- Monitoring the activities of the Trust with a view to ensuring that they are being carried out in a manner that is consistent with the Trust's Constitution and its terms of authorisation
- Receiving the Trust's Annual Report and Accounts and the auditor's report on the Annual Accounts
- Representing the perspectives of the membership constituencies and partner organisations from which the members of the Council are drawn
- Providing feed back to members
- Developing the Trust's membership strategy.

In doing all these, the Council of Governors ensures that the Board of Directors is held to account by the Trust's key stakeholders for the performance of the Board's duty of directing and controlling the affairs of the Trust and ensuring the delivery its objectives.

In 2009/10, the Council of Governors successfully appointed three new non-executive directors, set their remuneration levels and appointed the Trust's auditors. The recruitment and selection of the three non-executive directors was carried out by the Council of Governors' Nominations and Remunerations Committee. The Committee retained the services of the Appointments Commission for this purpose.

The relationship between the Board of Directors and Council of Governors is an important one and this continued to develop throughout 2009/10. Governors are invited to attend the Trust's Open Board meetings so that they can understand the role of the Non-Executive Directors, develop their relationship with Executive Directors and learn more about the business of the Trust.

There were also two development sessions between the Board of Directors and Council of Governors to discuss and develop the Trust's annual objectives. The Board was able to give an indication of the Trust's priorities for the year ahead and sought the input of Governors in developing these. Governors then presented initial ideas to the Trust's members in October and asked for their views, which were then fed back to the Board of Directors.

The Trust also keeps members informed about its plans through the quarterly newsletter '*Involve'*. Making sure that the whole of the membership knows about the Trust's priorities is of great importance to both the Board of Directors and Council of Governors. This was demonstrated when the Trust refreshed its vision and sought the views of members through the newsletter and website. The Council of Governors was also asked for its input and Staff Governors played a role in seeking the views of the staff members.

Governors carry out their duties in a number of ways, not just by attending the Council meetings. They also sit on over 28 groups in the Trust, including the Trust's four key operational management groups, namely: Quality and Risk Group, HR and Workforce Group, Policy and Information Group and the Service and Business Development Group.

Through this wide variety of groups, Governors make sure that their views and those of their constituents are heard.

Governors also have the responsibility for developing the Trust's membership strategy and monitoring communication between the Board of Directors and the Trust's management, Governors and members. They do this through the Membership and Communication Group. In 2009/10, this group (on which both Governors and members sit) revised the membership strategy, gave direction to the Trust on the Annual Members' Meeting and developed an action plan for membership engagement.

The development of the Council of Governors continued throughout the year. Sessions were provided to keep Governors updated on the activities of each of the Trust's directorates, as well as other development sessions on Improving Access to Psychological Therapies (IAPT), the Care Quality Commission and support to attend regional governor events to develop their networks with governors in other Foundation Trusts.

As part of the commitment of both, the Board of Directors and the Council of Governors, to ensuring that the Council continues to develop, a comprehensive review of the Council was undertaken in 2009/10. This review highlighted areas in the relationship between Governors and the Board of Directors which needed strengthening, in order to enable the two bodies to agree the way forward for meaningful mutual engagement in 2010/11. The findings of this review were taken to the Board of Directors for its consideration before being referred to the Council of Governors for further deliberation and final agreement.

The Register of Interests for the Council of Governors is available from the Foundation Trust Company Secretary who can be contacted on (0114) 271 6310 or by emailing foundation.trust@shsc.nhs.uk

Below is a complete list of all the Governors (as at the 31 March 2010), their tenure of office and Council meeting attendance record for 2009/10.

Five Council meetings were held between 1 April 2009 and 31 March 2010. It should be noted that Governors whose term began partway through the year were not able to attend all five meetings.

Name	Governor Category	Term Began	Term Expires	Number of meetings attended
Carol Field	Public South East	01.04.2008	30.06.2011	3
Dorothy Cook	Public South East	01.04.2008	30.06.2010	5
Dr. Jim Monach	Public South West	01.04.2008	30.06.2011	2
Julian Oakley	Public South West	01.04.2009	30.06.2010	5
Ruth Mitchell	Public North East	01.04.2008	30.06.2011	3
Michael Whittington	Public North East	01.10.2009	30.06.2010	1
Paul Harvey	Public North West	01.04.2008	30.06.2011	0
Susan Wood	Public North West	01.04.2008	30.06.2010	2
Alan Dallman	Service User	01.04.2008	30.06.2010	2
Bill Andrews	Service User	01.04.2008	30.06.2011	1
Brendan Stone	Service User	01.04.2008	30.06.2011	1
David Shine	Service User	01.04.2009	30.06.2010	3
John Kay	Service User	01.04.2009	30.06.2010	5
Marie Harris	Service User	01.04.2008	30.06.2011	2
Myra Wilson	Service User	01.04.2008	30.06.2011	5
Nev Wheeler, OBE	Service User	01.04.2008	30.06.2010	5
Peter Frith	Service User	01.04.2008	30.06.2010	5
Stephanie de-la-Haye	Service User	01.04.2008	30.06.2011	1
Naomi Cooper	Young Service User & Carer	01.06.2009	30.06.2011	0
Nicholaus Hall	Young Service User & Carer	01.04.2008	30.06.2011	0
Elizabeth Draper	Carer	01.04.2008	30.06.2011	5
Lewis Atkinson	Carer	01.04.2008	30.06.2011	2
Linda Tonner	Carer	01.04.2008	30.06.2010	4
Lyn Mansfield	Carer	01.04.2008	30.06.2010	5
Dr. Alick Bush	Staff – Psychology	01.04.2008	30.06.2011	2
Elliott Hall	Staff – Central Support Staff	01.04.2008	30.06.2011	4
Gill Hancock	Staff – Support Work	01.08.2009	30.06.2011	0
Greg Harrison	Staff – Clinical Support Staff	01.04.2008	30.06.2011	3
Julia Walsh	Staff – Social Work	01.04.2008	30.06.2011	3
Julie Forrest	Staff – Nursing	01.04.2008	30.06.2011	4
Julie Leeson	Staff – Allied Health Professionals	01.04.2008	30.06.2011	4
Dr Rudwan Abdul-Al	Staff – Medical & Clinical	01.09.2009	30.06.2011	2
Councillor Mary Lea	Sheffield City Council	01.07.2008	30.06.2011	3
Councillor Pat White	Sheffield City Council	13.08.2009	30.06.2011	2
Councillor Penny Baker	Sheffield City Council	20.05.2009	30.06.2011	3
Helen Best	Sheffield Hallam University	01.04.2008	30.06.2011	3
Prof. Matthew Flinders	University of Sheffield	01.08.2008	30.06.2011	4
Sheila Paul	NHS Sheffield	12.09.2008	30.06.2011	2
Sue Highton	Staff Side	01.04.2008	30.06.2011	2
Ashton Wynter	VCFS (SACMHA)	01.04.2008	30.06.2011	1
Rosalind Eve	VCFS (Age Concern)	01.09.2009	30.06.2011	1
Tariq Kataria	VCFS (PMC)	01.09.2009	30.06.2011	1

The record of attendance of Non-Executive Directors at meetings of the Council of Governors is shown below:

Non Executive Director Attendance

Martin Rosling	17.11.2009
Mervyn Thomas	17.11.2009
Mick Rooney	17.11.2009
Susan Rogers	17.11.2009
Tony Clayton	17.11.2009

The Nominations and Remuneration Committee of the Council of Governors

Whilst the appointment of the Trust's Chair and Non-Executive Directors is the responsibility of the Council of Governors, the process of selecting suitable candidates to be recommended for these appointments is delegated to a committee of the Council of Governors known as the Nominations and Remuneration Committee. The Committee also has the responsibility for evaluating the performance of the Trust Chair and the Non-Executive Directors.

The Trust Chair (Professor Alan Walker) presides over the meetings of the Committee, except in those instances where there would be a conflict of interest, in which case, the Reserve Chair (Linda Tonner) presides.

The Committee embarked on the process of recruiting the Trust Chair who will (subject to appointment by the Council of Governors) take office in July 2010. The Committee retained the services of Odgers Berndtson, an external professional firm.

Between 1 April 2009 and 31 March 2010 the Committee held a total number of five (5) formal meetings and the attendance of Committee members at those meetings is shown in the table below:

Name	Position	Number of meetings attended
Alan Walker*	Chair	2/2
Linda Tonner	Reserve Chair and Committee Member	4/5
Jim Monach	Committee Member	4/5
Julie Forest	Committee Member	4/5
Lyn Mansfield	Committee Member	5/5
Matthew Flinders	Committee Member	3/5
Brendan Stone**	Committee Member	0/2
John Kay***	Committee Member	1/1

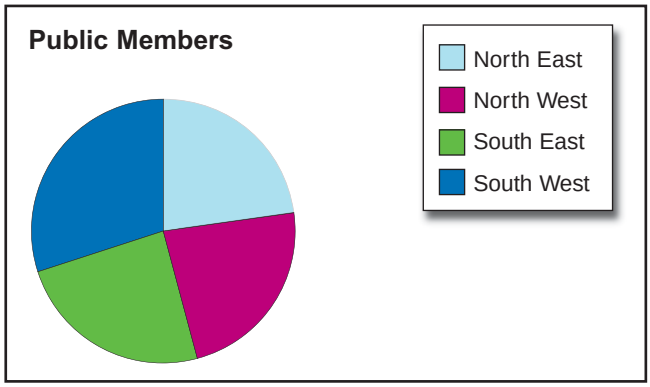
* The Chair could not have attended any meetings of the Committee (other than those which he is shown to have attended) without there being a conflict of interest as the meetings which he did not attend related to the recruitment of the Trust Chair. The table, therefore, shows the total number of meetings which he actually attended out of the total number of meetings which he possibly could have attended.

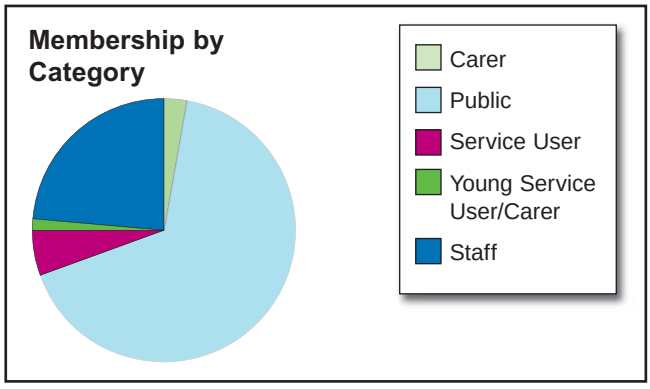
** This Committee member resigned from their membership of the Committee during the course of the period covered by this report. The table, therefore, shows the total number of meetings which the Committee member actually attended out of the total number of meetings which they possibly could have attended.

*** This Committee member joined the Committee towards the end of the period covered by this report. The table, therefore, shows the total number of meetings which the Committee member actually attended out of the total number of meetings which they possibly could have attended.

The Membership

2009/10 has been a successful year for membership recruitment with over 1,200 new members joining the Trust. This has been achieved through the commitment of staff and Governors to a wide range of events including targeted membership events as well as community events which have taken place across Sheffield. The charts below show how the membership is comprised and its ethnicity profile.





	Membership as at 31.3.10	Membership as at 31.3.09	Sheffield Demographic
White	84.88%	88.76%	88%
Mixed	3.22%	3.01%	2%
Asian or Asian British	4.49%	4.01%	6%
Black or Black British	3.69%	3.47%	3%
Other	0.83%	0.66%	1%

	Public	Service User	Carer	Young Service User/Carer
1 April 2009	85.04%	8.40%	5.07%	1.48%
31 March 2010	85.62%	8.49%	4.88%	0.10%

There has been almost a 4% shift from white to other ethnic groups in the membership with a greater percentage of membership from mixed, Asian and other backgrounds. There still remains an under representation from the black or black British ethnic groups, although there has been a slight increase over the year.

In terms of constituency representation, there have been only minor shifts in each grouping. Because a large number of membership events held in 2009/10 were public ones, there has been a slightly greater increase in the number of public members in comparison to service user and carer ones. Also, because of the age parameters in the young service user/carer class, a significant percentage of this class have moved into either the service user or carer classes.

The year began with an excellently attended event on dementia, hosted by one of our Governors, Dr Paul Harvey and the Trust's Clinical Director of Dementia, Dr Peter Bowie. This was followed by another successful event on medicines hosted by the Trust's Chief Pharmacist, Peter Pratt.

Governors were also involved in the national anti-stigma campaign "Time to Change", participating in a city centre event in July co-hosted by Sheffield MIND, the Trust, Sheffield City Council and NHS Sheffield. This event raised awareness of mental health as well as helping to recruit a number of new members to the Trust. October is an important date in the Trust's calendar as it hosts World Mental Health Week. The Trust and Governors attended a number of events during this week to promote mental health and talk to people about their views on mental health issues.

Also, making sure that the Trust communicates with all its members and potential members, including black and ethnic minority groups and young people has been a key priority. As such, membership and community events have been targeted to try to make sure that the Trust and its Governors reach far and wide into the community. These events include:

- Black and Minority Ethnic (BME) network
- BME Information Event
- Carers' event
- Stradbroke Community Centre Event
- Art in the Winter Garden
- Time to Change Event
- World Mental Health Day
- Ecclesfield Gala
- Sheffield Fayre, Norfolk Park
- Careers Fayres for young people
- Student Nurse Careers Event
- Hillsborough Play Day
- Women's Health Event, Pakistan Muslim Centre
- Men's Health Event, Pakistan Muslin Centre
- Irish Festival
- Crystal Peaks Event
- University of Sheffield Refreshers' Fayre
- Dementia Event for Members
- Medicines Event for Members
- Annual Members' Meeting
- Member and Governor Event

It is very important to the Trust that it is able to communicate with its members and the Trust takes this responsibility seriously. The primary focus of communication is through *Involve*, our membership magazine. Both Governors and members sit on the magazine's editorial group to make sure that it keeps its focus on issues that are important to members. The Trust is really proud of the positive feedback, with members saying how they have enjoyed reading the magazine and how interesting they find it.

The Trust has developed its website to make sure that members can easily communicate with both the Trust's leadership and its Governors if they want to, and the ways in which members can communicate with Governors is stressed on all new membership letters, and again, through *Involve*.

If you want to contact your Governor, you can telephone (0114) 271 8825, or write to

The Council of Governors
FREEPOST
SHSC NHS FOUNDATION TRUST

Alternatively, you can email
foundation.trust@shsc.nhs.uk

9. Meet the Board

Powers of the Board of Directors

The Board of Directors is the body upon which the Trust's Constitution confers the responsibility for exercising the powers of the Trust. These powers are set out in the National Health Service Act 2006 and are subject to the restrictions set out in the Trust's terms of authorisation. The Board may delegate the exercise of any of the powers conferred upon it to any Committee of Directors or to an Executive Director. The Standing Orders of the Board of Directors provide for the manner in which the Board may arrange the delegation of its powers. The 'Scheme of Reservation and Delegation of Powers' (which forms part of the Board of Directors' Standing Orders), sets out in detail those powers which the Board has reserved to itself and those it has delegated and to whom.

The Role of the Board

The Board sets the strategic aims and objectives of the Trust. It provides oversight to the Trust's executive management team by monitoring the Trust's performance against its set objectives, ensuring that corrective action is taken, where necessary.

Composition of the Board

The Board comprises six Non-Executive Directors (including the Trust Chair) and five Executive Directors (including the Chief Executive). During the period covered by this report, the Board met every month (except August) in private and had six additional meetings which were open to members of the public. The Board's confidential and commercially sensitive matters were discussed during its private sessions and the rest of its business which was not confidential or commercially sensitive in nature was discussed in the sessions of its meetings which were open to members of the public.

All Board members use their expertise, experience and interest to contribute to the work of the Board in carrying out its role of setting the strategic direction of the Trust and monitoring its management and performance. A full list of all the directors who have served on the Board during the period of this report (including details of their qualifications and experience) is set out in a further part of this section of the report.

The Board Chair

Professor Alan Walker is the Trust Chair and Councillor Mick Rooney is the Vice Chair. The Trust Chair presides over the meetings of the Board of Directors and the Council of Governors. The Chair is responsible for: providing leadership to the Board of Directors and the Council of Governors; ensuring that the Board of Directors and the Council of Governors work effectively together; enabling all Board members to make a full contribution to the Board's affairs and that the Board acts as an effective team; leading the Non-Executive Directors through the Board of Directors' Remuneration and Nominations Committee in the appointment and in setting the remuneration of the Chief Executive (and with the Chief Executive) other Executive Directors.

The evaluation of the performance of the Chair and all other non-Executive Directors is the responsibility of the Council of Governors' Nominations and Remunerations Committee.

Balance and completeness of the Board

A review of the Board of Directors' balance, completeness and appropriateness was undertaken as part of the application for Foundation Trust status. Since then, some changes to the portfolios of Executive Directors have been made, and three new Non-Executive Directors were appointed in September 2009 to replace those whose terms of office expired either immediately prior to the end of the financial year 2008/09 or in the course of the financial year 2009/10. The newly appointed non-Executive Directors bring with them high level skills and experience from both the private and public sectors. The Board is thus satisfied that the composition of its membership is balanced, complete and appropriate.

Associate Directors

There are also two Associate Directors in place to support the effective functioning of the Board. This ensures strong progress on key agenda items relating to:

- the Trust's strategic positioning
- managing external relationships and interfaces
- workforce development
- progressing the Trust's broader social responsibility agendas and commitments
- ongoing development of organisational wide skills
- the Trust's capabilities and capacity to continue to perform strongly and reap the benefits of its Foundation Trust status

The Management Team

The Board of Directors delegates the day-to-day

management of the operational activities of the Trust to the Executive Directors Group (EDG). The EDG comprises the Executive Directors and the Associate Directors. The EDG meets on a weekly basis to ensure that its delegated duties are appropriately discharged.

Attendance at Board meetings

Attendance at the Board of Directors' meetings in the period commencing 1 April 2009 and ending on 31 March 2010 is presented in the table below:

Name	Position	Number of meetings attended
Professor Alan Walker	Chair	16/16
Kevan Taylor	Chief Executive	15/16
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	16/16
Clive Clarke	Executive Director of Operations	15/16
Karen Tomlinson	Executive Director of Service Development and Chief Nurse	12/16
Dr. Tim Kendall	Medical Director	11/16
Martin Rosling	Non-Executive Director and Senior Independent Director	13/16
Councillor Mick Rooney	Non-Executive Director and Vice Chair	14/16
Anthony Clayton*	Non-Executive Director	10/10
Mervyn Thomas*	Non-Executive Director	10/10
Susan Rogers*	Non-Executive Director	9/10
Elizabeth Jones**	Non-Executive Director	4/6
Angela Barney**	Non-Executive Director	3/5

Note: *The terms of office of these directors commenced during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

** The terms of office of these directors expired during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

Remuneration and Nominations Committee

The Remuneration and Nominations Committee of the Board of Directors comprises the Non-Executive Directors. The Committee is chaired by Professor Alan Walker, the Trust Chair.

The Committee has the authority to determine the remuneration and terms and conditions of service of the Chief Executive, Executive and Associate Directors in order to ensure that they are properly rewarded having proper regard to the Trust's circumstances.

The Committee has only met once during the financial year commencing 1 April 2009 and the details of members' attendance are as follows:

Name	Position	Meetings Attended
Professor Alan Walker	Chair	1/1
Martin Rosling	Non-Executive Director	1/1
Councillor Mick Rooney	Non-Executive Director	1/1
Angela Barney**	Non-Executive Director	1/1
Elizabeth Jones**	Non-Executive Director	0/1
Mervyn Thomas*	Non-Executive Directors	0/0
Susan Rogers*	Non-Executive Director	0/0
Anthony Clayton*	Non-Executive Director	0/0

*The terms of office of these directors commenced during the course of the period covered by this report. During that period, the Committee did not hold any meetings which any of them could possibly have attended.

** The terms of these directors expired during the course of the period covered by this report.

Kevan Taylor, the Trust's Chief Executive, attends the Committee's meetings (including those shown in the table above) in an advisory capacity. The Director of Human Resources and the Company Secretary also attend these meetings to provide advice and support to the Committee members.

Further details relating to remuneration of the Board of Directors is provided within the remuneration report on pages 70 and 71.

The Audit and Assurance Committee

The Audit and Assurance Committee provides independent and objective oversight of the effectiveness of the governance, risk management and internal control systems of the Trust. Revised terms of reference of the Committee were approved by the Board during the period to which this report relates.

The Committee membership comprises all the Non-Executive Directors of the Board (excluding the Trust Chair). The meetings of the Committee are chaired by one of the Non-Executive Directors drawn from its membership. The current Chair of the Committee is Mr. Martin Rosling.

The Committee has met on eight occasions in the financial year commencing 1 April 2009 and details of members' attendance are as follows:

Name	Position	Meetings Attended
Martin Rosling	Non-Executive Director (and Chair of the Committee)	8/8
Councillor Mick Rooney	Non-Executive Director	5/8
Anthony Clayton*	Non-Executive Director	5/5
Susan Rogers*	Non-Executive Director	4/5
Mervyn Thomas*	Non-Executive Director	5/5
Angela Barney**	Non-Executive Director	2/3
Elizabeth Jones**	Non-Executive Director	3/3

Note:

*The terms of office of these directors commenced during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

** The terms of office of these directors expired during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

Also in attendance at the Committee's meetings are the Executive Director of Finance, Executive Director Service Development and Chief Nurse, the Foundation Trust Company Secretary, representatives from internal and external audit and the Trust's Local Counter Fraud Specialist.

Following a tender and interview process, a Committee of the Council of Governors (assisted by members of the Audit & Assurance Committee), recommended the appointment of the Audit Commission as the external auditors for the Trust for a four year period commencing from 2010/11(with an option to extend the term of appointment for a further year subject to satisfactory service and performance). This recommendation will be put to the full Council of Governors at its 15 April 2010 meeting for ratification of the appointment decision.

Finance and Investment Committee

The Finance and Investment Committee of the Board maintains oversight of the Trust's financial processes and quarterly submissions on the Trust's financial performance to Monitor (the independent regulator for NHS Foundation Trusts). The Committee ensures that the Trust's finances are managed within the allocated resources in order to deliver an effective and efficient service.

The Committee membership comprises both Non-Executive and Executive Directors. Also in attendance at the meeting are the Deputy Director of Finance and the Foundation Trust Company Secretary. The current Chair of the Committee is Mr. Anthony Clayton.

The Board of Directors

The Committee members' attendance at its meetings for the financial year commencing 1 April 2009 is as follows:

Name	Position	Meetings Attended
Anthony Clayton*	Non-Executive Director and Committee Chair	5/6
Clive Clarke	Executive Director	9/10
Karen Tomlinson	Executive Director	6/10
Mick Rodgers	Executive Director	9/10
Susan Rogers*	Non-Executive Directors	4/5
Mervyn Thomas*	Non-Executive Director	5/6
Martin Rosling	Non-Executive Director	9/10
Elizabeth Jones**	Non-Executive Director	2/4
Angela Barney**	Non-Executive Director	2/3

Note: *The terms of office of these directors commenced during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

** The terms of office of these directors expired during the course of the period covered by this report. The table therefore shows the total number of meetings which these directors actually attended out of the total number which they possibly could have attended.

EXECUTIVE AND NON-EXECUTIVE DIRECTORS' BIOGRAPHIES

Professor Alan Walker

Chair

Appointed as the initial Foundation Trust Chair from 01.07.2008 to 30.06.2009. The appointment was renewed for another year from 01.07.2009 to 30.06.2010.

(*Following a recruitment and selection process carried out by the Council of Governors' Nominations and Remuneration Committee, the appointment of the Trust Chair is expected to be made by the Council of Governors on 27 May 2010*)

Experience

- Professor of Social Policy and Social Gerontology
- Vice President, Age Concern Sheffield
- Patron Abbeyfield Society, National Pensioners' Convention and Greater London Forum for Older People
- Chair of European Foundation on Social Quality
- Former Head of Department of Sociological Studies and Director of Social Sciences Research, University of Sheffield, and Chair of Sheffield Health and Social Care Research Consortium

Qualifications

- BA (Hons), D.Litt, Hon D. Soc Sci, AcSS, FRSA

Declarations of interest:

- Professor of Social Policy - University of Sheffield.
- Vice President - Age Concern Sheffield.
- Patron - Abbeyfield Society (provider of Sheffield Housing to older people).
- Member of the Governing Board of the NIHR School for Social Care Research.

Kevan Taylor

Chief Executive

Appointed as the initial Chief Executive of the Foundation Trust from 01.07.2008

Experience

- Executive Director, Planning and Performance Management, Sheffield Care Trust
- Head of Commissioning / Director of Commissioning, Sheffield Health Authority
- Former Chairman of a School Governing Body
- Football Association Club Welfare Officer, Junior Football

Qualifications

- NHS Chief Executive Development Programme 2002
- BA - dual honours in Sociology and Social Administration

Declarations of Interest:

- Wife is a Trust employee.

Mick Rodgers

Executive Director of Finance and Deputy Chief Executive

Appointed as an initial Executive Director of the Foundation Trust from 01.07.2008

Experience

- Deputy Chief Executive, Sheffield Care Trust since 2001
- 21 years as Director of Finance
- 40 years in NHS Finance and General Management
- Advisor to the Board of Age Concern (Sheffield)

Qualifications

- Member of Chartered Institute of Public Finance and Accounting (CPFA)
- Member of Association of Accounting Technicians (MAAT)
- Member of the Institute of Health Service Managers (MIHSM)

Declarations of interest:

- Member of the Institute for Health Management.
- "Critical Friend" in respect of governance issues, Age Concern Sheffield.
- Member and Trustee of Dronfield RUFC (Ended February 2010).

Clive Clarke

Executive Director of Operations and Social Care

Appointed as an initial Executive Director of the Foundation Trust from 01.07.2008

Experience

- Director Adult Mental Health Services
- Head of Social Services Mental Health
- 26 years experience in health and social care provision
- Advisor to the Board of Sheffield African Caribbean Mental Health Association

Qualifications

- Kings Fund Top Managers Leadership Programme 2001
- Diploma in Social Work (CQSW)

Declarations of Interest:

- None.

Karen Tomlinson

Executive Director Service Development and Chief Nurse

Appointed as an initial Executive Director of the Foundation Trust from 01.07.2008

Experience

- Head of Strategy and Policy, South Yorkshire Strategic Health Authority
- Director of Strategic Development and Planning, Rotherham Hospitals NHS Foundation Trust
- Assistant Programme Director NHS Live, Department of Health
- Director of South Yorkshire Strategy, South Yorkshire Strategic Health Authority
- Deputy Chief Executive, Sheffield South West Primary Care Trust
- Non-Executive Director, Riverside Housing Association, Midlands (Current part-time role)

Qualifications

- MSc Healthcare Policy and Organisation
- Certificate in Health Service Management
- Kings Fund Leadership Programme
- State Registered Nurse

Declarations of Interest:

- Non Executive Director for Riverside Housing Association, Midlands branch.

Tim Kendall

Executive Director – Medical

Appointed as an initial Executive Director of the Foundation Trust from 01.07.2008

Experience

- Director of the National Collaborating Centre for Mental Health
- Chair of the first National Institute for Clinical Excellence (NICE) Guideline ever produced - Schizophrenia in Primary and Secondary Care (NICE Clinical Guideline Number 1)
- Lead Director for NICE Guidelines on self-harm, Obsessive Compulsive Disorder in adults and children, adult depression, childhood depression, dementia, Attention Deficit Hyperactivity Disorder in children and adults and borderline personality disorder
- Current Chair of the Expert Group developing national quality standards for dementia

Qualifications

- MB ChB, B Med Sci, FRC Psych.
- Recipient of the 'Lancet Paper of the Year Award', 2004

Declarations of Interest:

- Director, National Collaborating Centre for Mental Health (NCCMH), Royal College of Psychiatrists.
- Receives about £1.44 million per year at the NCCMH to undertake guideline development for NICE.
- Member, NICE Topic Selection Consideration Panel for Mental Health (Chair Louis Appleby).
- Member, English Policy Committee, Royal College of Psychiatrists.
- Member, Central Coordinating Policy Committee.
- Member, Council, Royal College of Psychiatrists.
- Chair, National Quality Standards for Dementia Expert Group.
- Member, National Quality Standards Programme Board.
- Member/leader, NICE International/NCCMH collaboration to develop 'NICE guideline' on Caesarean Section on Maternal Request with Turkish Ministry of Health for the Turkish Health System (Circa £65,000).
- Member/leader, NICE International/NCCMH Collaboration with the Georgian Ministry of Health.
- Academic Lead, Systematic Review of mental health effects of abortion for Academy of Royal College and Department of Health (C£75K).
- Wife is a Clinical Director for Rehabilitation and Recovery Directorate.
- Daughter employed by the Trust as a Drug Support Worker.

Councillor Mick Rooney

Non-Executive Director, Vice-Chair

Appointed as an initial Non-Executive Director of the Foundation Trust from 01.07.2008 to 02.07.2011

Experience

- Sheffield City Councillor (1996 to date)
- Cabinet Member for Adult Services, Health and Social Cohesion
- Member of Mental Health Partnership Board
- Member of Sheffield First for Health & Wellbeing Board
- Member of Sheffield First Agreement Board
- Chair of Learning Disabilities Partnership Board
- Chair of Sheffield Labour Group

Declarations of Interest:

- Sheffield City Council Councillor, Labour.
- Chair of the Sheffield City Council Health Scrutiny Committee.
- Member of Darnall Area Panel.

Martin Rosling

Non-Executive Director, Senior Independent Director

Appointed as an initial Non-Executive Director of the Foundation Trust from 01.07.2008 to 31.10.2010

Experience

- Established own accountancy practice
- Range of senior financial roles across public and commercial sector
- Finance Director - Turning Point (1998-2004)
- Assistant Director - London Voluntary Services Council
- Financial Secretary to the Government of St Helena

Qualifications

- Member of Chartered Institute of Public Finance and Accounting (CIPFA)

Declarations of Interest:

- Own franchise accountancy practice with AIMS Accounting for Business.
- Appointed by a new client of his, VIEMASTER Ltd, who imports ultra violet sterilising machines for sale to the health services in and around Sheffield.
- Receives a pension from Turning Point, which now works in partnership with the Trust.

Susan Rogers, MBE

Non-Executive Director

Appointed from 01.09.09 to 31.08.2012

Experience

- Teacher since 1967
- 1985 to 2009: Elected representative on the National Executive Committee of the National Association of Schoolmasters Union of Women Teachers (NASUWT), the largest teachers' trade union in the UK
- 1991-1992: President of the NASUWT
- 2002-2009: Honorary National Treasurer of the NASUWT
- 2002-2009: Member of the TUC General Council and member of the TUC's Women's Committee, TUC's Race Relations Committee and TUC's Iraq Solidarity Committee
- 2006-2009: Chair of the Assessment and Qualifications Alliance (AQA), the largest Unitary Awarding Body in England, Wales and Northern Ireland
- Has served on Employment Tribunals as a lay member since 2002

Qualifications:

- BA (Hons) History
- Recently honoured with an MBE for her extensive contribution to the trade union movement.

Declarations of Interest:

- Past President 1991-92 and National Honorary Treasurer of NASUWT (Teacher's Union) 2002-2009.
- Member TUC General Council 2002-2009.
- MBE.

Anthony Clayton

Non-Executive Director

Appointed from 01.09.09 to 31.08.2012

Experience

- Worked for Siemens, General Electric and Philips Medical Systems in PFI and Managed Equipment Services
- 35 years experience in healthcare markets including blood group serology /virology/microbiology/computed tomography and magnetic resonance imaging
- International Marketing Director and Sales Management
- Global Sales and Marketing Manager – Semiconductor Industry
- General Business Manager Scandinavia – General Electric Medical Systems Imaging Systems
- Radiographer

Qualifications

- MBA
- MSc in Marketing Practice
- DMS Postgraduate Diploma in Management Studies
- DCR Diploma to the College of Radiographers

Declarations of Interest:

- Sales Director, Advantage Healthcare (Full time position but flexible for his Non-Executive Directorship role with the Trust).

Mervyn Thomas

Non-Executive Director

Appointed from 01.09.09 to 31.08.2012

Experience

- Management Consultant, whose last role involved consultancy work with Newport City Council and the position of Director of Social Services
- Dairy farm owner (1975-1984)
- Has held various senior management roles for both Coventry and Doncaster Metropolitan Borough Councils (MBC) including Executive Director of Doncaster MBC (1999-2005) and Operational Service Manager of Coventry MBC (1990-1993)
- Currently a Non-Executive Director for South Yorkshire Probation Service, a post he has held since 2007
- Previously a Non-Executive Board Member of Newport Local Health Board (2007-2009) and the former Sheffield South West PCT (2005-2006).

Qualifications

- BA (Hons) Politics
- MA Social Policy
- CQSW (Certificate in the Qualification of Social Work)
- Fellow of the Royal Society of the Arts (FRSA)

Declarations of Interest:

- Non Executive Director – South Yorkshire Probation Service.
- Director – Mervyn Thomas Associates Ltd.
- Wife, Victoria Ferres, is a Non-Executive Director of Sheffield Teaching Hospital NHS Foundation Trust.

Former Directors:

Angela Barney

Appointed as an initial Non-Executive Director of the Foundation Trust from 01.07.08 to 30.06.09

Experience

- Chief Officer of Unstone Grange Trust
- Chair Derbyshire Learning & Development Consortium
- Board Member of North Derbyshire Voluntary Action
- Grants Advisor Derbyshire Community Foundation
- Ex School Governor
- Former Counsellor, Advice and Publicity & information Worker
- Over 25 years experience in statutory and voluntary sectors

Qualifications

- LLB
- MA in Social-Legal Studies
- Postgraduate Certificate of Education
- Various in Counselling, Advice Work, Group Facilitation, Social Enterprise, Voluntary Sector Management, Mentoring

Declaration of Interests

- Chief Officer – Unstone Grange Trust.
- Grants Advisor with Derbyshire Community Foundation Northern Grants Panel.
- Board Member of North Derbyshire Voluntary Action.
- Chair of Derbyshire Learning and Development Consortium.

Elizabeth Jones

Appointed as an initial Non-Executive Director of the Foundation Trust from 01.07.08 to 30.08.09

Experience

- Former Managing Partner, Howells Solicitors
- Chair of Sheffield Hospitals Charitable Trust
- Managing Director, Pensions for Family Lawyers Ltd
- Monitor of Trainee Solicitors for the Solicitors Regulation Authority

Qualifications

- Solicitor of the Supreme Court
- BA Hons in English and American Literature

Declaration of Interests

- Managing Director of Pensions for Family Lawyers Ltd.
- Monitor of Trainee Solicitors for The Law Society.
- Chair of the Sheffield Hospitals Charitable Trust.
- Member of the Sheffield Civic Trust.

10. Remuneration Report

Executive Directors' Remuneration

There is a Remuneration and Nominations Committee of the Board of Directors comprising all Non-Executive Directors (including the Chair of the Board). When it is appropriate, the Chief Executive attends the Committee's meetings in an advisory capacity.

The Committee meets at least once a year to decide on the appropriate remuneration and terms and conditions of service of the Executive Directors. The terms and conditions of service of the Executive Directors, which are determined by the Committee, include all aspects of remuneration, provisions for other benefits including pensions, cars, and arrangements for termination of employment or other contractual terms.

The Committee is also responsible for monitoring and evaluating the performance of the Chief Executive, based on an annual review provided by the Trust Chair and of all the other Executive Directors based on an annual report provided by the Chief Executive.

The Executive Directors are on permanent contracts and six months' notice is required by either party to terminate the contract. The only contractual liability on the Trust's termination of an Executive's contract, prior to age 65, is six months' notice. Any other liability, such as unfair dismissal compensation, would depend on the circumstances of the case.

See table below for details of Executive Directors' contracts.

Executive Director	Date of Contract	Unexpired Term (years)
Kevan Taylor	February 2003	16
Mick Rodgers	April 2003	6
Clive Clarke	April 2003	19
Karen Tomlinson	April 2007	13
Dr Tim Kendall	April 2003	13

The Chief Executive undertakes annual appraisals, including 360 degree feedback, with all Executive Directors, and progress on objectives is assessed at monthly one to one meetings with each Executive Director. The Chief Executive reports the outcomes of these appraisals to the Board's Remuneration and Nominations Committee. The Chief Executive's own performance is monitored by the Chair at regular one to one meetings, and he is subject to annual appraisal by the Chair, who in turn reports the outcome of his appraisal to the Board's Remuneration and Nominations Committee.

This Board reviews the remuneration of Executive Directors annually, taking account of information on remuneration rates for comparable jobs in the National Health Service. During the year, the Committee undertook a review of Executive Directors' remuneration and agreed to a 2.4 per cent pay increase to be applied from 1 April 2009. This is the same percentage applied to other staff in the Trust.

The Executive Directors' remuneration levels are based on a percentage of the Chief Executive's remuneration. Performance related pay is not applied under current arrangements.

Non-Executive Directors' Remuneration

There is also a Nominations and Remuneration Committee of the Council of Governors whose responsibility, among others, is to make recommendations to the Council of Governors on the remuneration, allowances and other terms and conditions of office of the Chair and all other Non-Executive Directors. It is for the Council of Governors, in general meeting, to determine the remuneration, allowances and other terms and conditions of office of the Chair and the Non-Executive Directors.

The Council of Governors' Nominations and Remuneration Committee has embarked upon a Trust Chair recruitment exercise with a view to ensuring that the successful candidate takes office in July 2010. The Committee retained an external professional adviser to carry out a market-test of remuneration level of the Trust Chair to be recruited, following which the remuneration was, by a resolution of the Council of Governors, set at £40,000 per annum. This level of remuneration will apply to the Trust Chair taking office from 1 July 2010.

It is also the responsibility of the Council of Governors' Nominations and Remuneration Committee to monitor the performance of the Chair and Non-Executive Directors. The Committee may, in appropriate cases or if specifically requested by the Council of Governors to do so, report its findings to the Council.

Details of the actual remuneration paid to the directors in 2009/10 are shown in the table below. The Non-Executive Directors' duration of office is shown on pages 64, 66-68.

Directors' Remuneration and Pension Entitlements

A) Remuneration and Allowances 1.4.2009 to 31.3.2010

	Period 1.4.09 to 31.3.10			Period 1.7.08 to 31.3.09		
Name and title	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Benefits in kind (rounded to the nearest £00)**	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Benefits in kind (rounded to the nearest £00)**
Prof. A Walker, Chairman	25 - 30			20 - 25		
A Barney, Non-Executive Director	0 - 5			5 - 10		
E Jones, Non-Executive Director	0 - 5			5 - 10		
Cllr. M Rooney, Non-Executive Director	10 - 15			5 - 10		
M Rosling, Non-Executive Director	10 - 15			5 - 10		
H Morris, Non-Executive Director	0			0 - 5		
A Clayton, Non-Executive Director	5 - 10			0		
M Thomas, Non-Executive Director	5 - 10			0		
S Rogers, Non-Executive Director	5 - 10			0		
K Taylor, Chief Executive	130 - 135			95 - 100		
M Rodgers, Deputy Chief Executive /Executive Director of Finance	105 - 110			75 - 80		
Dr T Kendall, Executive Medical Director	60 - 65	115 - 120		40 - 45	80 - 85	
C Clarke, Executive Director of Operations and Social Care	95 - 100			70 - 75		
K Tomlinson, Executive Director of Governance, Performance and Nursing	95 - 100			70 - 75		

The 2008/09 figures relate to the 9 month period from 1 July 2008, the date the Trust was authorised as a Foundation Trust.

All Executive Directors are contributing members of the NHS defined benefit pension scheme and are eligible for a pension of up to half of final salary on retirement. The scheme also provides a lump sum of three times the final salary on retirement. Executive Directors in the scheme receive the same benefits as other staff members. The 'Pension Benefits' table below provides details of the current pension and lump sum position for each Director.

B) Pension Benefits 1.4.2009 to 31.3.2010

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

	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
K Taylor, Chief Executive	0 - 2.5	2.5 - 5.0	35 - 40	115 - 120	725	635	59	0
M Rodgers, Deputy Chief Executive / Executive Director of Finance	0 - 2.5	0 - 2.5	50 - 55	155 – 160	1,323	1,211	51	0
Dr T Kendall, Executive Medical Director	0 - 2.5	5.0 – 7.5	40 - 45	120 – 125	843	728	79	0
C Clarke, Executive Director of Operations and Social Care	2.5 - 5.0	10 - 12.5	10 - 15	40 - 45	242	156	78	0
K Tomlinson, Executive Director of Governance, Performance and Nursing	0 - 2.5	0 - 2.5	40 - 45	120 - 125	828	744	47	0

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

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

Pension Liabilities
The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities.

A small number of staff are, however, members of South Yorkshire Pensions scheme. Further details can be found in the Annual Accounts at note 1.2.

Kevan Taylor
Chief Executive

11. Directors' Statement

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Sheffield Health and Social Care 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").

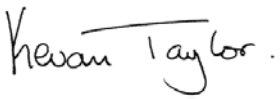
Under the National Health Service Act 2006, Monitor has directed Sheffield Health and Social Care NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sheffield Health and Social Care 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 Annual 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 Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- 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*.



Kevan Taylor
Chief Executive

Date: 1 June 2010

12. The NHS Foundation Trust Code of Governance

Commitment to Good Governance

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance followed by all those who play a part in the conduct of the Trust's business. The Board also recognises that the purpose of the NHS Foundation Trust Code of Governance (the 'Code') (which is published by Monitor, the independent Regulator of NHS Foundation Trusts) is to assist NHS Foundation Trust Boards and their Governors to improve their governance practices by bringing together the best practices from the public and private sectors.

Application of the main and supporting principles of the Code of Governance

The Board implements the main and supporting principles of the Code through a number of key governance documents, policies and procedures including:

- The Trust's Constitution
- The Standing Orders for the Board of Directors and the Council of Governors
- The Scheme of Reservation and Delegation of Powers of the Board of Directors
- The Standing Financial Instructions
- The Statement of Internal Control
- Codes of Conduct and Standards of Business Conduct
- The Annual Plan and the Annual Report
- Authority Structures and Terms of Reference for the Committees of the Board of Directors and Council of Governors.

Compliance with the provisions of the Code

In view of the foregoing, the Board of Directors considers that, except where non-compliance or limited compliance is mentioned below, the Trust has complied the requirements of the Code. Non-compliance or limited compliance is reported as follows:

A.1.3

The Chairman should hold meetings with non-executive directors without executives present. Led by the Senior Independent Director, the non-executive directors should meet without the chairman at least annually to evaluate the chairman's performance, as part of the process which should be agreed with the board of governors, for appraising the chair and on such other occasions as are deemed necessary.

The Standing Orders of the Council of Governors confer the responsibility of carrying out the appraisal of the Trust Chair on the Council of Governors' Nominations and Remunerations Committee. The Committee suspended the process of appraising the Trust Chair's performance as the carrying of such an appraisal coincided with the process of recruiting a Trust Chair which the Committee had initiated at the time when the appraisal would have been carried out.

Disclosure of corporate governance arrangements

In accordance with the disclosure requirements of the Code, the Board of Directors makes the following disclosures:

- A statement on how the Board of Directors and the Council of Governors operate, including high level statements of which types of decisions are to be taken by each one of them and which are to be delegated to the management by the Board of Directors, is contained on pages 54 and 60.
- The names of the Chair, the Vice-Chair, the Chief Executive, the Senior Independent Director, Chairs and members of the Board of Directors' Remunerations and Nominations Committee, the Council of Governors' Nominations and Remuneration Committee, the Audit and Assurance Committee are contained on pages 57 & 61-68.
- The number of meetings of the Board of Directors, its committee and the individual attendance by directors are shown on pages 61-63.
- The Board considers the following Non-Executive Directors to be independent in character and judgment:

  i) Alan Walker

  ii) Martin Rosling

  iii) Anthony Clayton

  iv) Mervyn Thomas

  v) Susan Rogers

  vi) Mick Rooney

The Board holds this view in relation to all of the above-mentioned directors for the following reasons:

(i) none of them are employed by the Trust or have been in the last five years;

(ii) none of them have, or have had, within the last three years a material business relationship with the Trust, either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust;

(iii) none of them has received or receives additional remuneration from the Trust apart from their director's fee; they do not participate in any performance-related pay scheme run by the Trust nor are they a member of the Trust's pension scheme;

(iv) none of them has close family ties with any of the Trust's advisers, directors or senior employees;

(v) none of them hold cross-directorships or have significant links with other directors through involvement (with those other directors) in other companies or bodies;

(vi) none of them is a member of the Council of Governors; and

(vii) none of them has served on the Board of the Foundation Trust for more than nine years.

- A description of each director's expertise and experience is contained in pages 64-68.
- A statement on the Board of Directors' balance, completeness and appropriateness is contained on page 60.
- The names of the governors, and details of their constituencies, whether they are elected or appointed and the duration of their appointment is contained on pages 57.
- The number of meetings of the Council of Governors and the individual attendance by governors and directors is contained on pages 57.
- The Chair's other significant commitments and any changes to them during the year are contained on page 64.
- The work of the Nominations Committee, including the process it used in relation to Board appointments together with an explanation of whether a search consultancy was used in the appointment of the Chair or the Non-Executive Directors, is contained in pages 55, 57, 61 and 69.
- No Executive Director who serves as a non-executive director elsewhere earns any income from their non-executive directorship. In the event of this occurring, the Board would treat each case according to its own merits.
- A statement from the Directors that the business is a going concern, together with supporting assumptions or qualifications as necessary, is contained on page 73.
- A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls is contained on pages 78-85.
- The Board of Governors has not refused to accept the recommendation of the Audit and Assurance Committee on the appointment or re-appointment of an external auditor, and this matter is therefore not reported on.
- The auditor does not provide any non-audit services to the Trust and this matter is therefore not reported on.
- Members wishing to communicate with Governors and/or Directors may do so by informing the Trust's Membership Manager of the Foundation Trust Company Secretary.
- Non-Executive Directors attend meetings of the Council of Governors and Board members are further informed of the views of the Governors by the Trust Chair. During the year, the Trust Chair sent a formal consultation to members of the Council of Governors seeking their views on various aspects of the relationship between members of the Board of Directors and members of the Council of Governors.

  These views were collated and presented to the Board at one of its meetings. This informed the Board on the type of strategies it needs to develop to improve the flow of information between the Board of Directors and the Council of Governors.

  There is also a Membership Communication Sub-Group at which members and Governors meet to express their areas of concern. Issues raised by members and Governors are, at the request of members of the sub-group, communicated to the Board of Directors.

13. Auditor's Report

Independent Auditor's report to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust

I have audited the financial statements of Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of remuneration and allowances of senior managers and (Table A) related narrative notes; and
- the table of pension benefits of senior managers (Table B) and related narrative notes.

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

Respective Responsibilities of the Accounting Officer and Auditor

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

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

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report subject to audit have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether in my opinion, the information which comprises the commentary on financial performance within the Performance Overview section included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor, contained in the NHS Foundation Trust Annual Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises: the Statement from Chair, About Us, Our Vision, Annual Quality Accounts, Performance Review as well as sections on Climate Change and Sustainability, Equality and Diversity, FT Trust Membership and Council of Governors, Meet the Board, Disclosure of Corporate Governance Arrangements, Internal Controls and the unaudited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

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

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

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

Opinion
In my opinion:

- the financial statements give a true and fair view of the state of affairs of Sheffield Health and Social Care NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended, in accordance with the accounting policies adopted by the Trust;
- the financial statements and the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the commentary on financial performance within the Performance Overview section included in the Annual Report, is consistent with the financial statements.

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

Mr D Murray
Engagement Lead
Audit Commission
3 City Leeds Office Park
Holbeck
Leeds, LS11 5BD
4 June 2010

14. Statement on Internal Control – 1 April 2009 – 31 March 2010

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Sheffield Health and Social Care 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 Sheffield Health and Social Care 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.

Sheffield Health and Social Care NHS Foundation Trust forms part of the Sheffield social and healthcare economies. As the Accounting Officer I work closely with NHS Sheffield, which is the main commissioner of our mental health and learning disabilities services. We are also accountable to Sheffield City Council for the social care it provides through the Section 75 Agreement which is monitored on a monthly basis by a joint performance group, and quarterly via a partnership board. Part of the agreement includes an accountability framework. We also have an elected councillor who sits on the Trust Board as a Non-Executive Director. Positive networking relationships with Yorkshire and the Humber Strategic Health Authority have been maintained.

2. 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 on-going process designed to:

Identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Health and Social Care NHS Foundation Trust; evaluate the likelihood of those risks being realised and their impact should they be realised and to; manage them efficiently, effectively and economically.

The system of internal control has been in place in Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

Risk Management, Leadership and Structure
Corporate leadership, support and advice for handling risk is provided through the Executive Team (including risk management and clinical governance functions) in the Service Development Directorate. The Directorate is led by the Executive Director/Chief Nurse who has the Executive Director lead role for risk management and governance.

Roles and responsibilities for risk management are described in detail in the Trust's Safety and Risk Strategy which was ratified by the Board of Directors February 2009. Responsibilities include:

- All staff in the Trust, including those on temporary contracts, placements or secondments, and contractors must keep themselves and others safe. All staff have a duty of care to provide safe services and do no harm. All health and social care staff working directly with service users and carers are responsible for ensuring that their work is safe and that they use systematic clinical risk assessment and management processes in the delivery of care and treatment
- All managers including team managers/leaders and heads of departments are responsible for health and safety and the effective management of risks within their teams, services or departments
- All directors are operationally responsible for safety and the effective management of risk within their areas of responsibility.

Staff Training and Development
Staff training and development needs with regard to risk management and safety are described in the Trust's Statutory and Mandatory Training Policy for risk management, training matrix and training needs analysis.

Development for the Board and senior managers in 2009/10 has included work on the Board Assurance Framework, financial challenges, annual planning, partnership working and delivery of the Trust vision.

Training provided by the Trust for its staff includes:-

- Corporate Induction – A local induction package and a specific induction for managers, all of which include elements of risk management
- Incident Reporting and Investigation
- Health and Safety

- Managing Violence and Aggression
- First Aid and Resuscitation
- Root Cause Analysis
- Clinical risk assessment and management
- Safeguarding Children and Vulnerable Adults
- Infection Control
- Care Programme Approach
- Improving Access to Psychological Therapies (IAPT)

The 6 service directorates and IAPT (primary care) and psychological service (secondary care) also provided a range of regular training up-dates for their staff during the year.

National Institute for Clinical Excellence (NICE) guidelines and evidence-based practice are being incorporated into clinical practice. NICE implementation groups have been set up for the mental health guidelines; progress is reported into quarterly joint Operational Management Group/NICE Implementation Group meetings and monitored by the Medical Director.

The Trust employs a range of suitably qualified and experienced persons who are accessible to all staff to advise on risk issues, e.g. clinical risk, infection control, risk assessment, health and safety, litigation, liability, fire & security, environmental, estate management, medicines management, psychological therapies governance, safeguarding children and vulnerable adults, human resources, finance etc.

Learning from Good Practice
The Trust utilises a number of methods for ensuring that good practice and lessons learned are shared across the services. These include:

- Utilising clinical audit/clinical effectiveness
- Staff and patient surveys and the dissemination of results
- Improving Quality events
- Team and directorate governance reports and events
- Acute Care Forum
- Community Care Forum
- Sharing good practice events
- Making contributions at conferences
- Safety subgroup and Risk register leads meetings
- Reports of Compliments received
- Information is also shared through newsletters, for example Risk Matters, Lessons Learned Bulletin and Sheffield Health and Social Care Foundation Trust News. As Chief Executive, I send out a monthly letter to all staff, which includes references to good practice and achievements that the Trust has identified.

4. The Risk and Control Framework

Safety and Risk Strategy and Risk Management Policy Manual
The Trust recognises that positive and managed risk taking is essential for growth, development and innovation. 'Risks' are not set as barriers to change and improvement; instead they are recognised, thought about and managed effectively as part of improvements.

The Trust's Safety and Risk Strategy ratified by the Trust Board in February 2009 is handed out at training courses and available on the Trust's intranet, together with other policies and procedures to inform practice. The Trust also has a revised Risk Management Policy Manual (ratified in February 2009) which provides operational guidance.

The Safety and Risk Strategy describes:

- The Trust's vision, values, attitude and strategic approach to safety and risk management
- The Trust's structure and governance arrangements for safety and risk management
- Roles, responsibilities and accountabilities for safety and risk management
- The risk assessment and management process
- Key components of risk management –
  - Board Assurance Framework,
  - Risk Register
  - Incident and Serious Incident Reporting and learning from incidents
- Staff learning and development
- Involving service users and carers
- Implementation of the strategy

The Risk Management Policy Manual includes:

- The Trust's attitude and operational approach to risk management
- Definitions of key terms
- Guidance on the risk management process in all areas of the Trust's work; the use of risk

assessments, identification of hazards and risks, analysis for severity and likelihood, control measures and monitoring progress

- Using evidence-based practice
- Risk Register procedures
- Reporting, reviewing and investigating incidents
- Using information effectively
- Sharing lessons learned
- Policies and procedures
- Cascading hazard warning notices
- Employing competent persons
- Reviewing complaints and claims
- Trust integrated governance structure

Other policies related to the effective assessment management of risk are available to all staff via the Trust Intranet and referenced in the Safety and Risk Strategy and the Risk Management Policy Manual. A system is in place to prompt the review and revision of policies as required.

Risk Assessment and Monitoring Systems
Identifying and managing risk is embedded in the activity of the organisation through the governance structure. This includes service governance within each of the Service Directorates and team governance in all multidisciplinary teams. The Trust reviewed its committee and governance structure in 2009. Each team produces a report at least annually, for Directorate review. All Directorates are reviewed through a quarterly performance review with the Executive team.

Risks to achieving the Trust's corporate objectives and risks to the viability of the Trust are recorded and monitored through the Board Assurance Framework process which is linked to the broader Trust Risk Register. All moderate or high risks are entered onto the Trust Risk Register. This is a single electronic database with sub sections for each Directorate and certain categories of cross-Trust risks e.g. information risks. Within Directorates, individual teams or departments may also have their own sub-sections.

Directorate Risk Registers are reviewed as part of the service review process to ensure that they are 'live'. Each Directorate has a risk register lead that is responsible for the review and updating of their risk register. The Trust Risk Register is administered by the Risk Register Co-ordinator, who also provides advice and support for the Directorate risk register leads.

Cross-Trust risks which impact on several or all Directorates but do not meet the criteria for the Board Assurance Framework are managed by accountable individuals and reviewed and monitored through the appropriate operational governance group.

The Executive Directors' Group is responsible for reviewing all these risks when they are first identified and allocating responsibility to the appropriate member of the group and the appropriate governance group. Assurance and exception reports come back to the Executive Directors Group and are reported on to the Board for review at least quarterly. The register of all cross-Trust moderate and high level risks is reviewed as a whole by the Executive Directors' Group and reported to the Board at least annually.

Risks are also highlighted via feed-back from Incidents, Serious Incidents, Complaints and Patient Advice Liaison Service queries. There are weekly serious incident reports distributed to Executive Directors and Clinical, Service and Support Directors. The Executive Directors' Group, Quality and Risk Group and Trust Board all receive reports which analyse the data from these sources, report on trends and any issues identified. National benchmarking information from the National Patient Safety Agency is used to understand and interpret the Trust's incident and serious incident reports. The findings of external inquiries and national reports are also shared and acted upon as described in the Trust's Clinical Effectiveness Policy.

Information Governance and Data Security
The Trust's information governance policies have recently been revised, approved by the Performance and Information Group and ratified by the Executive Directors' Group. The management and monitoring of information risks is the responsibility of the Trust Senior Information Risk Officer (the Finance Director) and information risks and incidents are reviewed and monitored through the Information Governance Steering group, which is a sub-group of the Performance and Information Group. The Information Governance Steering group has a number of sub-groups including Confidentiality & Disclosure Group.

The Trust continues to adhere to the Information Governance Toolkit. The Trust submitted the Information Governance Toolkit in March 2010 and has met the required level on all required Statement of Compliance items. An overall score of 71% is

compliant with Level 2. Action plans are being developed, within the limits of current resources, to improve the score next year.

The IT department has ensured all laptops have been encrypted locally and has rolled out a nationally procured encryption solution for portable computers and storage devices.

Information Governance is included on the New Starters Induction day and other training sessions have been provided for managers. Information Governance is also covered in the Trust Induction Checklist.

There were no linked Serious Untoward Incidents of severity 3-5 reported in the Trust between 1 April 2009 and 31 March 2010.

A summary of other personal data related serious incidents notified in the Trust during the period are shown in the table below:

Incident Number Grade	Incident Date	Incident type	Details Of Incident	Outcome	Type
70803	03.06.2009	Organisation Confidentiality	Due to the proposed sale of site and the need to identify equipment to be kept or sold to prospective buyer it was necessary to force entry into 3 filing cabinets. All 3 contained information identifying both clients and staff.	Closed	1
71506	04.07.2009	Patient Confidentiality	SHSC Laptop, phone, ID badge and patient notes stolen during burglary of employee's home.	Ongoing	1
71547	15.07.2009	Employee Confidentiality	Secure Data store failure allowing open access to personal folders.	Ongoing	1
72174	26.08.2009	Employee Confidentiality	Ward report taken home by member of staff.	Closed	0
75179	27.01.2010	Patient Confidentiality	Print out appearing at locations other than those intended.	Ongoing	1

Board Assurance Framework

The Board approved the 2009-10 Board Assurance Framework in June 2009. The Trust Assurance Framework is based on the Trust's strategic aims, as described in the Integrated Business Plan, and the corporate objectives derived from these strategic aims. The key high level and corporate risks identified through the Risk Register were also incorporated into the development of the Assurance Framework. Implementation of the actions in the Framework is monitored monthly through the Executive Directors' Group and the Assurance Framework is updated quarterly and monitored by the Audit and Assurance Committee.

As at 1st April 2010, there were 2 moderate level risks with outstanding actions to address gaps in their controls and assurances in the Assurance Framework. I am confident that none of these outstanding actions represent a significant or serious risk to the effectiveness of the systems of Internal Control. All residual risks and actions will carry forward into the 2010-11 Board Assurance Framework and will be entered onto the Trust Risk Register.

The Internal Audit Annual Report is due in May 2010 and it is anticipated it will declare that the Assurance Framework meets year end requirements and the requirements of the Statement on Internal Control.

Public Stakeholder Involvement in Managing Risks
Service users and carers are members of the service governance structures at Directorate and team level and contribute to planning and service improvement groups such as the Acute Care Forum Safety Group. Their contribution includes addressing issues of service user safety and improving the quality and effectiveness of care. Service user views are also actively sought through surveys and focus groups.

During the past year, successful and well attended Improving Quality events for service users, carers and Governors have been held to review quality in the Trust and build greater service user and carer involvement in work to improve the quality of services throughout the Trust. The Trust is also a partner to Sheffield Local Involvement Network (LINk).

As a Foundation Trust SHSC has public members and a Council of Governors. The overall role of the Council of Governors is to assist the Trust in the drive to raise standards by providing services of the highest possible quality that meet the needs of the people of Sheffield. The Council of Governors receive updates on the Trust's compliance against regulations and standards and help plan and steer the Trust and help set priorities for improvements and changes. Governors are also members of key governance meetings where they can represent the interests of the local community, users and carers and make sure that the Trust does what it says it will do.

Compliance with External Standards
The Trust declared full compliance with the Healthcare Commission Standards for Better Health core standards in 2009. Its rating on the Annual Health check 2009 was 'Good' for Quality of Care and 'Good' for Management of Resources.

Action plans are in place following previous Healthcare Commission reviews. Delivery of the action plans is monitored through the Quality and Risk Group and by the Board. The action plan arising from the HCC review of the Acute In-patient services was completed in the 2009-10 monitoring period and signed off by Trust Board of Directors. The Trust has full registration with the Care Quality Commission for all its services across all locations.

The Trust declared none compliance with two of the CQC outcomes (Outcome 15 'Safety and Suitability of Premises' and Outcome 23 'Supporting Workers') for some of its locations. Action plans are in place to achieve compliance; these plans are monitored through the Trust governance systems.

The Trust met the NHSLA risk management standards for mental health and learning disability trusts at level 1 in March 2008. Work towards consolidating level 1 status is ongoing in preparation for assessment at this level in March 2011.

The Trust meets all the standards for Infection Control including compliance with the Hygiene Code.

NHS Pensions Scheme Regulations
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure the Trust complies with all employer obligations contained within the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme, are in accordance with the Scheme rules, and that member Pension Scheme records are accurately up-dated in accordance with the time-scales detailed in the Regulations.

Diversity, Equality Standards and Human Rights
The Trust is compliant with the relevant equality standards and duties. The single equality scheme which replaced the previous separate schemes for race, gender and disability is available on the Trust's website.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with including: A nominated lead for the Trust (Executive Director) Reporting to Quality and Risk Group and Human Resources and Workforce Group on statutory reporting requirements and delivery of the Single Equality Scheme.

The consideration of risk and equality impact are integrated within the Trust's business and programme management processes, with equality impact assessments carried out where required. The Trust's project plan, business case and policy templates all include sections on equality impact assessment.

Carbon Reduction Plans
The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Board of Directors have agreed a robust governance structure which allows proper control and monitoring of the efficient and effective use of its resources. This structure has been reviewed over the last year and submitted to the Board of Directors with suggested amendments. These amendments were approved in the interim until a further review of the implications of the Francis Report are considered and tested against this revised structure.

Through its infrastructure, the Committees of the Board of Directors, namely the Audit & Assurance Committee and Finance & Investment Committee, together with various operational groups, the Board of Directors is assured that the organisation is financially monitored. This is undertaken by a number of reports received by the Board and its Committees, which are produced via the operational governance groups and consider areas including workforce, quality, risk and business related matters on a monthly basis. The Executive Directors' Group provides operational governance for all plans to develop new or reconfigured services, supported by the Service & Business Development Group.

Considerable work has also been undertaken on a number of operational efficiency metrics, including our Reference Costs and benchmarking of services with other organisations. This will continue to be enhanced in the coming year and the Trust has recently purchased a system to enable reports to be produced on service line reporting of income and expenditure, to further focus on the areas of overspending or inefficiency. From 2008/2009 onwards, the Trust's Cost Improvement Programme (CIP) continues to be targeted on the Trust's high reference cost areas and these areas will be subject to a full transformation to ensure Quality, Innovation, Preventative and Productivity (QIPP) are maximized to enable the CIP targets to be achieved.

The organisation has strong leadership through its Operational Directors, where a Service and Clinical Director have joint management of clinical directorates and Support Directors have the same responsibility for Corporate Directorates. Each of these Directors have budget training and are responsible for ensuring that the resources they manage are done so effectively and efficiently and are economic. These budget managers are provided with the monthly budget reports and activity statements for their areas of responsibility to assist them in undertaking this role. A service review, including financial matters, is undertaken on a six monthly basis and a financial sign off for current year budgets are performance managed by the respective Executive Directors.

The Trust has, as part of its Internal Audit Plan, requested the review on a number of service areas including an assessment of the effectiveness of the IM&T Service provision; value for money studies on the Trust Housekeeping Services and the use of the training facility at Lightwood House.

6. 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 this system of internal control is informed by the work of the internal auditors and the executive managers within Sheffield Health and Social Care 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.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Reports from the Board of Directors and the Board Committees
- Reports from the Audit Commission
- External assessment from the National Health Service Litigation Authority
- External assessment from the Health & Safety Executive
- The declaration of compliance through the self-assessment of Standards for Better Health
- Assessments by the Care Quality Commission
- Council for Social Care Inspection reports
- Registration with Care Quality Commission
- The quarterly Performance Review is held with all

Service Directorates to review their progress and performance against targets

- 6 monthly Performance review held with all support/corporate directorates
- Visits from the Mental Health Act Commission

I have been advised on the implications of the result of my review of the effectiveness of the system on internal control by the relevant internal mechanisms e.g. Trust Board, Audit and Assurance Committee, Finance and Investment Committee, Quality and Risk Group, Performance and Information Group, HR and Workforce Group, Service Business and Development Group, Operational Management Group and via weekly meetings of the Executive Directors' Group.

These meetings and their accountability and reporting relationships are described more fully below and in the Trust's Integrated Business Plan. I believe that they form an effective and robust system of governance for the Trust and a plan to address weaknesses and ensure continuous improvement of the system in place.

Annual Quality Report
The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements and on the arrangements in the *NHS Foundation Trust Annual Reporting Manual*.

There have been a series of Board Development Sessions and reviews at the Board of Directors on the Quality Accounts to determine key objectives. Additionally, a joint meeting of the Board of Directors and Council of Governors considered other quality indicators to ensure there was ownership of the process. Furthermore a review by the Local Authority Scrutiny Committee was completed.

As a result of these discussions, four objectives were agreed:

- Four hour wait from referral to assessment for the Crisis Service;
- Improve satisfaction of people from BME groups;
- Improve experience of privacy and dignity of people in ward areas;
- Reduce potential harm to people who use our services from having wrong drugs or dosage when moving to a new team or ward.

These objectives and performance of them throughout the year form a significant element of the Quality Account Report and will feature in the Trust's Annual Report.

In preparing the Quality Report, Directors satisfied themselves that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data was taken from the Trust's systems for patient records (Insight) and risk management (Ulysses Safeguard) and public website (Care Quality Commission). The Trust meets the appropriate Information Governance requirements for data quality.

The Quality Report has also been received and considered by the Trust's Audit & Assurance Committee and the Quality & Risk Committee.

Trust Board of Directors
The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance. This includes the development of systems and processes for financial control, organisational control and risk management.

Audit and Assurance Committee
The Trust's Audit and Assurance Committee is a Committee of the Board and is chaired by a Non Executive Director. It provides assurance to the Board that effective internal control is in place within the Trust. It monitors the effectiveness of the systems in place for the management of risk and governance, and delivery of the Board Assurance Framework.

Finance and Investment Committee
The Finance and Investment Committee is the Committee of the Board which provides assurance on the management of financial risk. This Committee is also chaired by a Non Executive Director.

Remuneration and Nominations Committee
The Remuneration and Nominations Committee of the Board of Directors comprises Non-Executive Directors and is chaired by the Chair of the Trust. The Chief Executive attends meetings of the Committee in an advisory capacity, except in relation to issues affecting the Chief Executive's own remuneration (in which case he does not attend). The Committee has delegated authority for all decisions relating to the remuneration and terms of service of the Chief Executive, Executive and Associate Directors.

Operational Governance Groups

Six operational governance groups report to the Executive Directors Group:

- Service and Business Development
- Performance and Information
- Quality and Risk
- HR and Workforce
- Operational Management Group
- Strategic Leadership Group

In addition, a series of professional advisory groups and committees are established whose role is to provide clinical and professional advice.

The Quality and Risk operational governance group oversees risk management and service quality within the Trust. A number of sub groups report to the Quality and Risk Group e.g. Medicines Management Committee, Infection Control Committee, Safeguarding Adults and Children, Psychological Therapies Governance Committee. These groups regularly meet to discuss risks in their specific areas. The Safety sub group has a particular role in reviewing risks to the safety of service users, staff and the public.

The HR and Workforce Group and the Performance and Information Group cover relevant aspects of risk. For example, the HR and Workforce Group considers staff-related risks such as the Trust's response to staff sickness rates; Performance and Information Group monitors risks to performance and information risks are monitored through its subgroup, the Information Governance Steering Group.

The new integrated governance and performance structure, incorporating risk, is fit for purpose for the Trust's future as a Foundation Trust, as assessed by due diligence and the Monitor review process.

The reporting and accountability relationships of the Trust Board, its Committees, the Executive Directors' Group and the operational governance groups is illustrated in the chart below:

Executive Directors' Group
The role of the Executive Directors' Group is to ensure the operational and performance delivery of services in line with Trust strategic and business objectives.

The Executive Directors' Group is the key team which manages strategic and operational risk issues, and receives frequent reports on risk and governance. The Director of Nursing and Quality has executive responsibility for risk and governance.

Conclusion
Plans to address weaknesses and ensure continuous improvement of the system are in place.

In my view, there are no significant control issues outstanding for the period from 1 April 2009 to 31 March 2010.

Kevan Taylor
Chief Executive Officer

June 2010

15. Annual Accounts 2009/10

Director of Finance's Introduction to the Accounts

2009/10 was the first full year for the organisation as a Foundation Trust and the annual financial plan was agreed as part of the Integrated Business Plan submitted as part of its application process and updated in May 2009 to reflect some small changes. While there were some difficulties associated with the delivery of the Cost Improvement Programme targets set by the Board of Directors, it was delivered in full but with around £900,000 achieved by non-recurrent measures.

The benefits outlined for becoming a Foundation Trust have provided the organisation with the mechanism to better plan its finances whereby it is enabled to carry forward any surplus and have this fully cash protected. Under the previous financial regime, any surplus achieved on its income and expenditure account would have been simply an accounting record, as it would not have had cash support to be able to spend in the following years. This is because the cash balance was required to be as close to zero as possible.

Given the problems which arose during the year, especially the financial situation experienced throughout the world economy, the Trust is pleased to report the organisation achieved all its financial targets. This is due to the hard work of all budget managers and their staff, supported by the work of the finance team.

The main elements the Trust's financial performance are as follows:

- Achievement of planned surplus of £2,127,000
- Delivery of EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) although this is slightly worse than expected and will need to be stabilised for the future;
- Delivery of planned financial rating with the Independent Regulator, Monitor, of a Level 4 from Level 3 in the previous year.

The Trust is also expected to pay its non-NHS creditors within a 30 day target and the Trust achieved a compliance of of 87% by value and 86% by number of invoices paid. As stated in previous years, it is incumbent upon Government bodies such as the Trust to support the general economy and ensure this target is increased if at all possible, especially in the economic downturn which will be facing the broader economy of the next few years.

With respect to money spent on our property, plant and equipment assets for this year of operation, some of the allocation was committed as noted below:

- Relocation of South Community Mental Health Team
- Relocation of Fairlawns
- I.T. Schemes
- Vehicle and Major Equipment Replacements
- Additional funding was provided by the Local Authority Capital Grants for the development of Grenoside Cafe, a joint venture project with the Busters Organisation

External monitoring of the financial plan is contained within the Board of Directors agreed Annual Plan which sets out the Trust's intentions for the coming year. This plan is scrutinised and approved by the Independent Regulator, Monitor, and rigorously reviewed on a quarterly basis to ensure the Trust is achieving its targets as outlined the Annual Plan. This includes the financial elements of this document. For each quarter, the Trust has had a green light sign off by Monitor which identifies maintained plan delivery. This is reported via a summary document which in turn is highlighted at the Board of Directors meetings each quarter.

The Trust has successfully introduced the transfer to the International Financial Reporting Standards (IFRS) regime and was commended by its External Auditors for having a robust and comprehensive implementation plan.

Even allowing for the challenges we will be facing in the next few years, the Trust is confident that we can work together with our partners and maintain financial stability. This, however, requires the entire organisation to be ready for the changes needed to deliver excellent services. The Foundation Trust regime requires us to keep our surplus cash and, consequently, the Trust will be in a better position to maintain and, where appropriate, develop the quality of services for the population we serve.

As a Foundation Trust, we are required to market test our External Auditors and this process is undertaken by the Council of Governors. During February and March, Trust Officers and Non-Executive Directors have assisted a small sub-group of the Council of Governors to advertise and interview a number of Accountancy Firms plus our exiting External Auditors. The outcome was that the Audit Commission was successful and re-appointed for a further four years. This decision was ratified by the full Council at its meeting on the 15 April.

We have seen a number of cost challenges this year and have been successful in delivering our financial performance by targeting areas which are of high cost. The coming years will see unprecedented financial demands on public services as well as the NHS and as an organisation we must ensure we deliver the financial targets placed upon us and at the same time deliver the quality of services the public expect and require.

M. J. Rodgers
Executive Director of Finance

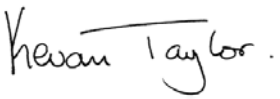
June 2010

FOREWORD TO THE ACCOUNTS

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31 March 2010 have been prepared by Sheffield Health and Social Care NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed:



Kevan Taylor
Chief Executive (as Accounting Officer)

Date: June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £'000	2008/09 £'000
Operating income	3	**115,856**	84,600
Operating expenses	4	**(111,720)**	(82,174)
Operating surplus		**4,136**	2,426
Gain on disposal of property, plant and equipment		**293**	4
Surplus before finance costs		**4,429**	2,430
Finance costs:			
Finance income	6	**35**	82
Public dividend capital dividends payable		**(2,337)**	(2,111)
Net finance costs		**(2,302)**	(2,029)
SURPLUS FOR THE YEAR		**2,127**	401
Other comprehensive income			
Revaluation gains / (losses) and impairment losses on property, plant and equipment		**(13,712)**	(4,667)
Reduction in the donated asset reserve in respect of depreciation of donated assets		**(22)**	(23)
Actuarial gains / (losses) on defined benefit schemes		**(64)**	-
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(11,671)**	**(4,289)**

The comparative amounts for 2008/09 are for the nine month period from 1 July 2008 to 31 March 2009.

The notes on pages 93 to 124 form part of these accounts.

All revenue and expenses are derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010

	NOTE	31 March 2010 £'000	31 March 2009 £'000	Opening position 1 July 2008 £'000
Non-current assets				
Intangible assets	8	-	-	-
Property, plant and equipment	9	58,097	73,457	82,790
Investment property	10	200	-	-
Trade and other receivables	12	3,647	1,976	4,557
Total non-current assets		61,944	75,433	87,347
Current assets				
Inventories	11	182	428	124
Trade and other receivables	12	4,325	5,436	5,635
Non-current assets held for sale	14	-	4,850	587
Cash and cash equivalents	13	10,981	2,103	1,460
Total current assets		15,488	12,817	7,806
Total assets		77,432	88,250	95,153
Current liabilities				
Trade and other payables	15	(6,165)	(7,082)	(8,386)
Provisions	18	(226)	(621)	(125)
Taxes payable	15	(1,910)	(1,809)	(1,752)
Other liabilities	16	(497)	(384)	(120)
Total current liabilities		(8,798)	(9,896)	(10,383)
Total assets less current liabilities		68,634	78,354	84,770
Non-current liabilities				
Provisions	18	(470)	(493)	(477)
Other liabilities	16	(3,571)	(1,598)	(3,739)
Total non-current liabilities		(4,041)	(2,091)	(4,216)
Total assets employed		64,593	76,263	80,554
Financed by taxpayers' equity:				
Public dividend capital		33,572	33,572	33,572
Revaluation reserve		18,552	34,639	39,796
Donated asset reserve		626	723	746
Income and expenditure reserve		11,843	7,329	6,440
Total taxpayers' equity		64,593	76,263	80,554

The financial statements on pages 88 to 124 were approved by the Board on 1st June 2010 and signed on its behalf by:

Signed: Heesan Taylor (Chief Executive) Date: 1st June 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

Changes in taxpayers' equity for 2009-10	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income & Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 April 2009	33,572	34,639	723	7,329	**76,263**
Total comprehensive income for the year					
Surplus for the year	0	0	0	2,127	**2,127**
Revaluation gains / (losses) and impairment losses on property, plant and equipment	0	(13,636)	(76)	0	**(13,712)**
Reduction in the donated asset reserve in respect of depreciation of donated assets	0	0	(22)	0	**(22)**
Other recognised gains and losses					
Actuarial gains / (losses) on defined benefits pension scheme				(64)	**(64)**
Transfer to the income and expenditure account in respect of assets disposed of	0	(2,172)	0	2,172	**0**
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	0	(279)	0	279	**0**
Other			1		**1**
Taxpayers' equity 31 March 2010	**33,572**	**18,552**	**626**	**11,843**	**64,593**

Changes in taxpayers' equity for 2008-09	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income & Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 July 2008	33,572	39,796	746	6,440	80,554
Total comprehensive income for the period					
Surplus for the period	-	-	-	401	401
Revaluation gains / (losses) and impairment losses on property, plant and equipment	-	(4,667)	-	-	(4,667)
Reduction in the donated asset reserve in respect of depreciation of donated assets	-	-	(23)	-	(23)
Transfers between reserves					
Transfer to the income and expenditure account in respect of assets disposed of	-	(9)	-	9	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(492)	-	492	0
Other	-	11	-	(13)	(2)
Taxpayers' equity at 31 March 2009	33,572	34,639	723	7,329	76,263

The amounts included within the revaluation reserve relate to property, plant and equipment.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus		**4,136**	2,426
Gain on disposal of property, plant and equipment		**293**	4
Depreciation and amortisation		**2,058**	2,134
Impairments and reversals		**286**	417
Transfer from donated asset reserve		**(22)**	(23)
Amortisation of government grants		**(8)**	(9)
(Increase)/decrease in trade and other receivables		**(510)**	2,772
(Increase)/decrease in other assets		**0**	(428)
(Increase)/decrease in inventories		**246**	(304)
Increase/(decrease) in trade and other payables		**(563)**	(195)
Increase/(decrease) in other liabilities		**2,030**	(2,058)
Increase/(decrease) in provisions		**(418)**	512
Other movements in operating cash flows		**(293)**	(4)
Net cash generated from / (used in) operations		**7,235**	5,244
Cash flows from investing activities			
Interest received		**34**	90
(Payments) for property, plant and equipment		**(1,174)**	(1,880)
Proceeds from disposal of property, plant and equipment		**5,167**	4
Net cash generated from / (used in) investing activities		**4,027**	(1,786)
Cash flows from financing activities			
PDC dividends paid		**(2,384)**	(2,815)
Net cash generated from / (used in) financing activities		**(2,384)**	(2,815)
Net increase/(decrease) in cash and cash equivalents		**8,878**	643
Cash and cash equivalents at 1 April 2009 / 1 July 2008		**2,103**	1,460
Cash and cash equivalents at 31 March	13	**10,981**	2,103

NOTES TO THE ACCOUNTS

1. Accounting policies and information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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.

Sheffield Health and Social Care NHS Foundation Trust ('the Trust') achieved foundation trust status on 1 July 2008. For 2009/10, the full year results to 31 March 2010 are disclosed. However, the comparatives shown in these financial statements for 2008/09 relate to the nine month period from 1 July 2008 to 31 March 2009.

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health and social care services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.2 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. 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. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The notional deficit of the scheme at the 2004 valuation was £3.3 billion. However, the conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme, administered by the South Yorkshire Pensions Authority, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. These postings are mostly countered by the terms of the current partnership agreement.

The terms of the current partnership agreement with Sheffield City Council ('the Council') provide that any long term pension liability arising from the scheme will be funded by the Council, with the exception of any pension changes which relate to salary increases in excess of any local government grading agreements. The impact on current and prior year Statement of Comprehensive Income and Statement of Changes in Taxpayers Equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is mostly negated by the inclusion of a corresponding non-current receivable with the Council. As at 31 March 2010, the deficit on the scheme was £3,120,000 (31 March 2009 - £1,366,000), which is offset by a non-current receivable of £3,051,000 (31 March 2009 - £1,366,000). For further information see note 26.

1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these

components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. The current revaluation policy of the Trust is to perform a full valuation every five years with an interim valuation in the third year. These valuations are carried out by professionally qualified valuers in accordance with Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Fair values are determined as follows:

- Land and non-specialised buildings – market value taking into account existing use
- Specialised buildings – depreciated replacement cost

On 1 July 2008, the Trust's predecessor organisation, Sheffield Care Trust, was granted foundation trust status and its assets and liabilities were transferred to the Trust. The valuation policy adopted by the predecessor organisation was that all land and buildings were restated to current value using professional valuations every five years and in the intervening years by the use of appropriate indices. This policy was applied up to the date of transfer on 1 July 2008.

Until 31 March 2009, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, the Trust has used the alternative site valuation method.

A full valuation exercise was undertaken by the Trust's valuers, GVA Grimleys, during 2009/10. The revised valuation methodology detailed above has been utilised within this revaluation, which was performed as at 1 April 2009. The impact of this change in valuation methodology is a reduction in asset values of £13,202,000.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 30 June 2008, plant and equipment was carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 July 2008 indexation ceased. The carrying value of plant and equipment transferred to the Trust at that date is now written off over their remaining useful lives and new plant and equipment is carried at depreciated historic cost as this is not considered to be materially different from fair value.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses. Where considered appropriate, when a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying value of the component replaced is de-recognised.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The estimated useful economic lives are as follows:

	Minimum life Years	Maximum life Years
Buildings - Freehold	**15**	**50**
Plant and Machinery	**5**	**15**
Transport Equipment	**3**	**7**
Information Technology	**5**	**10**
Furniture and Fittings	**7**	**10**

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating revenue.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
  - the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated property, plant and equipment is capitalised at its current value on receipt and this value is credited to the donated asset reserve. Donated property, plant and equipment is valued and depreciated as described above for purchased property, plant and equipment. 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 Statement of Comprehensive Income Account. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income Account is matched by a transfer from the donated asset reserve. On the sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Statement of Comprehensive Income Account.

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6 Investment property

Investment property comprises properties that are held to earn rentals or for capital appreciation or both. It is not depreciated but is stated at fair value based on regular valuations performed by professionally qualified valuers. Fair value is based on current prices for similar properties in the same location and condition. Any gain or loss arising from the change in fair value is recognised in the statement of comprehensive income. Rental income from investment property is recognised on a straight line basis over the term of the lease.

1.7 Government grants

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

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First in First Out (FIFO) method.

1.9 Financial instruments, financial assets and financial liabilities

Recognition

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

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'.

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 and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All 'other' financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest

rate is that which produces a constant periodic rate of interest on the outstanding liability.

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 annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position 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.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 18.

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

1.12 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 Trust's control) are not recognised as assets, but are disclosed in note 19 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19, 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.

1.13 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 predecessor NHS trust, being Sheffield Care Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of the PDC), the dividend for the year is calculated on the average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value Added Tax

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

1.15 Corporation Tax

The Trust has carried out a review of corporation tax liability of its non healthcare activities. At present all activities are either ancillary to patient care activity or below the de-minimis £50,000 profit level at which corporation tax is due.

1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 21 to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

2 Operating segments

The Trust considers that it has one operating segment, that being the provision of health and social care. Details of operating income by classification and operating income by type are given in Note 3.

3 Operating income

3.1 Operating income by classification comprises:

	2009/10	2008/09
	£000	£000
Income from patient care activities		
Block contract income	**70,855**	51,474
Clinical partnerships providing mandatory services (including Section 31 agreements)	**5,207**	3,768
Clinical income for the secondary commissioning of mandatory services	**11**	96
Other clinical income from mandatory services	**1,067**	707
	77,140	56,045
Other operating income		
Research and development	**464**	726
Education and training	**6,554**	4,631
Charitable and other contributions to expenditure	**301**	2,014
Transfers from donated asset reserve in respect of depreciation	**22**	23
Non-patient care services to other bodies	**30,667**	20,748
Other income	**708**	413
	38,716	28,555
Total operating income	**115,856**	84,600

Income is almost totally from the supply of services. Income from the sale of goods is immaterial.

In addition to operating income there has been a gain on disposal of assets held for sale (£286,000) and the profit on disposal of plant and equipment (£7,000) relate to disposals of non protected assets.

3.2 Private patient income

The Trust has no private patient income.

3.3 Operating lease income

Rental income from operating leases:	2009/10	2008/09
	£000	£000
Rents recognised as income in period	33	27

Future minimum lease payments due:	2009/10	2008/09
	£000	£000
Receivable:		
Not later than one year	12	33
Later than one year and not later than five years	51	-
Later than five years	-	-
	63	33

3.4 Operating income by type comprises:

	2009/10	2008/09
	£000	£000
Income from patient care activities		
NHS foundation trusts	6	2
NHS trusts	-	1
Primary care trusts	71,926	52,271
Local authorities	5,207	3,768
Non-NHS: Other	1	3
	77,140	56,045
Other operating income		
Research and development	464	726
Education and training	6,554	4,631
Charitable and other contributions to expenditure	301	225
Transfers from donated asset reserve in respect of depreciation	22	23
Non-patient care services to other bodies	30,667	22,537
Other income	708	413
	38,716	28,555
Total operating income	115,856	84,600
Profit on disposal of plant and equipment	7	4
Gain on disposal of assets held for sale	286	-
Total income	116,149	84,604

4 Operating expense

4.1 Operating expenses comprise:

	2009/10	2008/09
	£000	£000
Services from NHS foundation trusts	692	673
Services from other NHS bodies	25	-
Purchase of healthcare from non-NHS bodies	92	-
Employee expenses - Executive directors	678	687
Employee expenses - Non-executive directors	83	44
Employee expenses - Staff	92,561	66,451
Drug costs	1,622	1,119
Supplies and services - clinical (excluding drug costs)	1,622	958
Supplies and services - general	996	728
Establishment	2,758	1,930
Research and development	209	178
Transport	583	531
Premises	4,806	3,934
Increase / (decrease) in provision for impairment of receivables	(11)	4
Depreciation on property, plant and equipment	2,058	2,134
Impairments of property, plant and equipment and investment property	286	210
Audit fees: statutory audit *	58	70
Other auditors remuneration: Other services	7	12
Clinical negligence	188	94
Impairment of assets held for sale	-	207
Legal fees	149	84
Consultancy costs	585	466
Training, courses and conferences	579	585
Patient travel	112	53
Car parking and security	5	-
Insurance	128	94
Losses and ex gratia payments	142	34
Other	707	894
	111,720	82,174

* There is no limit on Auditors liability.

4.2 Operating leases

4.2.1 Payments recognised as an expense

	2009/10	2008/09
	£000	£000
Minimum lease payments	729	527

4.2.2 Future minimum lease payments

	2009/10	2008/09
	£000	£000
Payable:		
Not later than one year	647	690
Later than one year and not later than five years	1,651	1,835
Later than five years	15,323	15,433
	17,621	17,958

4.2.3 Significant Leasing Arrangement

The term of the operating lease for properties on the Northern General Hospital site is 125 years from 1 April 1991. The rent payable to Sheffield Teaching Hospitals is £12,025 a month and is based on the capital charges for the buildings. There is no option to renew when the lease finishes on 31 March 2116. At the end of the lease period or following a termination by the tenant, if the landlord sells the property or any part of it, the net proceeds of the sale will be divided between the landlord and the tenant in accordance with a table contained in the lease ranging from 50% / 50% within 1 year of reversion to 100% / nil in favour of the landlord after 10 years from the reversion date.

Under the terms of the lease the following restrictions are imposed; not to assign, sub let, mortgage, charge or part with possession of the whole or part of the property and to only use the property, or any part of it, for the housing and treatment of the mentally handicapped.

5 Employee expenses and numbers

5.1 Employee expenses

	2009/10 £000	2008/09 £000
Salaries and wages	76,539	54,871
Social security costs	5,932	4,338
Employer contributions to NHS pension scheme	8,719	6,173
Employer contributions to other pension schemes	-	-
Agency / contract staff	2,049	1,756
	93,239	67,138

No other employee benefits were provided to staff other than those disclosed above in 2009/10 (nine months ended 31 March 2009 - £nil).

5.2 Average number of people employed

	2009/10 Number	2008/09 Number
Medical and dental	143	132
Ambulance staff	-	-
Administration and estates	495	472
Healthcare assistants and other support staff	189	181
Nursing, midwifery and health visiting staff	1,268	1,080
Nursing, midwifery and health visiting learners	-	-
Scientific, therapeutic and technical staff	356	314
Social care staff	158	158
Bank and agency staff	56	55
Other	6	6
	2,671	2,398

5.3 Early retirements due to ill health

During 2009/10 there were 4 (nine months ended 31 March 2009) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £305,000 (nine months ended 31 March 2009 - £50,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

The employer contributions shown above relate to the NHS Pensions Scheme. There were no share options or long term incentive schemes. No advances, credits or guarantees of any kind were entered into by the Trust on behalf of the directors.

5.4 Directors' Remuneration

Name and title	Period 1.4.09 to 31.3.10				Period 1.7.08 to 31.3.09			
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Employer National Insurance Contributions (rounded to the nearest £000)	Employer Superannuation Contributions (rounded to the nearest £000)	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Employer National Insurance Contributions (rounded to the nearest £000)	Employer Superannuation Contributions (rounded to the nearest £000)
Prof. A Walker, Chairman	25 - 30	-	3	-	20 - 25	-	2	-
A Barney, Non-Executive Director	0 - 5	-	-	-	5 - 10	-	-	-
E Jones, Non-Executive Director	0 - 5	-	-	-	5 - 10	-	-	-
Cllr. M Rooney, Non-Executive Director	10 - 15	-	1	-	5 - 10	-	-	-
M Rosling, Non-Executive Director	10 - 15	-	1	-	5 - 10	-	-	-
H Morris, Non-Executive Director	0	-	-	-	0 - 5	-	-	-
A Clayton, Non-Executive Director	5 - 10	-	1	-	-	-	-	-
M Thomas, Non-Executive Director	5 - 10	-	1	-	-	-	-	-
S Rogers, Non-Executive Director	5 - 10	-	1	-	-	-	-	-
K Taylor, Chief Executive	130 - 135	-	15	18	95 - 100	-	11	12
M Rodgers, Deputy Chief Executive/Executive Director of Finance	105 - 110	-	11	15	75 - 80	-	8	11
Dr T Kendall, Executive Medical Director	60 - 65	115 - 120	20	19	40 - 45	80 - 85	14	12
C Clarke, Executive Director of Operations and Social Care	95 - 100	-	11	14	70 - 75	-	6	9
K Tomlinson, Executive Director of Governance, Performance and Nursing	95 - 100	-	11	14	70 - 75	-	8	10

The employer contributions shown above relate to the NHS Pensions Scheme. There were no share option or long term incentive schemes. No advances, credits or guarantees of any kind were entered into by the Trust on behalf of the directors.

6 Finance income

	2009/10	2008/09
	£000	£000
Interest income:		
Bank accounts	29	82
Other loans and receivables	6	-
Total	35	82

7 Finance costs

The Trust did not incur any interest expense in 2009/10 (nine months ended 31 March 2009 - £nil).

In addition, no payments were made during 2009/10 under The Late Payment of Commercial Debts (Interest) Act 1998 (nine months ended 31 March 2009 - £nil).

8 Intangible assets

	Computer Software - Purchased	
	2009/10	2008/09
	£000	£000
Gross cost at 1 April 2009 / 1 July 2008	18	18
Disposals	(10)	-
Gross cost at 31 March	8	18
Amortisation at 1 April 2009 / 1 July 2008	18	18
Disposals	(10)	-
Amortisation at 31 March	8	18
Net book value - opening		
At 1 April 2009 / 1 July 2008	-	-
Net book value - closing		
At 31 March	-	-

9 Property, plant and equipment

	Land	Buildings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
2009/10:								
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Cost or valuation at 1 April 2009	14,414	59,325	279	799	607	1,723	1,687	78,834
Additions purchased	-	9	765	60	39	40	-	913
Impairments charged to revaluation reserve	(6,754)	(14,217)	(307)	-	-	-	-	(21,278)
Reclassifications	-	(20)	(96)	56	9	51	-	-
Revaluation surpluses	1,524	3,897	-	-	-	-	-	5,421
Reclassified as held for sale	-	-	(16)	-	-	-	-	(16)
Disposals	-	(230)	-	(72)	(228)	(195)	(1,547)	(2,272)
At 31 March 2010	**9,184**	**48,764**	**625**	**843**	**427**	**1,619**	**140**	**61,602**
Depreciation at 1 April 2009	-	1,892	-	337	403	1,112	1,633	5,377
Provided during year	-	1,678	-	87	57	224	12	2,058
Impairments recognised in operating expenses	14	242	-	-	-	-	-	256
Impairments charged to revaluation reserve	-	(1,927)	-	-	-	-	-	(1,927)
Revaluation surpluses	(14)	(203)	-	-	-	-	-	(217)
Disposals	-	-	-	(72)	(228)	(195)	(1,547)	(2,042)
Depreciation at 31 March 2010	**-**	**1,682**	**-**	**352**	**232**	**1,141**	**98**	**3,505**
Net book value								
Purchased	14,414	56,710	279	462	204	611	54	72,734
Donated	-	723	-	-	-	-	-	723
Total at 1 April 2009	**14,414**	**57,433**	**279**	**462**	**204**	**611**	**54**	**73,457**
Net book value								
Purchased	9,184	46,456	625	491	195	478	42	57,471
Donated	-	626	-	-	-	-	-	626
Total at 31 March 2010	**9,184**	**47,082**	**625**	**491**	**195**	**478**	**42**	**58,097**
Analysis of property, plant and equipment - net book value								
Protected	4,525	35,553	-	-	-	-	-	40,078
Unprotected	4,659	11,529	625	491	195	478	42	18,019
Total at 31 March 2010	**9,184**	**47,082**	**625**	**491**	**195**	**478**	**42**	**58,097**

An amount of £256,000 was charged to operating expenses in respect of the impairment of property in the year ended 31 March 2010.

No assets were held under finance leases or hire purchase contracts as at 31 March 2010

Prior year:	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
2008/09:	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 July 2008	14,450	65,794	1,776	716	637	1,663	1,687	86,723
Additions purchased	-	57	1,434	83	56	91	-	1,721
Additions donated	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	(2)	(5,322)	-	-	-	-	-	(5,324)
Impairments recognised in operating expenses	-	-	-	-	-	-	-	-
Reclassifications	-	2,864	(2,931)	-	-	67	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-
Reclassified as held for sale	(34)	(4,068)	-	-	-	-	-	(4,102)
Disposals		-	-	-	(86)	(98)	-	(184)
At 31 March 2009	**14,414**	**59,325**	**279**	**799**	**607**	**1,723**	**1,687**	**78,834**
Depreciation at 1 July 2008	-	597	-	277	444	1,020	1,595	3,933
Provided during period	-	1,801	-	60	45	190	38	2,134
Acquisition through business combination	-	-	-	-	-	-	-	-
Impairments recognised in operating expenses	-	210	-	-	-	-	-	210
Reversal of Impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluation surpluses	-	(716)	-	-	-	-	-	(716)
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(86)	(98)	-	(184)
Depreciation at 31 March 2009	**-**	**1,892**	**-**	**337**	**403**	**1,112**	**1,633**	**5,377**
Net book value								
Purchased	14,450	64,451	1,776	439	193	643	92	82,044
Donated	-	746	-	-	-	-	-	746
Total at 1 July 2008	**14,450**	**65,197**	**1,776**	**439**	**193**	**643**	**92**	**82,790**
Net book value								
Purchased	14,414	56,710	279	462	204	611	54	72,734
Donated	-	723	-	-	-	-	-	723
Total at 31 March 2009	**14,414**	**57,433**	**279**	**462**	**204**	**611**	**54**	**73,457**
Analysis of property, plant and equipment - net book value								
Protected	10,339	46,745	-	-	-	-	-	57,084
Unprotected	4,075	10,688	279	462	204	611	54	16,373
Total at 31 March 2009	**14,414**	**57,433**	**279**	**462**	**204**	**611**	**54**	**73,457**

An amount of £210,000 was charged to operating expenses in respect of the impairment of property in the nine month period ended 31 March 2009.

No assets were held under finance leases or hire purchase contracts as at 31 March 2009

10 Investment Property

10.1 Investment Property - Carrying Value

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
As at 1 April 2009 / 1 July 2008	-	-	-
Additions in year - reclassification	230	-	-
Impairments recognised in expenses	(30)	-	-
As at 31 March	**200**	-	-

10.2 Investment property expenses

	2009/10 £000	2008/09 £000
Direct operating expense arising from investment property generating rental income in the year	**27**	-

10.3 Investment property income

	2009/10 £000	2008/09 £000
Investment property income	33	-

11 Inventories

11.1 Inventories

	31 March 2010 £000	31 March 2009 £000	1 July 2008 £000
Consumables	**182**	428	124

11.2 Inventories recognised in expenses

	2009/10 £000	2008/09 £000
Inventories recognised as an expense in the period	**2,307**	1,545
Write-down of inventories (including losses)	**7**	-
	2,314	1,545

12.1 Trade and other receivables

	Current			Non-current		
	31 March 2010	31 March 2009	1 July 2008	**31 March 2010**	31 March 2009	1 July 2008
	£000	£000	£000	**£000**	£000	£000
NHS receivables	**1,792**	2,938	3,334	**338**	353	376
Other receivables with related parties	**1,451**	1,672	1,719	**3,051**	1,366	3,498
Provision for impaired receivables	**(22)**	(33)	(29)	**-**	-	-
Prepayments	**300**	247	441	**258**	257	683
Accrued income	**438**	222	-	**-**	-	-
PDC receivable	**47**	-	-	**-**	-	-
Other receivables	**319**	390	170	**-**	-	-
	4,325	5,436	5,635	**3,647**	1,976	4,557

The majority of trading is with primary care trusts, as commissioners for NHS patient care services. As primary care trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary. In addition, commissioning of social care is through public sector funded bodies, such as councils and housing associations. Again, no credit scoring is considered necessary.

12.2 Ageing of impaired receivables

	31 March 2010	31 March 2009
	£'000	£'000
Up to three months	**-**	-
In three to six months	**-**	-
Over six months	**22**	33
	22	**33**

12.3 Receivables past their due date but not impaired

	31 March 2010	31 March 2009
	£'000	£'000
By up to three months	**708**	757
By three to six months	**30**	123
By more than six months	**419**	212
Total	**1,157**	**1,092**

12.4 Provision for impairment of receivables

	31 March 2010	31 March 2009
	£'000	£'000
Balance at 1 April 2009 / 1 July 2008	**33**	29
Increase in provision	**-**	4
Unused amounts reversed	**(11)**	-
Balance at 31 March	**22**	33

13 Cash and cash equivalents

	31 March 2010	31 March 2009	1 July 2008
	£'000	£'000	£'000
Balance at 1 April 2009 / 1 July 2008 / 31 March 2008	2,103	1,460	222
Net change in year	8,878	643	1,238
Balance at 31 March	10,981	2,103	1,460
Made up of			
Cash at commercial banks and in hand	346	238	112
Cash with the Government Banking Service	4,031	1,865	1,348
Other current investments	6,604	-	
	10,981	2,103	1,460

14 Non-current assets held for sale

Current year: 2009/10	Property, plant and equipment	Other assets	Total
	£000	£000	£000
As at 1 April 2009	4,422	428	4,850
Assets classified as available for sale in the year	16	-	16
Assets sold in year	(4,438)	(428)	(4,866)
As at 31 March 2010	-	-	-

Prior year: 2008/09	Property, plant and equipment	Other assets	Total
	£000	£000	£000
As at 1 July 2008	587	-	587
Assets classified as available for sale in the year	4,042	428	4,470
Impairment of assets held for sale	(207)	-	(207)
As at 31 March 2009	4,422	428	4,850

Details of the non current assets held for sale are:

Domestic Properties

At 1 July 2008, the Trust held four domestic properties which had been declared surplus to operational requirements by the predecessor Trust, Sheffield Care Trust. In addition a further domestic property was declared surplus to Trust requirements in July 2008.

As a result of the fall in the domestic housing market in Sheffield during 2008/09 and the impact of the general UK economic downturn, the domestic properties were not sold in 2008/09. A revaluation of these properties was undertaken in January 2009 and a reduction in carrying value of £207,000 was recorded in the nine months ended 31 March 2009.

The five properties were sold during the year, realising gross proceeds of £714,000. This reflects the improvement in the domestic property market in Sheffield during 2009/10.

Beighton

Beighton Hospital was declared surplus to operational requirements by the Trust in March 2009. The property was therefore classified as an available for sale asset.

The sale to Sheffield Childrens Hospital NHS Foundation Trust took place in October 2009 and realised proceeds of £4,500,000.

15 Trade and other payables

	Current			Non-current		
	31 March 2010	31 March 2009	1 July 2008	**31 March 2010**	31 March 2009	1 July 2008
	£000	£000	£000	**£000**	£000	£000
NHS payables	**2,359**	2,101	3,791	**-**	-	-
Amounts due to other related parties	**760**	493	87	**-**	-	-
Trade payables - capital	**75**	328	487	**-**	-	-
Other trade payables	**969**	1,976	1,669	**-**	-	-
Other payables	**-**	-	-	**-**	-	-
Accruals	**2,002**	2,184	2,352	**-**	-	-
	6,165	7,082	8,386	**-**	-	-
Taxes payable	**1,910**	1,809	1,752	**-**	-	-
	8,075	8,891	10,138	**-**	-	-

16 Other liabilities

	Current			Non-current		
	31 March 2010	31 March 2009	1 July 2008	**31 March 2010**	31 March 2009	1 July 2008
	£000	£000	£000	**£000**	£000	£000
Deferred Income	**489**	372	108	**-**	-	-
Deferred Government Grant	**8**	12	12	**451**	232	241
Net Pension Scheme Liability	**-**	-	-	**3,120**	1,366	3,498
	497	384	120	**3,571**	1,598	3,739

17 Prudential Borrowing Limit

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

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

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

Further information on the *NHS Foundation Trust Prudential Borrowing Code* and *Compliance Framework* can be found on the website of Monitor, the independent Regulator of Foundation Trusts

The Trust's prudential borrowing limit is:

	Year ended 31 March 2010 £'000	9 months ended 31 March 2009 £'000
Total long term borrowing limit set by Monitor	22,700	16,000
Working capital facility agreed by Monitor	8,100	8,100
Total Prudential Borrowing Limit	**30,800**	24,100

Neither of the above facilities were utilised by the Trust in 2009/10 or in the nine months to 31 March 2009.

The financial ratios for 2009/10 and 2008/09 as published in the Prudential Borrowing Code are shown below, together with the actual level of achievement by the Trust.

Financial ratio	Actual ratios 2009/10	Approved PBL ratios 2009/10	Actual ratios 2008/09	Approved PBL ratios 2008/09
Minimum Dividend Cover	2.8	>1	2.3	>1
Maximum Debt/ Assets Ratio	-	25%	-	25%
Minimum Interest Cover	-	>3	-	>3
Minimum Debt Service Cover	-	>2	-	>2
Maximum Debt Service to Revenue	-	<3%	-	<3%

As the Trust did not require any loans, only the minimum dividend cover ratio is applicable. The Trust has remained within the limits set in the Prudential Borrowing Code and is in line with plan.

18 Provisions

	Current			Non-current		
	31 March 2010	31 March 2009	1 July 2008	31 March 2010	31 March 2009	1 July 2008
	£'000	£'000	£'000	£'000	£'000	£'000
Legal claims	112	100	85	-	-	-
Agenda for change	-	282	-	-	-	-
Other	114	239	40	470	493	477
Total	226	621	125	470	493	477

	Legal claims	Agenda for change	Other	Total
	£'000	£'000	£'000	£'000
At 1 April 2009	100	282	732	1,114
Arising during the year	57	-	96	153
Used during the year	(22)	(72)	(110)	(204)
Reversed unused	(23)	(210)	(134)	(367)
At 31 March 2010	112	-	584	696
Expected timing of cash flows:				
Not later than one year	112	-	114	226
Later than one year and not later than five years	-	-	167	167
Later than five years	-	-	303	303

Legal claims relate to claims brought against the Trust for Employers Liability or Public Liability. These cases are handled by the NHSLA, who provide an estimate of the Trust's probable liability. Actual costs incurred are subject to the outcome of legal action. Costs in excess of £10,000 per case are covered by the NHSLA and are not included above.

Agenda for Change - the £282,000 opening balance relates to grading claims from former local authority resource centre staff transferring to Agenda for Change terms and conditions. £72,000 of these claims have been utilised and the balance reversed as the remaining liability is treated as 'accounts payable' as at 31st March 2010.

Details of 'Other' provisions are:

(i) £515,000 relating to Injury Benefits. These are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority. The value shown is the value of payments due to the individuals for the term indicated by Government Actuary life expectancy tables, and the actual value of this figure represents the main uncertainty in the amounts shown. (31 March 2009 - £532,000); and

(ii) £69,000 relating to Clinical Excellence Awards for Consultants (31 March 2009 - £200,000). In line with national requirements the Trust is obliged to award a number of discretionary local clincial excellence awards each year to consultant medical staff. Applications are submitted to a Trust Panel which determines the allocation of these awards. As this process is based on evidencing retrospective work undertaken, the awards cannot be made until the following year when the payments are then back dated. Although the number of awards allocated is specified the recipients and value of these awards can vary and a provision is made based on historical trends and a mix of lower and higher value awards.

Of the total provision of £696,000 (31 March 2009 - £1,514,000), £370,000 (31 March 2009 - £384,000) has been covered by 'back-to-back' income arrangements with the Trust's major customers.

£957,000 is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the Trust (31 March 2009 - £38,000).

19 Contingent liabilities

	2009/10	2008/09
	£000	£000
Gross value	90	62

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

20 Financial Instruments

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the international financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has low exposure to interest rate fluctuations as it has no borrowings and any excess funds are invested on a short term basis with low risk institutions.

Credit risk

As the majority of the Trust's income comes from contracts with public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2010 are in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts and local authorities, which are financed from resources voted annually by Parliament. The Trust finance its capital expenditure from funds made obtained within its prudential borrowing limit. The Trust is therefore not exposed to significant liquidity risks.

20.1 Financial assets

	31 March 2010	31 March 2009
	£'000	£'000
Denominated in £ Sterling - Floating interest rate	**10,917**	2,040

The financial assets which have a floating rate of interest are cash held at the Government Banking Service and cash held with commercial banks. This cash is held on short term deposit. All other financial assets, including non-current assets, are non interest bearing. The Trust has no financial assets with fixed interest rates.

20.2 Financial liabilities

The Trust has no financial liabilities with floating or fixed rates of interest. They are all non interest bearing.

20.3 Financial assets by category

	31 March 2010	31 March 2009
	£'000	£'000
Loans and Receivables		
NHS receivables	2,130	3,291
Other receivables with related parties	4,308	2,909
Provision for irrecoverable debts	(22)	(33)
Accrued income	438	222
Other receivables	319	364
Cash at bank and in hand	10,981	2,103
	18,154	8,856

20.4 Financial liabilities by category

	31 March 2010	31 March 2009
	£000	£000
Other financial liabilities		
NHS payables	2,359	2,101
Other payables with related parties	760	493
Trade payables - capital	75	328
Other trade payables	969	1,976
Other payables	-	-
Accruals	2,002	2,184
Provisions under contract	69	482
Total at 31 March	**6,234**	**7,564**

20.5 Fair values

The fair value of the Trust's financial assets and financial liabilities at 31 March 2010 equates to the book value.

21 Third Party Assets

The Trust held cash of £467,954 at bank and in hand at 31 March 2010 (31 March 2009 - £412,730) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand amount reported in the accounts.

22 Losses and Special Payments

There were 53 cases (nine months ended 31 March 2009 - 18 cases) of losses and special payments totalling £153,000 (nine months ended 31 March 2009 - £34,000) approved during the year ended 31 March 2010.

23 Events after the reporting period

There are no events after the reporting period.

24 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	31 March 2010	31 March 2009
	£000	£000
Property, plant and equipment	**126**	328

25 Related party transactions

Sheffield Health and Social Care NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year the Trust has had transactions with a number or organisations with which key employees/ directors of the Trust have some form of relationship. These are detailed below:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Beachcroft LLP	157,633	-	20,779	-
Royal College of Psychiatrists	13,013	76,734	3,408	150
University of Sheffield	628,012	32,961	208,010	4,348
Sheffield Hospitals Charitable Trusts	612	24,621	-	3,376

The relationships are:

- The Associate Director of Human Resources, who resigned during 2009/10, is a personal friend of one of the Partners at Beachcroft LLP.
- The Executive Medical Director is Deputy Director of the Royal College of Psychiatrists.
- The Chair is Professor of Social Policy at the University of Sheffield.
- A Non Executive Director, who resigned during 2009/10, is Chair of the Sheffield Hospitals Charitable Trust.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial position and results may have been affected by the existence of related parties and by material transactions with them. In the cases above, all payments shown have been made by the Trust to the companies concerned and not to the individual officers.

The value of transactions with related parties during the year is given below:

	2009/10		2008/09	
	Income	Expenditure	Income	Expenditure
	£000	£000	£000	£000
Department of Health	255	-	617	-
Other NHS bodies	92,653	(12,499)	67,031	(2,848)
Charitable funds	25	(1)	37	-
Other bodies (including WGA)	11,020	(8,035)	6,880	(11,176)
	103,953	**(20,535)**	74,565	(14,024)

The value of transactions with board members and key staff members in 2009/10 is £nil (2008/09 - £nil). Disclosures relating to salaries of board members are given in Note 5.4.

The value of receivables and payables balances held with related parties as at the date of the statement of financial position is given below:

	31 March 2010		31 March 2009	
	Receivables	Payables	Receivables	Payables
	£000	£000	£000	£000
Department of Health	103	-	1	-
Other NHS bodies	2,074	(2,359)	3,290	(1,055)
Charitable funds	3	-	14	-
Other bodies (including WGA)	4,507	(2,902)	3,024	(3,348)
	6,687	(5,261)	6,329	(4,403)

Value of balances (other than salary) with board members and key staff members at 31 March 2010 is £nil (31 March 2009 - £nil).

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2010 is £nil (31 March 2009 - £nil). In addition, the value of balances (other than salary) with related parties in relation to the writing off of receivables during 2009/10 is £nil (2008/09 - £nil).

The Department of Health is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Yorkshire and the Humber Strategic Health Authority

Sheffield Primary Care Trust (NHS Sheffield)

Barnsley Primary Care Trust

Derbyshire County Primary Care Trust

Rotherham Primary Care Trust

Derbyshire Mental Health Services NHS Trust

Nottinghamshire Healthcare NHS Trust

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust

Sheffield Childrens Hospital NHS Foundation Trust

Sheffield Teaching Hospital NHS Foundation Trust

NHS Litigation Authority

NHS Professionals

NHS Purchasing and Supply Agency

In addition, the Trust has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with HM Revenue and Customs, the NHS Pension Scheme as well as with Sheffield City Council in respect of joint enterprises and the South Yorkshire Pension Scheme.

26 South Yorkshire Pensions Fund - Retirement Benefit Obligations

The total defined benefit pension cost for 2009/10 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £410,000 (nine months ended 31 March 2009 - £428,000). A pension deficit of £3,120,000 is included in the statement of financial position as at 31 March 2010 (31 March 2009 - £1,366,000 deficit).

The terms of the current partnership agreement with Sheffield City Council provide that any long term pension liability arising from the scheme will be funded by the Council, with the exception of any pension changes which relate to an increase in salary in excess of any local government grading agreements. The impact on the current and prior year statement of consolidated income and taxpayers equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is negated by the inclusion of a corresponding non-current receivable with the Council. As at 31 March 2010, the deficit on the scheme was £3,120,000 (31 March 2009 - £1,366,000 deficit), the majority of which is offset by a non-current receivable of £3,051,000 (31 March 2009 - £1,366,000).

The main actuarial assumptions used at the date of the statement of financial position in measuring the present value of defined benefit scheme liabilities are:

	31 March 2010	31 March 2009
	%	%
Rate of inflation	**3.5**	3.3
Rate of increase in salaries	**5.0**	4.8
Rate of increase in pensions and deferred pensions	**3.5**	3.3
Discount rate	**5.8**	7.1
Expected rate of return on assets	**0.5 - 7.5**	0.5 - 7.5

The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:

	31 March 2010	31 March 2009
	Years	Years
Non retired member - Male (aged 65 in 20 years time)	**21.3**	21.3
Non retired member - Female (aged 65 in 20 years time)	**24.1**	24.1
Retired member - Male	**20.4**	20.3
Retired member - Female	**23.2**	23.2

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme assets	**31 March 2010**	Scheme assets	31 March 2009
	%	**£'000**	%	£'000
Equities	**64.6**	**6,649**	59.8	4,608
Government Bonds	**15.4**	**1,585**	17.1	1,317
Other Bonds	**7.9**	**813**	7.5	578
Property	**9.1**	**937**	10.7	824
Cash / Liquidity	**3.0**	**309**	4.9	377
Total fair value of assets	**100.0**	**10,293**	100.0	7,704
Present value of defined benefit obligation		**(13,413)**		(9,070)
Net retirement benefit deficit		**(3,120)**		(1,366)

Movements in the present value of the defined benefit obligations are:

	2009/10	2008/09
	£'000	£'000
At 1 April 2009 / 1 July 2008	**(9,070)**	(12,553)
Current service cost	**(239)**	(308)
Interest on pension liabilities	**(645)**	(567)
Member contributions	**(132)**	(92)
Actuarial (losses) / gains on liabilities	**(3,657)**	4,159
Benefits paid	**330**	291
At 31 March	**(13,413)**	(9,070)

Movements in the fair value of the scheme's assets were:	**2009/10**	2008/09
	£'000	£'000
At 1 April 2009 / 1 July 2008	**7,704**	9,055
Expected return on plan assets	**474**	447
Actuarial gains / (losses) on assets - current year	**2,013**	(1,820)
Employer contributions	**300**	221
Member contributions	**132**	92
Benefits Paid	**(330)**	(291)
At 31 March	**10,293**	7,704

The net pension expense recognised in operating expenses in respect of the scheme is:	**Year ended 31 March 2010**	9 months ended 31 March 2009
	£'000	£'000
Current service cost	**(239)**	(308)
Past service costs	**-**	-
Pension expense charged to operating surplus	**(239)**	(308)
Expected return on plan assets	**474**	447
Interest on pension liabilities	**(645)**	(567)
Pension expense credited	**(171)**	(120)
Net pension charged	**(410)**	(428)

The reconciliation of the opening and closing statement of financial position is as follows:	**2009/10**	2008/09
	£'000	£'000
At 1 April 2009 / 1 July 2008	**(1,366)**	(3,498)
Expenses recognised in the statement of comprehensive income	**(410)**	(428)
Contributions paid	**300**	221
Actuarial gains / (losses) - current year	**(1,644)**	2,339
At 31 March	**(3,120)**	(1,366)

Actuarial gains and losses are recognised directly in the Income and Expenditure reserve. At 31 March 2010, a cumulative amount of £69,000, was recorded in the Income and Expenditure Reserve.

The history of the scheme for the current and prior year is:	**Year ended 31 March 2010**	9 months ended 31 March 2009	3 months ended 30 June 2008
	£'000	£'000	£'000
Present value of defined benefit obligation	**(13,413)**	(9,070)	(12,553)
Fair value of scheme assets	**10,293**	7,704	9,055
Net retirement obligation	**(3,120)**	(1,366)	(3,498)

Experience gains on scheme liabilities for 2009/10 are £nil (nine months ended 31 March 2009 - £nil) and experience gains on scheme assets are £2,013,000 (nine months ended 31 March 2009 - loss of £1,820,000).

27 Transition to IFRS

27.1 Statement of Financial Position

These financial statements are prepared in accordance with adopted IFRSs

The accounting policies set out in notes 1.1 to 1.17 have been applied in preparing the financial statements for the year ended 31 March 2010, the comparative information presented in these financial statements for the year ended 31 March 2009 and in the preparation of an opening IFRS balance sheet at 1 July 2008.

In preparing its opening IFRS balance sheet the Foundation Trust has adjusted amounts reported previously in financial statements prepared in accordance with its old basis of accounting (UK GAAP). An explanation of how the transition from UK GAAP to adopted IFRSs has affected the Trust's financial position, financial performance and cash flows is set out in the following table and notes that accompany the table.

31st March 2009	Note	UK GAAP	Effect of transition to adopted IFRSs	Adopted IFRSs	1st July 2008 UK GAAP	Effect of transition to adopted IFRSs	Adopted IFRSs
		£000	£000	£000	£000	£000	£000
Non-current assets							
Intangible assets		0		0			0
Property, plant and equipment	a	81,146	(7,689)	73,457	88,562	(5,772)	82,790
Trade and other receivables	b	0	1,976	1,976	0	4,557	4,557
Total non-current assets		81,146	(5,713)	75,433	88,562	(1,215)	87,347
Current assets							
Inventories		428		428	124		124
Trade and other receivables	b	6,686	(1,719)	4,967	9,503	(4,309)	5,194
Other current assets		469		469	0	441	441
Cash and cash equivalents		2,103		2,103	1,460		1,460
Non-current assets held for sale	c		4,850	4,850	0	587	587
Total current assets		9,686	3,131	12,817	11,087	(3,281)	7,806
Current liabilities							
Trade and other payables	d	(7,152)	70	(7,082)	(8,224)	(162)	(8,386)
Borrowings		0		0	0		0
Provisions	e	0	(621)	(621)	0	(125)	(125)
Tax payable		(1,809)		(1,809)	(1,752)		(1,752)
Other liabilities	f	0	(384)	(384)	0	(120)	(120)
Total current liabilities		(8,961)	(935)	(9,896)	(9,976)	(407)	(10,383)
Total assets less current liabilities		81,871	(3,517)	78,354	89,673	(4,903)	84,770

Non-current liabilities							
trade and other payables		**(1,598)**	1,598	**0**	(3,739)	3,739	0
Borrowings				**0**	0		0
Provisions	**e**	**(1,115)**	**622**	**(493)**	(602)	125	(477)
Other liabilities	**f**		**(1,598)**	**(1,598)**	0	(3,739)	(3,739)
Total non-current liabilities		**(2,713)**	**622**	**(2,091)**	**(4,341)**	**125**	**(4,216)**
Total assets employed		**79,158**	**(2,895)**	**76,263**	**85,332**	**(4,778)**	**80,554**
FINANCED BY:							
Taxpayers' equity							
Public dividend capital		**33,572**		**33,572**	33,572		33,572
Revaluation reserve		**36,588**	**(1,949)**	**34,639**	43,882	(4,086)	39,796
Donated asset reserve		**723**		**723**	746		746
Income and expenditure reserve		**8,275**	**(946)**	**7,329**	7,132	(692)	6,440
Total taxpayers' equity		**79,158**	**(2,895)**	**76,263**	**85,332**	**(4,778)**	**80,554**

Notes

a. Reclassification of long leashold land and of properties held for sale under IFRS

b. Longer term receivables re-categorised under IFRS.

c. Reclassification of buildings to non current assets held for sale under IFRS.

d. Re-categorisation of deferred income to other liabilities and inclusion of additional holiday pay accrual

e. Shorter term provisions re-categorised under IFRS.

f. Reclassification of deferred income to other liabilities

27.2 Statement of Total Comprehensive Income

	£,000
Surplus for 2008/09 under UK GAAP	**642**
Adjustment for:	
Leasehold land	(4)
Accrual for compensated absences	(30)
Impairment of non current assets held for sale	(207)
Revaluation loss on property, plant and equipment	(4,667)
Reduction in donated asset reserve in respect of depreciation of donated assets	(23)
Total Comprehensive Income for 2008/09 under IFRS	**(4,289)**

27.3 Cash flow for 2008/09

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £643,000. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

16. Glossary of Key Financial Information and Technical Terms

Annual Accounts
Documents prepared by the Trust to show its financial position.

Accounts Payable (Creditor)
A supplier who has delivered goods or services in the accounting period and has invoiced the Trust, but has not yet been paid.

Accounts Receivable (Debtor)
An organisation which has received a service from the Trust in the accounting period and has been invoiced by the Trust, but has not yet paid.

Asset
Something which is owned by the Trust. For example, a building or a piece of equipment, some cash or an amount of money owed to the Trust.

Budget
Represents the amount of money available for a service in a period of time and is compared to actual spend for the same period

Capital Expenditure
Money spent on buildings and valuable pieces of equipment such as major computer purchases.

Cash Equivalent Transfer (Pensions)
This is the total value of the pension scheme benefits accrued (i.e. saved up) which are the contributions paid by a member of staff and the Trust over the period of employment. These funds are invested and valued at a point in time by an actuary. The cash equivalent transfer value is the amount which would be transferred, if a staff member moved to work for a different organisation.

Current Assets
There are assets, which are normally used or disposed of within the financial year.

Current Liabilities
Represents monies owed by the Trust that are due to be paid in less than one year.

Deferred Income
Funding received from another organisation in advance of when we will spend it.

Depreciation
An accounting charge which represents the use, or wearing out of an asset. The cost of an asset is spread over its useful life.

Donated Asset Reserve
This represents the value of property, plant and equipment which has been, either donated to the Trust, or purchased from donated funds.

EBITDA
Earnings Before Interest, Tax Depreciation and Amortisation - this is a key indicator of financial performance and profitability and indicates the ability to pay the dividends due to the Government in respect of the 3.5% return on assets the Trust is expected to achieve. The EBITDA is used to calculate some of Monitor's risk ratings.

Going concern
The accounts are prepared on a going concern basis which means that the Trust expects to continue to operate for at least the next 12 months.

IFRS (International Financial Reporting Standards)
The professional standards trusts must use from April 2009 when preparing the annual accounts.

Impairment
A decrease in the value of an asset.

Income and Expenditure Reserve
This is an accumulation of transfers to / from the Revaluation Reserve as well as the cumulative surpluses and deficits reported by the Trust, including amounts brought forward from when it was an NHS Trust.

Intangible asset
An asset which is without substance, for example computer software.

Inventories
Stocks such as clinical supplies.

Liability
Something which the Trust owes, for example a bill which has not been paid.

MEA (Modern Equivalent Asset)
This is an instant build approach, using alternative site valuation in some circumstances.

Monitor
The organisation Monitor was established in January 2004 to authorise and regulate NHS Foundation Trusts.

Net Book Value
The net book value is the lower of the cost to the business to replace a fixed asset or the recoverable amount if the asset was sold (net of expenses).

Non-current assets held for sale
Buildings which are no longer used by the Trust which have been declared surplus by the Board and available for sale.

Non-current asset or liability
An asset or liability which the FT expects to hold for longer than one year**.**

Non-executive director
These are members of the Trust's board of directors, however they do not have any involvement in the day to day management of the Trust. Their role is to provide the Board with independent challenge and scrutiny.

Payment By Result
A national tariff of fixed prices that reflect national average prices for hospital procedures. Already in use in acute trusts and currently being developed for mental health and learning disabilities services.

Provisions for Liabilities and Charges
These are amounts set aside for potential payments to third parties, which are uncertain in amount or timing, for example claims arising from litigation.

Public Dividend Capital
This is a type of public sector equity finance based on the excess of assets over liabilities at the time of the establishment of the predecessor NHS Trust. It is similar to a company's share capital.

Public Dividend Capital Payable
This is an amount paid to the Government for funds made available to the Trust.

Prudential Borrowing Limit
An NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This means that the total of borrowings by an NHS Foundation Trust from all sources must be contained within the borrowing limit set for it by Monitor in the Terms of Authorisation.

Reference Cost
The costs of the Trust's services are produced for the Department of Health for comparison with other similar trusts.

Revaluation Reserve
This represents the increase or decrease in the value of property, plant and equipment over its historic cost.

Service Line Reporting
A system which identifies income and expenditure and then produces gross profit across defined 'business units', with the aim of improving quality and productivity.

Statement of Cashflows
Shows the cash flows in and out of the Trust during the period.

Statement of Changes in Taxpayers' Equity
This statement shows the changes in reserves and public dividend capital during the period.

Statement of Comprehensive Income
This statement was previously called 'Income and Expenditure Account'. It summarises the expenditure on pay and non pay running costs less income received, which results in a surplus or deficit.

Statement of Financial Position
A year end statement which provides a snapshot of the Trust's financial position at a point in time. The top half shows the Trust's total net assets (assets minus liabilities). The bottom half shows the Taxpayers Equity or investment in the Trust.

Statement on Internal Control
A statement about the controls the FT has in place to manage risk.

UK GAAP (Generally Accepted Accounting Practice
This was the standard basis of accounting in the UK before the international financial reporting standards were adopted.

17. Contacts

Headquarters
Sheffield Health and Social Care NHS Foundation Trust
Fulwood House
Old Fulwood Road
Sheffield
S10 3TH

Tel: 0114 271 6310 (24 hour switch board)
www.shsc.nhs.uk

Patient Advice and Liaison Service (PALS)
The PALS team offers support, information and assistance to service users, their carers, families and visitors.

Tel: 0114 271 8768

Human Resources
If you are interested in a career with SHSC, please visit the website for vacancies within the Trust – www.shsc.nhs.uk.

Communications
If you have any comments on this report or would like to have a version in another language or format such as in audio or easy to read, please contact Chipo Kazoka, Company Secretary, on 0114 271 6710.

Membership
If you want to become a member of the Trust or want to find out more about the services it provides, please contact 0114 271 8825.

Sheffield Health and Social Care
NHS Foundation Trust

NHS

Sheffield Health and Social Care NHS Foundation Trust
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